Essex Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS MEETING
PART 1

BOARD OF DIRECTORS MEETING PART 1

5 August 2026

10:00 GMT+1 Europe/London

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

AGENDA

AGENDA

REFERENCES

Only PDFs are attached

#0 Part 1 BoD Agenda 05.08.2026.pdf

Meeting of the Board of Directors held in Public
Wednesday 5 August 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**	LL	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	LL	Verbal	Noting
PRESENTATION **South Essex Trauma Alliance work** Georgina Beadon Ekers, Senior Physiotherapist, South Essex Alliance Sonam Verma, Assistant Psychologist, South East Essex Trauma Alliance Madeleine Bean, Assistant Psychologist for Southend in South East Essex Adult Community				
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 3 June 2026	LL	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	LL	Attached	Noting
5	Chairs Report (including Governance Update)	LL	Attached	Noting
6	Chief Executive Officer (CEO) Report	AG/TS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
7.1	Quality & Performance Scorecard	AG/TS	Attached	Noting
7.2	Committee Chairs Report	Chairs	Attached	Noting
7.3	CQC Assurance Report	AS	Attached	Noting
7.4	Learning from Deaths Q4 2025/26 Report	AS	Attached	Noting
Questions taken from the General Public				
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
8.1	Board Assurance Framework	AG/TS	Attached	Approval
8.2	Emergency Preparedness, Resilience And Response Annual Report 2025-26	LW	Attached	Noting
8.3	Patient Safety Incident Response Plan	AS	Attached	Noting

8.4	Patient Safety Strategy Q1 2026/27	AS	Attached	Noting
Questions taken from the General Public				
9	**REGULATION AND COMPLIANCE**			
9.1	Safeguarding Annual Report 2025/26	AS	Attached	Noting
9.2	Quarterly Report on Safe Working of Resident Doctors	KS	Attached	Noting
9.3	Responsible Officers & Revalidation Annual Report and Statement of Compliance	KS	Attached	Approval
10	**OTHER**			
10.1	Use of Corporate Seal	AG/TS	Attached	Noting
10.2	Correspondence circulated to Board members since the last meeting.	LL	Verbal	Noting
10.3	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
10.4	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
11	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
11.1	Reflection on risks, issues or concerns including: • Risks for escalation to the CRR or BAF • Risks or issues to be raised with other standing committees	ALL	Verbal	Noting
12	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
13	**DATE AND TIME OF NEXT MEETING** Wednesday 7 October 2026 at 10:00, The Lodge Training room 1			
14	**DATE AND TIME OF FUTURE MEETINGS** Wednesday 2 December 2026 at 10:00, The Lodge Training room 1			

Loy Lobo
Acting Chair

1. APOLOGIES FOR ABSENCE

Standing item LL

2. DECLARATIONS OF INTEREST

Standing item LL

PRESENTATION: SOUTH ESSEX TRAUMA ALLIANCE WORK

Information Item

Georgina Beadon Ekers, Senior Physiotherapist, South Essex Alliance
Sonam Verma ? Assistant Psychologist, South East Essex Trauma Alliance
Madeleine Bean ? Assistant Psychologist for Southend in South East Essex Adult Community Psychological Services

3. MINUTES OF THE PREVIOUS MEETING HELD ON: 3 JUNE 2026

Decision Item LL

REFERENCES

Only PDFs are attached

Board Part 1 Minutes 03.07.2026.pdf

Minutes of the Board of Directors Meeting held in Public

Held on Wednesday 03 June 2026
Held in person at Training Room 1, The Lodge, Lodge Approach, SS11 7XX

MEMBERS PRESENT:

Dr Mateen Jiwani	MJ	Non-Executive Director / Senior Independent Director (Chair)
Paul Scott	PS	Chief Executive Officer
Anna Bokobza	AB	Director of Strategy (for Zephan Trent)
Denver Greenhalgh	DG	Executive Director of Corporate Governance
Ruth Jackson	RJ	Non-Executive Director
Diane Leacock	DL	Non-Executive Director
Loy Lobo	LL	Acting Chair (via MS Teams)
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	Executive Chief Medical Officer
Lizzy Wells	LW	Director of Mental Health Urgent Care and Inpatient Services (for Alex Green)

IN ATTENDANCE:

Angela Laverick	AL	Executive Assistant to Chief Executive, Chair and NEDs (minutes)
Chris Jennings	CJ	Assistant Trust Secretary
Dr Hilary Scott	HS	Director of Pharmacy and Accountable Officer for Controlled Drugs (for Presentation)
Bernie Rochford	BR	Principle Freedom To Speak Up Guardian (for item….)

There were eight members of the Public / Staff Members present.

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

The meeting commenced at 10am.

Tribute to Hattie Llewelyn-Davies
The Chair invited PS to share reflections on the recent passing of the Hattie Llewelyn-Davies, Chair of the Trust.

PS advised that Hattie had sadly passed away on 23 May following a short illness. Hattie had served as the Chair of EPUT for the last year and was widely known and greatly respected locally, regionally and nationally through her previous leadership roles. This included at Princess Alexandrea Hospital NHS Trust and Hertfordshire Partnership University NHS Foundation Trust, as well as through her work within the housing sector.

PS said that Hattie had made a significant and positive impact across the Trust during her time at EPUT and was admired for the compassion, kindness and authenticity she brought to her work. He

described her as a warm, generous individual with a sharp wit and a genuine commitment to others. He also acknowledged her personal advocacy for equality and inclusion, particularly in relation to hidden disabilities, and her support for those experiencing personal challenges. PS noted his personal gratitude for having the opportunity to work alongside Hattie and advised that many heartfelt tributes had been received from colleagues and partners who had worked with her throughout her distinguished career.

MJ acknowledged that the loss of Hattie had been deeply felt across the organisation and wider system. He noted her unwavering appreciation for the contribution of Trust staff and her regular recognition of the dedication and hard work demonstrated by colleagues across EPUT. MJ expressed his thanks to staff for their continued professionalism and commitment during this difficult period.

The Board noted that support remained available to any colleague affected by the loss of Hattie and recognised the importance of continuing the work of the Trust in the manner that reflected the values and principles she championed throughout her career.

The Board recorded its sincere condolences to the family, friends and colleagues of Ms Hattie Llewellyn-Davies and observed a moment of reflection in recognition of her contribution and service.

056/26 APOLOGIES FOR ABSENCE

Apologies were received from:

Alex Green, Executive Chief Operating Officer / Deputy CEO
Sarah Teather, Non-Executive Director
Zephan Trent, Executive Director of Strategy, Transformation & Digital

057/26 DECLARATIONS OF INTEREST

There were no declarations of interest.

058/26 PRESENTATION: PHARMACY AND MEDICINES OPTIMISATION

The Board received a presentation from HS, following an introduction from AS, who noted that this would be HS's final Board meeting before leaving the Trust after many years of service. AS expressed the Board's thanks for HS's contribution to the organisation and offered personal thanks for the support provided since AS joined the Trust.

HS presented an overview of Pharmacy and Medicines Optimisation services, highlighting the critical role pharmacy plays in ensuring patients receive the right medication at the right time, in a person-centred manner that supports adherence to treatment and reduces waste. HS highlighted the following:

- More than two million doses of medication are administered annually within inpatient wards, with significantly greater volumes supplied to community patients.
- The service manages annual medicines expenditure of approximately £5m and undertakes more than 10,000 clinical interventions each year.
- Reflecting on the development of the service, HS noted that, when first joining the organisation and its predecessor bodies 20 years ago, pharmacy services were delivered by a single pharmacist and largely outsourced through acute trust arrangements. The service has since expanded to a multidisciplinary team of more than 100 pharmacy staff, providing comprehensive support to clinicians and patients.
- Pharmacists and pharmacy technicians remain in short supply nationally, making workforce development and retention a key priority. The service continues to invest in trainee placements, apprenticeships and career

progression pathways, while also supporting the development of local Schools of Pharmacy through partnerships with Anglia Ruskin University and other organisations. Newly qualified pharmacists are now entering the profession as both registered pharmacists and independent prescribers.

- Substantial progress had been made to address workforce challenges, with pharmacy vacancy levels reducing from approximately 50% in 2022 to a position where the service is now close to full establishment.
- The Pharmacy and Medicines Optimisation Strategic Plan 2024 – 2028 aims to ensure pharmacy professionals are recognised as valued members of multidisciplinary teams. Progress against the strategy has included increased pharmacist participation in ward rounds, medication reviews and MDT meetings, with pharmacists now contributing to around 280 ward rounds each month.
- The electronic prescribing across inpatient mental health wards, Health Based Places of Safety and Mental Health Urgent Care Departments was successfully implemented. The focus has now shifted to supporting the development of electronic prescribing and medicines administration functionality within the Nova programme. HS noted that establishing effective interoperability between Nova and pharmacy systems would be a significant priority and challenge.
- The service had achieved recurring savings of approximately £1 million per annum over the previous two years through changes to prescribing practices and increased use of non-branded medications where clinically appropriate.

Questions and Discussions

- AM thanked HS for her support and commended the work of the Pharmacy team. Referring to workforce challenges, AM noted that vacancy levels can fluctuate and asked what future opportunities existed to strengthen career pathways and retention. HS advised that structured development pathways had been introduced for pharmacists and pharmacy technicians, providing opportunities for progression through natural career development routes. HS also highlighted the success of the pharmacy technician apprenticeship programme, which had enabled the Trust to recruit apprentices into substantive posts upon qualification.
- KS acknowledged the significant progress achieved within pharmacy services under HS's leadership and thanked HS for support provided to the Medicines Management Group. KS asked about the future integration of EPMA and Nova, noting that the current EPMA system was functioning well and expressing hope for a smooth transition. HS advised that Nova would include electronic prescribing functionality and that work was underway to develop the necessary interfaces between Nova and pharmacy systems.
- During discussion regarding medicines reconciliation, the Board noted the potential benefits of enabling medical staff to access this functionality directly. HS confirmed that this capability was also being developed within Nova.
- EL congratulated HS on the transformation of the pharmacy service and asked how current workforce challenges affected wider service delivery. HS advised that the principal challenge remained the national shortage of pharmacists and pharmacy technicians, which could make some vacancies difficult to fill. HS highlighted ongoing work to increase training opportunities, including partnerships with local higher education institutions and continued support for pharmacy technician training. HS reflected that, historically, workforce shortages had required the service to operate under business continuity arrangements for prolonged periods, limiting pharmacy involvement in clinical teams. Workforce improvements had now enabled pharmacists to play a more active role in ward rounds and multidisciplinary team meetings, ensuring patients benefited from specialist medicines expertise.
- TS recalled the significant staffing challenges previously faced by the service and recognised HS's leadership in developing the team, securing

implementation of the EPMA system and transforming pharmacy services. TS thanked HS for her substantial contribution to the Trust and noted that the pharmacy team was being left in a significantly stronger position than when HS had joined.

- LL referred to the establishment of a single Essex Integrated Care Board and asked about the implications for partnership working. HS advised that, while the new Essex ICB remained at an early stage of development, many key individuals had longstanding experience of working within Essex, supporting strong existing relationships. HS noted that the Trust already worked closely with the ICB Medicines Management Team and that the terms of reference of the Area Prescribing Committee recognised the autonomy of EPUT's Medicines Management Group in relation to mental health prescribing decisions.

MJ thanked HS for the presentation, commending the pharmacy service's success in recruiting and retaining staff through clear development and progression pathways. MJ also highlighted the importance of supporting patients to understand and manage their medications effectively and emphasised the need for the Trust to continue investing in workforce development. Whilst recognising the challenges associated with transformation and system change, MJ reiterated the Board's commitment to supporting the pharmacy team as it continues to develop and respond to future challenges.

The Board noted the presentation and thanked HS for the significant contribution made to the development of pharmacy services during her tenure with the Trust.

059/26 MINUTES OF THE PREVIOUS MEETING HELD ON 01 APRIL 2026

The Board of Directors reviewed the minutes of the meeting held on 01 April 2026, noting the following amendments:

- Page 10 – 042/26 and 043/26 provided a bullet point summarising the timescale of the reporting period and the next report to be presented in October. This should be replicated in 041/26.
- Page 12 – remove final sentence following the date and time of the next meeting.
- Page 13 – amend line "had a completed an equality…" to "had a completed equality…"

With the above amendments, the Board of Directors agreed the minutes as an accurate record and noted the record of questions from Governors/members of the public and the responses.

060/26 ACTION LOG AND MATTERS ARISING

The action log from the meeting held on 1 April 2026 was reviewed and noted all actions had been completed.

061/26 CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

MJ presented a report providing a summary of key headlines and shared information on governance developments within the Trust since the last Board meeting. MJ highlighted changes to Executive Portfolios, the appointment of Loy as the Acting Chair and the forthcoming departure of Paul Scott as CEO.

The Board of Directors:

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

062/26 CEO REPORT

PS presented a report providing an update on key organisational developments and matters for noting, highlighting the following:

- The appointment of Alex Green and Trevor Smith as Interim Joint Chief Executive Officers, providing continuity of leadership across the organisation.

- The appointment of Lizzy Wells as Interim Executive Chief Operating Officer and Jenny Davis as Interim Executive Chief Finance Officer respectively.
- The appointment of Catherine O'Connell as the Senior Responsible Officer for the Lampard Inquiry programme, thanking Denver Greenhalgh for her leadership in the Trust's response to the Inquiry as she transitions back into her substantive role.
- The Trust remained fully committed to supporting the Lampard Inquiry and reported that activity and demand associated with the Inquiry had continued to increase. In response, the Trust had invested additional resources to ensure sufficient capacity was available to meet its obligations.
- The Trust's recognition of Autism Acceptance Month and commended the work being led by Dr Catherine Dakin to improve understanding of autism and support the delivery of more personalised care. This work focused on developing a shared understanding of the experiences and needs of autistic people, both service users and staff, and ensuring that services responded appropriately. PS noted the strong levels of autism training already in place across the Trust and the ambition to further develop this programme.

Reflecting on his tenure as EPUT Chief Executive, PS described the role as a powerful and rewarding experience, highlighting the compassion and commitment demonstrated by colleagues across the Trust. PS noted the important role mental health services play within wider society and reflected on the significant progress achieved during the previous six years despite considerable challenges, including the Covid-19 pandemic and the demands associated with the Lampard Inquiry.

PS reflected that one of the most significant developments during recent years had been the growth of peer support and lived experience roles across the organisation. PS highlighted the positive contribution these roles were making, both to the care provided to patients and to the strategic direction of the Trust. PS noted that this represented the beginning of a continuing journey towards greater inclusion and co-production, supported by local communities and people with lived experience.

Questions and Discussions

- AM provided an update regarding industrial action, noting that since the publication of the report further strike action had been announced for 15th and 19th June.
- RS welcomed the development of the middle management develop programme, referenced in the report, in partnership with Anglia Ruskin University (ARU) and commented positively on the opportunities presented for leadership development. AM agreed, advising the Trust was establishing an enhanced partnership arrangement with ARU, supported by both strategic and operational forums. AM noted the shared commitment to developing leadership capability across the system and confirmed that the new middle management development programme was scheduled to commence in January 2027.
- MJ reflected on the organisation's ongoing development journey and emphasised the importance of maintaining momentum in delivering the improvements already underway, ensuring that these continued to translate into measurable benefits for the organisation, its staff and service users.

The Board of Directors:

1. **Received, noted the content of the report and thanked PS for their leadership and significant contribution to the Trust during their tenure as CEO.**

063/26 QUALITY AND PERFORMANCE SCORECARD

PS presented a report providing a high-level overview of operational performance, quality indicators, safer staffing, financial performance and key NHS England metrics.

Operations (LW)

- The Trust continued to experience significant demand pressures, which was reflected in inpatient capacity challenges, consistent with national trends.
- The average length of stay continued to reduce. There was focus on reducing length of stay within older adult services.
- Out of Area Placements had been reclassified nationally and dedicated discharge and flow leads maintained oversight of patients placed out of area. The number of out of area placements had reduced to 16 in March and work was underway to achieve the Trust objective of eliminating out of area placements by March 2029.

Nursing and Quality (AS)

- There had been continued improvement in the Cardio-Metabolic Inpatient Score. Within community services, performance stood at 63.5% against a target of 75%. Significant work was underway to improve performance further, recognising the importance of the interface between physical and mental health care. A further update would be provided to the Board in August, with continued focus on improvement in partnership with the Chief Operating Officer.
- Referrals to Talking Therapies had increased, whilst waiting times continued to meet agreed targets.
- Virtual Ward occupancy was reported at 73%, above the target level. Work was ongoing to further improve performance.

People and Culture (AM)

- The Trust vacancy rate remained stable and recruitment continued to focus on three key areas; Estates & Facilities, Medical Consultants and Health Care Assistants.
- There was particular focus on reducing locum and agency expenditure through the recruitment of substantive consultants.
- The Trust had challenged itself in establishing workforce trajectories and the approach would be strengthened through enhanced wellbeing support and more detailed analysis of sickness absence data.
- There was ongoing work to enhance the workforce key performance indicators, including measures relating to equality, diversity and inclusion.

<u>Questions and Discussions</u>

- RJ welcomed the work being undertaken to better understand the drivers of long-term sickness absence and noted the greater visibility now available. Referring to temporary staffing pressures, particularly during holiday periods, RJ sought assurance regarding actions being taken to mitigate risks over the summer. AM advised that plans were being developed to strengthen controls around roster sign-off. A paper would be considered by the Executive Team outlining staffing fill rates across a six-week period, together with the proportion of bank and agency staffing planned. This would enable improved oversight and assurance that appropriate mitigations were in place before periods of increased

leave demand. The approach could subsequently be replicated for other holiday periods throughout the year.

- EL queried the reported figure showing 25 wards operating below a 90% fill rate in April, seeking clarification as to whether this referred to wards or individual shifts. AM advised the figures related to shifts and agreed for this to be made clearer in future reports.

Finance (TS)

- The prior year financial outturn remained subject to external audit, which was expected to conclude by the end of the week.
- The Trust had delivered a small surplus of £93k and had fully utilised its capital allocation of £43m. The Board noted that the successful financial position had resulted in a cash balance of approximately £45m.
- Financial challenges remained, with the Trust reporting a £0.5m adverse position at Month 1, primarily attributable to Out of Area Placement costs
- Further work was required to strengthen the efficiency pipeline and a range of schemes had already been identified. The Trust faced the largest efficiency programme it had committed to delivering.

The Board of Directors:

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

064/26 COMMITTEE CHAIRS' REPORT

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

Audit Committee (EL)

- The Internal Auditors had made good progress with the work plan. The Committee would continue to scrutinise the work of the Internal Auditors and the implementation of recommendations.
- The External Auditors were planning to finalise their work this week and thanks were expressed to colleagues for the volume of work conducted to allow the audit to be completed.

Finance and Performance Committee (DL)

- The Committee had received a comprehensive report on Estates and Facilities, recognising staffing challenges and support being received from HR / Organisational Development.

Questions and Discussions

- RJ highlighted a discussion held at the Committee regarding the importance of closing the gap around collective estates opportunities across the system. MJ agreed and suggested the Board considered the future of healthcare provision and having conversations with peers about how this would impact the current estate. TS agreed this would be useful and proposed potentially including as part of a future Board Seminar discussion.

People Committee (RJ)

- The Committee had reviewed the refreshed People Strategy which was due to be presented at today's meeting.

Quality Committee (MJ)

- The Committee had been scrutinising record keeping and supervision / training in relation to controlled drugs, with there being continued progress on assurance.

- There had been changes in law around deprivation of liberty and the Committee would have oversight of the implementation of these changes.
- The Committee continued to review patient safety data and bringing together PSIRF and Learning from Deaths to ensure it is considered collectively.

The Board of Directors:

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

065/26 FREEDOM TO SPEAK UP

BR presented a report providing an update on Freedom to Speak Up (FTSU) activity for the period 1 October 2025 to 31 March 2026. The report outlined emerging themes, progress in embedding a culture of speaking up, actions taken to strengthen accountability for listening and follow-up, and proposals to improve clarity regarding the various speaking-up routes available across the Trust. BR highlighted the following:

- Staff continued to utilise the service, with activity levels exceeding those seen in previous years. Whilst this demonstrated growing confidence in speaking up, additional structure and resources were required to manage the associated risks effectively.
- The majority of individuals raising concerns had previously sought to speak up through other routes but did not feel that their concerns had been heard or responded to appropriately. This indicated a need to strengthen communication, listening skills and organisational learning to ensure staff felt heard.
- The oversight of Freedom to Speak Up would move into the Accountability Framework from July, strengthening performance oversight and accountability
- The most common themes raised through the service related to perceived unfairness, inconsistencies and concerns regarding grievance processes. Whilst progress had been made, further work was required across the Trust to identify and learn from themes raised and to support wider cultural change.
- There had been an increase in concerns raised during Quarter 1, contrasting with national trends during the same period. This may have been linked to the announcement of the Mutual Aided Resignation Scheme (MARS).
- The backlog of open cases had been successfully cleared.

<u>Questions and Discussion</u>

- DG thanked BR for prioritising the clearance of the backlog of cases and acknowledged the significant progress made.
- DL sought further information regarding the proposed Cultural Ambassador role referenced in the report. BR advised that there were already numerous champion roles across the organisation and that previous speaking-up champions had, at times, expanded beyond their intended remit. BR considered that greater progress could be achieved through a cultural ambassador approach focused on wider organisational culture.
- RJ noted the significant emphasis placed on training managers to receive concerns and observed that compliance rates for FTSU training were high. RJ asked what further action could be taken to help staff understand the various routes available for raising concerns and ensure issues reached the most appropriate person. BR responded that there needed to be a clearer organisational commitment regarding the overall purpose of speaking up within the Trust and the role of the FTSU function within that framework. BR emphasised the importance of ensuring that resources were appropriate to support this work. BR identified a particular need to strengthen manager capability in listening effectively and understanding underlying concerns.

- AM offered support from the Workforce and OD Team, suggesting that staff survey themes and trends could be used to inform and align future FTSU activity.

MJ thanked BR for the report and welcomed the progress that had been achieved, emphasising the importance of ensuring that sufficient resources were available to deliver the proposed priorities.

The Board of Directors received, noted the content of the report and:

1. **Agreed in principle the next steps as set out in the priority section.**
2. **Supported greater clarity around all speak-up routes, alignment and the triangulation of data.**

BR left the meeting at this point.

066/26 LEARNING FROM DEATHS Q3 2025/26

AS presented the quarterly report, which provided nationally mandated mortality data for reporting to the Board and summarised key learning arising from reviews undertaken under the Trust's Learning from Deaths arrangements. AS highlighted the following:

- Detailed learning is reviewed monthly by the Learning from Deaths Oversight Group and the Learning Oversight Sub Committee, with both immediate and longer-term actions being progressed through the Trust's safety improvement arrangements.
- There were 189 deaths reported within scope during the period. Of these, 151 had progressed through Stage 1 review, with 29 reviews remaining outstanding. A further 26 cases had undergone decision-monitoring review and eight cases had been escalated into the Patient Safety Incident Response Framework (PSIRF) process where further investigation was required.
- All outstanding historic Stage 1 reviews relating to the 2023-25 period had now been completed and the backlog of reviews from Quarters 1 and 2 had reduced significantly from 30 cases to six.
- The triangulation of learning from mortality reviews demonstrated that the majority of deaths reviewed were associated with physical health conditions and were clinically expected.
- Data quality relating to causes of death continued to present challenges and could limit opportunities for organisational learning; however, work was ongoing with the Registry Office to improve reporting processes and data quality.
- Mortality review processes had strengthened considerably and were increasingly proactive in identifying, sharing and embedding learning across services.

<u>Questions and Discussions</u>

- The Board discussed the ongoing work within inpatient mental health services to strengthen approaches to resuscitation and early identification of physical deterioration. AS advised that improvements in systems and processes, together with enhanced training, simulation exercises and bespoke education programmes, had strengthened the Trust's approach to resuscitation. Further work was required to improve consistency in the early detection of physical health concerns and the monitoring of patients' physical wellbeing.
- The Board discussed the Trust's wider physical healthcare improvement programme remaining a key priority. This included the use of resuscitation link workers on wards, the contribution of registered general nurses within inpatient settings, and strengthened multidisciplinary oversight to support the physical healthcare needs of patients within mental health services.

The Board of Directors received, noted the content of the report and:

1. **Noted the assurance provided by the content of the report that there were 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 were receiving safe, high quality services.**

067/26 CQC ASSURANCE REPORT

AS presented a report providing an update on CQC-related activity, progress against the Trust's CQC action plan, internal assurance regarding compliance with the CQC Quality Statements, and recent CQC guidance and developments, highlighting the following:

- The Trust remained fully registered with the CQC.
- Progress continued against the Trust's CQC improvement plan, with 16 key concerns and 73 supporting actions currently in progress. Actions were being closely monitored, with a particular focus on completing the more complex actions as quickly as practicable.
- Significant learning had been identified following work undertaken in relation to Ipswich Road. The learning had strengthened the Trust's ability to identify early warning signs in other services, particularly in relation to workforce, training and governance arrangements. The resulting intelligence had enabled the Trust to intervene proactively and address issues in a timely manner, ensuring safe and satisfactory outcomes for patients. AS highlighted the importance of strong local leadership, clear governance structures and a sustained focus on supervision and training in supporting service quality and improvement.

Questions and Discussions

- EL highlighted a thematic review of CQC enquiries which indicated that a significant proportion related to waiting times. AS advised that the concerns were primarily associated with ADHD waiting lists and reflected issues that had also been identified through the complaints process. Work was ongoing with commissioners to consider alternative approaches to responding to these challenges and to develop a more coordinated system-wide response.
- DG observed that CQC enquiries were often initiated following contact from an individual and could therefore be viewed in a similar way to complaints. Such enquiries could provide an important indicator of emerging risks, particularly where commissioned services were operating beyond capacity, and emphasised the value of continuing to monitor these themes as part of the Trust's assurance processes.
- LL asked for further clarity regarding the timescales for completion of the action plan. AS advised that the focus was to deliver all actions at the earliest opportunity, whilst recognising that a number of the remaining actions were more complex in nature and required ongoing oversight.

The Board of Directors:

1. **Received and noted the contents of the report.**
2. **Noted the assurance provided regarding progress against the Trust's CQC improvement plan.**

068/26 MENTAL HEALTH INPATIENT BI-ANNUAL SAFER STAFFING PAPER

AS presented a report which provided assurance regarding compliance with safer staffing regulations and standards and supported oversight of the Trust's arrangements to ensure the right number of staff, with the right skills, were available in the right place at the right time to deliver safe, high-quality care. AS highlighted the following:

- Positive assurance was provided that safer staffing standards continued to be maintained across services, with staffing fill rates consistently exceeding 95%.
- Sustained improvement had been achieved and the Trust's Safer Staffing Programme continued to progress.
- Whilst overall performance remained positive, there were a small number of one-off occasions within specialist and inpatient services where the required shift fill rates had not been achieved. Work was therefore ongoing to strengthen daily monitoring arrangements and provide greater clarity regarding the tracking and management of staffing fill rates across services.

Questions and Discussions

- AM advised that the report had been considered by the Quality Committee and suggested that future oversight should also be provided through the People Committee to ensure alignment between workforce planning, rostering and safer staffing arrangements. AM further noted the benefits of working with the Quality directorate to align implementation activity and streamline reporting across the Quality, People and Performance Committees.
- MJ emphasised the importance of ensuring that the wording of the report clearly reflected the position being reported. MJ also noted that variation in flow and capacity could impact workforce requirements, and the need for continued vigilance to ensure the Trust did not become complacent despite the positive assurance.

The Board of Directors:

1. **Confirmed assurance regarding compliance with safer staffing standards.**
2. **Acknowledged the progress made in delivering Stage 1 of the Safer Staffing Programme and noted the next steps in the programme's implementation**.

Action:

1. **Ensure Safer Staffing is included on the People Committee work plan to coincide with the Quality Committee. (AM / AS)**

069/26 BOARD ASSURANCE FRAMEWORK

DG presented a report which provided a summary of the Trust's strategic and high-level operational risks and progress against the actions in place to mitigate those risks, highlighting the following:

- The Board Assurance Framework, Strategic Risk Register and Corporate Risk Register had now been brought together into a single reporting framework to strengthen oversight and provide a more coherent view of organisational risk.
- Additional assurance had been received in relation to Strategic Risk 6 (Cyber Security) following the Internal Audit review of the Data Security and Protection Toolkit, which had received an overall High Assurance rating.
- All actions associated with Strategic Risk 13 (Quality Improvement) had now been completed and the risk would be refreshed and rescored to reflect the improved position.
- Strategic Risk 4 (Demand and Capacity) had recently been refreshed to reflect the ongoing review of patient flow and wider system approaches to managing demand and capacity pressures.
- New risks associated with the increasing use of artificial intelligence and digital technologies are emerging. These would be reflected within the Corporate Risk Register and would consider both the opportunities and risks associated with the use of such tools and behaviours.

- Risk profiling linked to the Operational Plan was currently being undertaken and could result in additional risks, or amended risk ratings, being brought forward for consideration as part of the Strategic Risk Register.

The Board of Directors:

1. **Noted the contents of the report.**
2. **Noted the addition of new corporate risks.**
3. **Did not request any further information or action.**

070/26 PATIENT SAFETY STRATEGY

AS presented a report, which provided the Board with an overview of the development of a positive patient safety culture across the Trust and progress in implementing the Patient Safety Incident Response Framework and associated improvement programmes. AS highlighted the following:

- This was the first occasion the report had been presented in public session, having previously been considered by the Quality Committee and at a Board Development Seminar.
- Approximately 7,000 incidents had been reported during Quarter 4, with the highest volumes relating to self-harm incidents and pressure ulcers.
- Governance arrangements had been strengthened through the introduction of daily incident triage, a weekly emerging review group and enhanced scrutiny at Care Unit level.
- Progress had been made in improving timeliness, although a small number of investigations had taken longer to conclude, including two cases requiring external review. AS reported that delivery of the Trust's five Safety Improvement Plan priorities continued and that there was a growing emphasis on bringing quality improvement methodologies closer to frontline teams to support sustainable improvements in patient safety.

Question and Discussions

- LL sought clarification regarding the patient safety goals and the Trust's current level of achievement against them. AS advised that the goals were nationally defined and that the improvements being implemented were providing greater organisational oversight and assurance regarding the effectiveness of patient safety processes and governance arrangements.
- AB emphasised the importance of positioning the Patient Safety Strategy within the wider context of the Trust's Quality of Care Strategy, noting that patient safety formed a key pillar of the organisation's overarching quality ambitions.
- MJ reflected that the report set the tone for the scale of work required to deliver the Trust's patient safety ambitions alongside other organisational priorities and strategic objectives.

The Board of Directors:

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

071/26 OPERATIONAL PLAN 2026/27 – 2028/29

TS presented a report which provided the final Operational Plan, previously approved by the Board, together with the feedback received from NHS England following its review of the submission, highlighting the following:

- The plan was now in the public domain following receipt of NHS England's sign-off letter.
- The Trust welcomed the earlier release of national planning guidance and the longer planning timeframe, which had supported a more comprehensive planning process.
- TS thanked AB for her work in leading the Planning Steering Group and bringing together clinical, operational and corporate colleagues to develop the final plan.

- The plan was challenging but reflected the requirement to meet increasing patient demand while improving operational effectiveness, reducing out-of-area placements and delivering the efficiency improvements required by NHS England.
- NHS England had issued a conditional acceptance letter and the associated requirements and actions would be monitored through the relevant Board standing committees, with progress reported back to the Board through the established governance framework.

Questions and Discussions

- MJ emphasised the importance of maintaining a focus on safe service delivery whilst responding to the financial and operational challenges set out within the plan.

The Board of Directors:

1. **Noted the final Operational Plan submitted to NHS England.**
2. **Noted the conditional acceptance and summary feedback received from NHS England dated 17 April 2026.**
3. **Noted the Trust's response to the feedback received from NHS England.**

072/26 PEOPLE STRATEGY

AM presented the final Trust People Strategy for 2026-31, which had been developed over several months through extensive engagement with Trust staff and a range of external stakeholders, highlighting the following:

- The strategy sets out the Trust's long-term ambitions for its workforce and provided the framework for developing, supporting and retaining staff over the next five years.
- The accompanying implementation plan set out a series of objectives that would be reviewed annually to ensure the strategy remained responsive to organisational priorities and workforce needs.
- A concise "strategy on a page" had been developed to support communication and engagement across the organisation.
- The strategy was ambitious but achievable and there was a strong emphasis on supporting local communities by creating and developing pathways into employment within the Trust.

Questions and Discussions:

- RS expressed support for the strategy and sought an update on the publication of the Trust's Cultural Review. AM advised that the Board Development Seminar scheduled for May would provide an opportunity to discuss the headline findings; however, the final Cultural Review report had not yet been received.
- MJ recognised the significant amount of work undertaken in developing the strategy and noted that it reflected the extensive feedback, scrutiny and challenge received throughout the development process. MJ welcomed the resulting strategy as a strong foundation for workforce development over the coming years.

The Board of Directors received, noted the content of the report and:

1. **Approved the publication and implementation of the Trust's People Strategy for 2026-31.**

073/26 STRATEGIC IMPACT REPORT MONTH 12

AB presented a report providing an update on the implementation of the Trust's Strategic Plan at Month 12 of 2025/26, marking the completion of the third year of the five-year planning period. AB highlighted the following:

- The Trust had now progressed beyond the midpoint of its five-year Strategic Plan
- The report demonstrated a strong foundation of delivery across key strategic priorities, together with significant progress
- There had been a shift towards more integrated, community-focused care pathways and there were early signs of positive impact alongside the delivery of planned actions.
- The next phase of the Strategic Plan would require greater focus, prioritisation and disciplined execution to maximise benefits for the communities served by the Trust.

Questions and Discussions

- RS welcomed the progress outlined in the report but sought clarification on whether the Trust was where it had expected to be at this stage of the Strategic Plan and whether there was sufficient clarity regarding future priorities and areas of focus. AB advised that delivery had taken place against a backdrop of significant change over the previous three years, both within the Trust and across the wider external environment. AB highlighted the successful delivery of key strategic foundations, including the Time to Care programme, strengthening the co-production agenda and developing strategic partnerships.
- MJ recognised the scale of change experienced by the Trust and the influence of external factors on delivery. MJ noted the importance of remaining alert to any changes in strategic priorities and suggested that a future Board seminar would provide an opportunity for a broader discussion regarding strategic direction and priorities, including consideration of the next five-year planning period.

The Board of Directors received and noted the report.

074/26 EPUT PROVIDER LICENCE REVIEW (INCLUDING CODE OF GOVERNANCE AND GOVERNOR TRAINING)

DG presented a report which set out the Trust's annual self-assessment against the NHS Provider Licence, the NHS Code of Governance for Provider Trusts and the statutory Governor Training Requirements. DG highlighted the following:

- The review had been undertaken in accordance with NHS England expectations and had been subject to scrutiny by the Executive Operational Committee, Finance and Performance Committee and the Council of Governors, where appropriate.
- The assessment concluded that the Trust was substantially compliant with all relevant requirements and that there were no material issues requiring disclosure.
- The approval of the self-certifications would enable the Trust to make the required declarations of compliance and support the associated disclosures within the 2025/26 Annual Report and Accounts.

Questions and Discussions

- TS referred to discussions at the Finance and Performance Committee regarding the importance of ensuring that the self-assessment process was not conducted as a purely procedural or "tick-box" exercise. TS noted that it had been agreed that future assessments should continue to identify areas where there were opportunities for further improvement and development, notwithstanding the overall position of compliance.

The Board of Directors:

1. **Confirmed compliance with Sections G6, CoS7 and NHS2 of the NHS Provider Licence.**

2. **Approved the annual self-assessment of compliance with the NHS Provider Licence.**
3. **Declared compliance with the NHS Code of Governance for Provider Trusts.**
4. **Approved the Governor Training Self-Certification.**

075/26 STATUTORY DUTY OF CANDOUR ANNUAL REPORT 2025-2026

AS presented a report which outlined how the Trust had fulfilled its statutory Duty of Candour responsibilities in relation to incidents occurring between 1 April 2025 and 31 March 2026. AS highlighted the following:

- The annual report had been reviewed by the Quality Committee prior to submission to the Board.
- The report highlighted work undertaken to strengthen patient safety pathways and processes to ensure that organisational learning was identified and acted upon in a timely manner. Through this work, some inconsistencies had been identified in the recording of notifiable safety incidents.
- A programme of activity had been undertaken to improve compliance, including enhanced staff training and awareness in relation to harm grading, strengthened governance arrangements, enhancements to the Datix system, and the introduction of functionality to record Duty of Candour activity within Datix. Following the intensive programme of work, processes were in place to enable the Trust to meet its statutory Duty of Candour obligations.

Questions and Discussions

- RS emphasised the importance of obtaining evidence that the improvements implemented were delivering the expected outcomes. AS confirmed that evidence of improvement and compliance would continue to be reported through the Executive Team and the Quality Committee, with escalation to the Board as appropriate.
- DG noted that discussions had taken place within the Executive Team regarding the potential use of external assurance in place of, or alongside, internal audit work in this area. Following discussion, the Board agreed that accountability for the assurance framework would be maintained through both the Quality Committee and internal audit controls.

The Board of Directors:

1. **Noted the contents of the report.**
2. **Approved the Statutory Duty of Candour Annual Report for 2025/26.**

076/26 QUESTIONS TAKEN FROM THE GENERAL PUBLIC

Questions and comments were taken from two members of the general public who were in attendance – see Appendix 1 which follows.

077/26 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

- Letter from Sir James Mackey, CEO for NHS England regarding Resident Doctor industrial action.

078/26 ANY OTHER BUSINESS

MJ noted that this was the final Board meeting for PS, who was leaving to become CEO of East Suffolk and North East Essex NHS Foundation Trust (ESNEFT). MJ reflected on learning from PS regarding his compassion and his leadership through challenging times. The transformation work that PS had started would continue thanks to his leadership during his time at EPUT.

TS reflected that PS was leaving the organisation in a different place from when he joined. He had been given the mandate to open the organisation to greater partnership and system working and this had been achieved. The Trust was part of collaborative working and PS had empowered and encouraged the organisation to move towards operationally led and clinically driven decision making. PS had also led the drive to develop the new Nova single electronic patient record, the implementation of the Time to Care programme and other achievements. He had done this with humility and honesty and it had been a pleasure to work have him as the CEO of EPUT.

PS thanked the Board for its support and challenge during his time at the Trust. PS reflected that he had achieved through the whole Board team and organisation and that the journey would continue. PS also confirmed that he would continue to be available to support the Lampard Inquiry response as the Inquiry progressed.

079/26 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.

08/26 DATE OF NEXT MEETING

The next meeting of the Board of Directors is to be held on Wednesday 05 August 2026.

Signed: Date:

Appendix 1: Governors / Public / Members Query Tracker (Item 076/26)

Governor / Member of the Public	Query	Response
Member of the Public	The individual did not feel that allegations of misconduct that they had previously raised had been investigated. They asked why the Board was not assuring itself that allegations against staff were being investigated in a timely way.	AS advised that: • She had met with the individual along with HLD and identified independent support for them, but acknowledged that additional support may be needed • The outcome of an independent review of allegations would be shared with the Board along with any wider learnings for the Trust MJ reiterated the Board's continued commitment to supporting the individual.
Service User	The Service User reported that a previous issue of Brockfield House staff being redeployed to other wards had been resolved, but raised further issues: • General understaffing of wards • Consideration of lifting a ban on the use of smartphones and laptops by patients and staff • Consideration of ceasing hourly checks on patients • Encouraging Board members to spend time at Brockfield House to see how patients experience the service	Board members responded specifically: • AM had previously discussed staffing levels with the care unit and would seek further feedback from patients and staff on staffing levels, use of electronic devices and observations • AS reiterated the importance of regular observations and therapeutic engagement • MJ agreed to review Board visits to Brockfield House and emphasised the role people with lived experience can play in providing feedback directly to the Board and executive team

4. ACTION LOG AND MATTERS ARISING

Standing item LL

REFERENCES

Only PDFs are attached

Action Log Part 1 05.08.2026.pdf

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting held on the 3 June 2026

Lead	Initials	Lead	Initials	Lead	Initials
Andrew McMenemy	AM	Ann Sheridan	AS		

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

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
068/26 June	Ensure Safer Staffing is included on the People Committee work plan to coincide with the Quality Committee.	AG / AS	August 2026	This has been added to the People Committee work plan.	Closed	

5. CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

Information Item LL

REFERENCES

Only PDFs are attached

Chairs Report 05.08.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 August 2026

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

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

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

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

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

Summary of Key Issues
Interim Chair arrangements; governor elections; staff inclusion and development; the July 2026 Lampard Inquiry hearings; and national legal and policy developments affecting Foundation Trust governance, oversight, personalised mental health care, capital investment and patient safety.

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

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

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

Acronyms/Terms Used in the Report			

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

Lead
 **Loy Lobo** **Acting 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 Acting Chair Arrangements

Following the death in Mayof our Chair, Hattie Llewelyn-Davies, the Board has put interim leadership arrangements in place in accordance with the Trust's constitution. These arrangements are intended to maintain continuity of governance, clear accountability and effective oversight during a difficult period for the organisation.

As Acting Chair, I want to record the Board's deep appreciation for Hattie's leadership and service, and to recognise the impact of her death on colleagues, governors, partners and the communities we serve. The process to appoint an interim Chair is under way. The Board will continue to work closely with the Council of Governors and other stakeholders to support an orderly transition and will provide further updates as the process progresses.

2.2 Governor Elections

Governor elections are taking place this summer, with nominations opening in July for five staff governor positions - three clinical and two non-clinical - alongside public governor vacancies across the Trust's constituencies.

Governors provide an important link between EPUT, its staff, members and local communities. They represent the views of those constituencies, contribute to the development of the Trust and, under the current statutory framework, hold the Non-Executive Directors to account for the performance of the Board. I encourage eligible colleagues and members to consider standing and to support the election process.

Further information is available on the EPUT Governor elections page or from epunft.membership@nhs.net.

2.3 RISE Graduation

Congratulations to colleagues who have recently completed the Resilience, Intelligence, Strength and Excellence (RISE) programme. This is the fifth cohort to complete the programme, which supports colleagues from global majority backgrounds to develop their confidence, leadership capability and career progression.

RISE is an important part of EPUT's commitment to developing diverse talent and strengthening a leadership pipeline that better reflects our workforce and the communities we serve. The achievements of this cohort demonstrate the value of sustained investment in inclusion, development and opportunity.

2.4 South Asian Heritage Month

Throughout July, EPUT marked South Asian Heritage Month. The 2026 theme, 'Unity in Diversity', celebrates the breadth of South Asian cultures, languages, faiths and histories while recognising the shared values and experiences that connect communities.

For EPUT, the month is both a celebration and an opportunity to reflect on how culture, identity and lived experience shape access to care, health outcomes and staff experience. We are proud of the contribution made by colleagues, patients, carers and communities with South Asian heritage. I encourage the Board and colleagues to carry this learning beyond the month itself by continuing to strengthen inclusion, cultural awareness and equity in our services and workplace.

3.0 Lampard Inquiry

The Inquiry's latest set of hearings ran from 6 to 23 July 2026. The hearings examined EPUT's engagement and compliance with the Inquiry, heard evidence from bereaved families, current and former staff and independent expert witnesses, and considered resuscitation, observations and the use of technology in mental health inpatient care.

I gave evidence on 7 July, following Paul Scott's evidence on 6 July, addressing the Trust's leadership transition, the EPUT position statement and our future engagement with the Inquiry. I restated the Board's commitment to cooperate fully, promptly and transparently and to ensure that leadership changes do not impede the Trust's response.

We are grateful to the bereaved families and to current and former colleagues who gave evidence. Sharing personal experiences and revisiting difficult events in a public setting requires considerable courage. Their evidence is essential to the Inquiry's work and must inform learning and improvement within EPUT and across mental health services more widely.

Board members, governors, executives and other senior leaders attended the hearings to hear the evidence first-hand and to demonstrate respect for bereaved families and staff. The Board will continue to seek assurance on the timeliness, quality and completeness of the Trust's responses, the wellbeing of staff involved and the translation of emerging evidence into service improvement. We will not wait for the Inquiry's final recommendations where the emerging evidence indicates that action can safely be taken sooner.

4.0 LEGAL AND POLICY UPDATE

The following update summarises the principal national legal and policy developments since the June 2026 Board meeting that are relevant to EPUT. The position is current as at 24 July 2026.

4.1 New Secretary of State for Health and Social Care

On behalf of the Board, I welcome the Rt Hon Yvette Cooper MP, who was appointed Secretary of State for Health and Social Care on 20 July 2026. We wish her well in the role and look forward to working constructively with the Department of Health and Social Care and national partners on the priorities that matter to our patients, carers, staff and communities, including mental health, community care, patient safety and sustainable service delivery.

***Source**:* GOV.UK - Secretary of State for Health and Social Care.

4.2 Health Bill - Foundation Trust governance and national oversight

The Health Bill completed its Public Bill Committee stage on 16 July 2026 and is scheduled to begin Report Stage in the House of Commons on 7 September 2026. It remains a Bill; therefore, the Trust's existing statutory duties and governance arrangements continue to apply unless and until Parliament enacts the legislation and relevant provisions are commenced.

The Bill proposes significant changes for NHS Foundation Trusts, including the abolition of NHS England; transfer of provider oversight, licensing and certain appointment functions to the Secretary of State; removal of the statutory requirement for Foundation Trusts to have members and councils of governors and a power to de-authorise a Foundation Trust in cases of serious failure. The government has stated that providers would remain responsible for effective engagement with patients, staff and local communities.

For EPUT, the immediate requirement is to track the Bill's passage, assess transition risks and ensure that the current Council of Governors and membership arrangements continue to operate

effectively. Any future governance model must preserve meaningful local accountability and patient, staff and community voice.

***Sources**:* UK Parliament - Health Bill; DHSC - Health Bill: providers fact sheet.

4.3 NHS Oversight Framework 2026/27

The NHS Oversight Framework 2026/27 sets out the approach to assessing performance and organisational capability and calibrating support or intervention. It places clear responsibilities on provider boards to ensure effective quality governance; sufficient executive capacity and capability; prudent and effective controls; compliance with statutory and regulatory duties; self-assessment and continuous improvement; and a 'no surprises' relationship with national and regional oversight bodies.

The Board should use the framework as an organising discipline for recovery and improvement, ensuring that assurance covers leadership and organisational capability as well as individual performance metrics.

***Source**:* NHS England - NHS Oversight Framework 2026/27.

4.4 Mental Health Personalised Care Framework

NHS England published the *Mental Health Personalised Care Framework: the modern care programme approach* on 17 July 2026. It establishes a common approach across community, crisis and inpatient services for adults and older adults with severe mental health problems.

The framework expects each person to have a current personalised care and support plan; a named person responsible for that plan and for developing a trusted therapeutic relationship; timely review and rapid re-access when needs change; and systematic use of patient experience to improve care. Its safety annex requires integrated assessment, formulation and management planning across risks to self, to others, from others and from iatrogenic harm, with relational safety at the centre.

EPUT will need to assess the implications for clinical policies, care planning, multidisciplinary working, workforce development, service-user and carer involvement, outcome measurement, and the design of the Nova electronic patient record. The Board should receive assurance on implementation through the appropriate quality and digital governance routes.

***Sources**:* NHS England - Mental Health Personalised Care Framework; Annex A - Safety assessment, formulation and management planning.

4.5 10 Year Capital Plan for Health and Social Care

On 8 July 2026, the government published its 10 Year Capital Plan for Health and Social Care. The plan is intended to provide a longer-term framework for modernising healthcare infrastructure, addressing estate condition and supporting the shift of care closer to home.

For EPUT, this reinforces the need for a prioritised and evidence-based estates and capital strategy covering safety-critical backlog, therapeutic mental health environments, community and neighbourhood infrastructure, digital capability and value for money. The plan does not remove the need for disciplined local prioritisation or robust business cases, but it provides a national context against which the Trust should position its capital programme.

***Source**:* DHSC - 10 Year Capital Plan for Health and Social Care.

4.6 NHS Patient Safety Strategy - July 2026 progress update

NHS England's July 2026 progress update highlights the continuing expansion of national patient-safety arrangements. Of particular relevance to EPUT are pilots of Martha's Rule in mental health and community settings; the contractual expectation that NHS organisations include Patient Safety

Partners in safety governance; and the ongoing review of the digital clinical risk-management standards DCB0129 and DCB0160.

These developments should be reflected in the Trust's patient-safety, escalation and digital-clinical-safety arrangements, including Nova and the governance of artificial intelligence. The Quality Committee should maintain oversight of readiness for any national implementation requirements arising from the current pilots and standards review.

***Source**:* NHS England - NHS Patient Safety Strategy progress update, July 2026.

6. CHIEF EXECUTIVE OFFICER (CEO) REPORT

Information Item AG/TS

REFERENCES

Only PDFs are attached

Chief Executive Officer (CEO) Report 05.08.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 August 2026

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

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

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

Recommendations/Action Required
The Board of Directors is asked to: 1. Receive and note the content of the report.

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

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

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

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

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

Supporting Reports and/or Appendices
CEO Report. Appendix 1 - Assurance Regarding End of Life Care, Care after Death, and Related Services within EPUT Letter and Board Assurance Statement

Executive/ Non-Executive Lead / Committee Lead:	
Alex Green **Interim Joint Chief Executive Officer**	**Trevor Smith** **Interim Joint Chief Executive Officer**

CHIEF EXECUTIVE OFFICER REPORT

1. CEO UPDATES

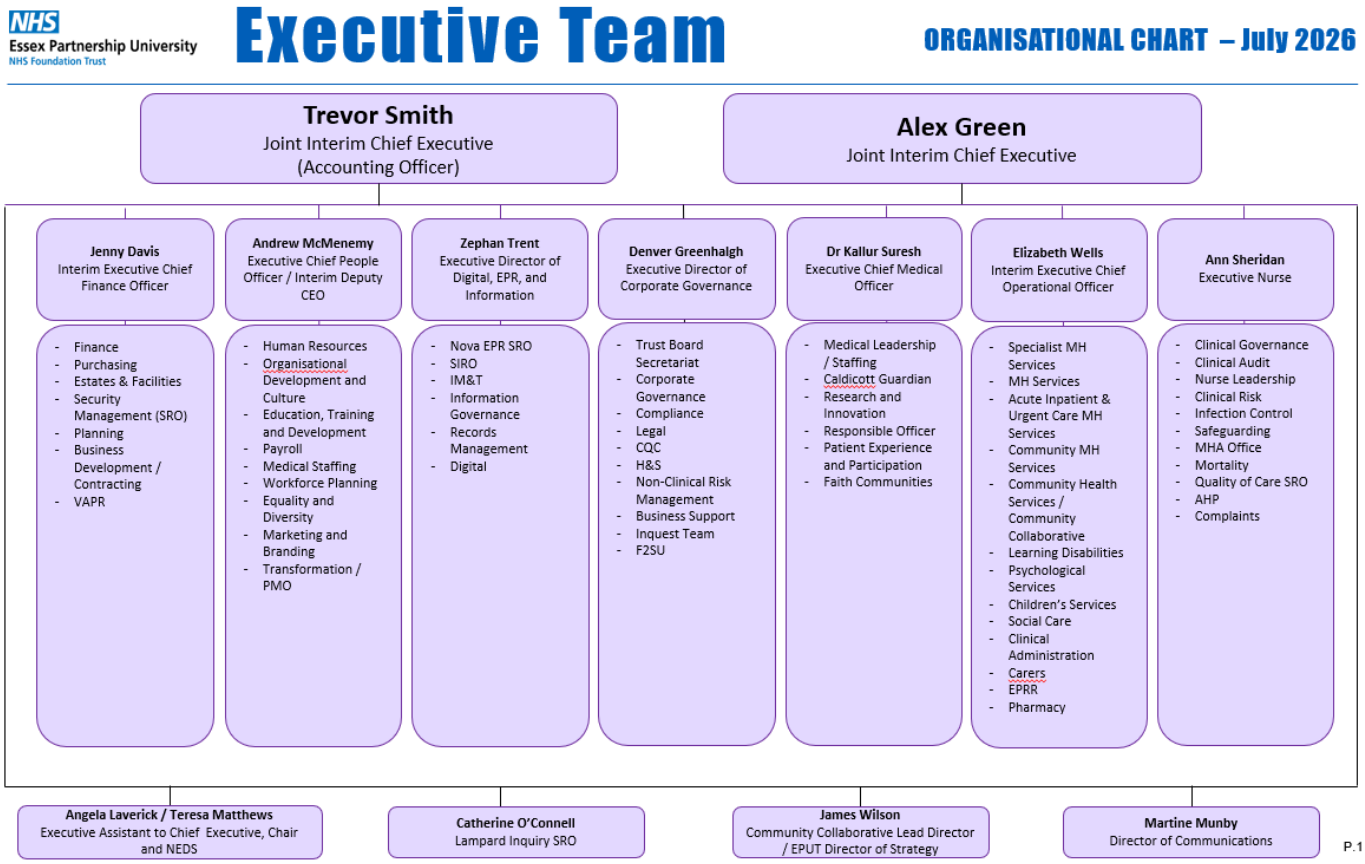
1.1 Changes to the Executive Team Portfolios

Following a recent review of Executive Team portfolios, together with an internal expression of interest process, I am pleased to confirm the following interim leadership arrangements.

- Andrew McMenemy, Executive Chief People Officer, has been appointed to the role of Interim Deputy Chief Executive Officer**.** In addition to his existing responsibilities, the Transformation portfolio will now sit within Andrew's remit, strengthening alignment between our people, culture and transformation priorities.
- I am also pleased to confirm that James Wilson, Transformation Director has been appointed as the lead for Strategy, and Matt Sisto, Director of Patient Experience has been appointed as the lead for Research**.**

These arrangements will ensure continued leadership capacity across these key areas and support the delivery of the Trust's strategic objectives.

An updated overview of Executive Team portfolios is provided below.



1.2 Lampard Inquiry Hearings

The Lampard Inquiry public hearings commenced on Monday 6 July until 23 July. Former CEO Paul Scott, and our Acting Chair Loy Lobo, both gave evidence about issues relating to EPUT's engagement with the Inquiry. The Inquiry also heard evidence around important issues they are considering making interim recommendations about, including observations and the use of technology, resuscitation, and evidence from current and former members of staff about their experiences while working at EPUT or one of its predecessor organisations.

As a Board, we have always encouraged colleagues to contact the Lampard Inquiry to share experiences of care across the Trust, as the evidence of current and former staff will play an important contribution to the evidence and information being gathered by The Lampard Inquiry. We

must continue to listen, learn and act to improve the safety and experience of our patients and people.

There has been some media reporting of the hearings and we continue to engage positively with journalists, responding to questions and offering media statements when contacted.

Our wards and services have changed dramatically since the formation of the Trust – they are safer and more comfortable environments which aim to give our patients a rich and engaging experience, with the voices of families and carers at the heart of individual care and service provision. We know that while there has been much change and improvement, there is more to do, and we will listen and respond to the accounts, information and stories being shared with the Inquiry.

We understand that the Lampard Inquiry hearings and the current media interest may affect colleagues, patients and their families and carers, and support is available for all.

1.3 NHS England's Request for Assurance following the Fuller Inquiry and Ockenden Report

In response to NHS England's request for assurance following the Fuller Inquiry and Ockenden Report, the Trust has confirmed that robust governance, policy, training and oversight arrangements are in place to support end-of-life care, care after death and bereavement services. Whilst the Trust does not operate mortuary facilities, comprehensive clinical guidance, staff training, safeguarding processes, Learning from Deaths arrangements, Medical Examiner scrutiny and tissue donation procedures provide assurance that safe, compassionate and dignified care is delivered, with appropriate governance and oversight in place.

No significant gaps in assurance were identified, although further enhancement of training relating to care after death is planned during 2026/27. The letter and Board Assurance Statement have been included in this report as Appendix 1.

1.4 CQC Rating for Child and Adolescent Mental Health Wards

The Care Quality Commission (CQC) has upgraded its rating for our child and adolescent mental health wards. Inspectors recognised a number of improvements and increased the rating from 'requires improvement' to 'good' following visits to the St Aubyn Centre Colchester and Poplar Unit in Rochford in March this year. We are delighted that the CQC has recognised improvements made, which is a testament to the relentless passion and dedication of colleagues over the last few years, and the support of our patients, their families and loved ones as we have continuously focussed on improving the care we provide.

EPUT has invested in its CAMHS wards to make them safer and more therapeutic spaces, staffing levels have been increased and new roles created as part of a multi-disciplinary team of nurses, healthcare assistance, psychologists, therapists and education staff focussed on providing person-centred and therapeutic care. A Therapeutic Education Department at St Aubyn Centre, rated Outstanding by Ofsted, also enables young people to continue their education during their care.

Amongst the improvements highlighted was staff working closely with families and carers to ensure they were fully involved in their loved one's care, medicine management and staff respecting young people's privacy and dignity. We know that there is more to do and look forward to building on the progress made to provide the best care for young people in need.

1.5 Working Towards Sustainable Woundcare

"Plastic free July" was the ideal time to highlight some of the good work that is happening in community care wound care services at the Trust to support the Green Plan by reducing waste and looking at more sustainable options. Around 5% of global emissions come from the healthcare sector and the NHS is recognised as one of the largest public sector contributors in the UK.

The Trust's Green Plan sets out a clear commitment to supporting the NHS net zero strategy and reducing environmental impact across all services. Key priorities within the plan include reducing waste, cutting carbon emissions from travel, improving sustainable procurement and embedding environmental awareness into everyday practice.

Our Hockley District Nursing Team are carrying out a six-week audit of their work with wound care patients in the community to see if there are areas where changes can be made to reduce the team's carbon footprint. This includes looking at the number of dressings used per patient visit alongside other consumables that are used such as gloves and aprons. Packaging waste is also a significant contributor with many dressings individually wrapped in materials that are difficult to recycle. Transport is one of the large contributors to carbon emissions in community healthcare and is another area being looked at as part of the audit.

The Trust's Green Plan suggests that sustainable change must be data driven and locally owned. It is hoped that some of the data derived from the audit can be used to introduce changes into the community wound care service and contribute to reducing EPUT's sustainability agenda.

1.6 EPUT Colleagues at National Forums

- Psychiatrists from EPUT recently showcased more than 17 projects, research findings and improvements at the Royal College of Psychiatrists International Congress. The annual RCPsyc International Congress brings together leading psychiatrists from across the world to share knowledge, debate, collaborate, educate and network. EPUT were one of the most strongly represented NHS organisations at this prestigious international event, with EPUT consultant psychiatrists, specialty and specialist psychiatrists and resident doctors showcasing innovative projects, research findings and improvements in clinical practice that are helping to advance mental health care. This exceptional recognition reflects the dedication and commitment of our psychiatry teams to generating evidence, sharing learning and shaping the future of psychiatry both nationally and internationally.

- EPUT colleagues have helped to write a new report to help health and care organisations better understand and apply trauma-informed care. Psychological Services colleagues and lived experience lead for Time to Care and Trauma Informed Care, led a trauma informed care development day organised by the East of England Clinical Senate. They contributed to a report summarising the key principles, case studies and practical tips from the session, which will be shared with organisations across the East of England.

- The Chelmsford Specialist Mental Health Team has been shortlisted for a HSJ Patient Safety Award for making simple but effective changes that have made a positive impact on reducing administration and improving patient care. The team, who are based at the Chelmsford and Essex Centre in New London Road, have been shortlisted for the Safety Improvement Through Technology Award. They streamlined the list of tasks that duty staff need to complete to ensure they were relevant and made the duty structure clearer for colleagues to follow. An electronic duty diary was also created for staff to track completion of tasks, and a formal referral and allocation tracking process introduced. These changes have increased staff confidence and improved efficiency, consistency and communication. This has led to improved quality of care and patient experience, with patients appreciating quicker responses and clearer communication. The winners of the HSJ Patient Safety Awards will be announced on 28 September.

2. EXECUTIVE UPDATES

2.1 People and Culture – Andrew McMenemy, Executive Chief People Officer / Deputy CEO

NHS Staff Standards

Working alongside the NHS People Promise and local initiatives, they set a nationally required minimum standard, providing a clear framework for accountability. There are six standards:

- **Line Management** - Good line management is one of the most powerful levers organisations have to improve staff experience. This standard sets out what employers must put in place to ensure line managers are properly trained, supported and given the time they need to lead their teams well, because investing in line managers is fundamental to a high-performing NHS workforce.

- **Health & Well Being** - NHS staff cannot care for patients if they are not cared for themselves. This standard requires employers to take a proactive, evidence-based approach to protecting the physical and mental health of their workforce, going beyond reactive support to prevent harm before it happens, with clear accountability at board level.

- **Tackling Racism** - Data consistently shows that ethnic minority staff face worse experiences at work, from higher rates of bullying and harassment to significant barriers in career progression. This standard sets out the minimum expectations for how NHS organisations must prevent, respond to and learn from racism, calling on employers to take sustained, meaningful action to change the cultures that allow it to persist.

- **Promoting Flexible Working** - Flexible working should be the norm, not the exception. This standard requires employers to embed a 'flexible first' culture where requests are openly encouraged, fairly considered and not unreasonably refused, supporting recruitment, retention and staff wellbeing across the NHS.

- **Violence Prevention and Reduction** - No one should come to work in fear. This standard requires employers to take consistent action to prevent and reduce violence, aggression and abuse in all its forms, with robust reporting systems, compassionate post-incident support, and appropriate training so staff feel safe and empowered at work.

- **Championing Sexual Safety** - Every member of NHS staff has the right to work free from sexual harassment, abuse and unwanted sexual behaviour. This standard sets out what employers must do to prevent sexual misconduct, support those affected, and ensure incidents are reported and acted upon swiftly, so staff can be confident their concerns will always be taken seriously.

Alignment to the relevant workstreams across People and Culture is in progress and will be measured through the National Staff Survey and the National Oversight Framework (NOF).

Medical Negotiations

SAS/Consultants

Following the conclusion of the BMA ballots on 6 July 2026, consultants in England have secured a mandate for industrial action after 76% voted in favour on a turnout exceeding the legal threshold. In contrast, whilst 90% of participating SAS doctors supported industrial action, the ballot did not meet the required turnout threshold and therefore no mandate exists for SAS industrial action. No consultant strike dates have yet been announced. EPUT will continue to monitor the national position and maintain appropriate contingency arrangements should industrial action be called.

Staff Experience

New Corporate Induction & Staff Experience

The new Corporate Induction programme will be launched in September 2026, alongside enhancements to local induction processes across the Trust. Pilot induction sessions will be delivered throughout the Summer to test and refine the new content and approach, ensuring alignment with EPUT's commitment to trauma-informed care principles. In addition, procurement is currently underway with ‘Great with Talent’ to introduce high-quality workforce intelligence for new starters and leavers. This will provide valuable insights to support recruitment, retention, employee experience, and workforce planning across the organisation.

NHS Leadership and Management Framework (MaLD)

The NHS Management and Leadership Framework, published on 6 July 2026, sets out the core standards and competencies expected of colleagues in leadership and management roles across the NHS. The framework provides a consistent national approach to strengthening leadership capability and supporting those who lead and manage people, helping them to succeed in their roles and create high-performing, inclusive teams. Workforce development priorities and internal leadership programmes are being aligned so that our own offer remains aligned to national expectations.

Equality, Diversity & Inclusion (Lord Mann Review)
Recommendations from the Lord Mann Review in tackling racism and islamophobia are being implemented with the seven immediate actions mapped internally. This work is being supported by the NHS Race Observatory to help steer our work alongside a review of internal policies. EPUT has signed up to the NHS National content for annual EDI training, refreshing the content to align to the national staff standards including tackling racism, sexism, misogyny and disability discrimination. In partnership with 'The Kings Fund' and 'brap', we are developing anti-racism training for all staff in the Trust and engaging with our Faith and EMREN Networks to consider the adoption of the new government definitions of Anti-Muslim Hostility and the International Holocaust Remembrance Alliance definition of antisemitism.

Education
The Trust has received confirmation of funding from NHS England for continued professional development and is currently working with all Care Units to map out key development opportunities to meet quality and contractual needs, as well as supporting career progression across the Trust.

2.2 Nursing and Quality – Ann Sheridan, Executive Nurse

Fundamentals of Care
The Trust is entering the next phase of its quality improvement journey by positioning Fundamentals of Care (FoC) as the organising framework for delivering person-centred, safe and reliable care. The priority now is to translate safety improvement themes into sustainable practice at care unit level through a combination of FoC, Quality Improvement methodology and leadership development. Key deliverables include strengthening the registered nurse role, embedding personalised care standards, developing a co-produced accreditation programme to provide assurance of care quality, and applying a combined FoC and systems-based approach to learning from incidents and improving patient outcomes. This work will support the Trust's Quality Priority for 2026–2028 and provide a coherent delivery model linking quality, safety, workforce and patient experience improvements.

Peer Academy
Work continues to strengthen our approach to lived experience, peer support and population health. The Essex Peer Academy is progressing into its first year of delivery, with the pilot being developed alongside system partners and NHS England-funded training secured for peer support workers and supervisors. The new lived experience casual worker model is now operational, enabling people with lived experience to continue contributing on a paid basis through a compliant workforce and payroll route, while retaining existing rates of pay and providing access to employment benefits. The Population Health and Health Inequalities Group has also been re-established, bringing together work on population health, prevention, CORE20PLUS5, PCREF, patient experience and community engagement, and providing clearer oversight of the Trust's contribution to reducing inequalities across Essex.

NHS Quality Strategy for funded care in England
The new Quality strategy for NHS-funded care in England explicitly recognises that future improvement must be centred on community, neighbourhood and mental health pathways. The strategy places equal emphasis on safety, effectiveness and experience, with a strong focus on reducing inequalities, improving outcomes for people with severe mental illness, listening to patients and carers, and strengthening quality governance across organisational boundaries. For organisations such as EPUT, this aligns closely with our existing priorities around PSIRF, patient safety, complaints learning, patient experience, Fundamentals of Care and integrated community-based care. The strategy identifies persistent variation in mental health services, ongoing concerns about inpatient quality, access delays, out-of-area placements, and the need for stronger governance, culture and oversight arrangements. It also links to the forthcoming Severe Mental Illness Modern Service Framework, increased use of patient feedback and PREMs, monitoring of population outcomes, and a greater focus on transparency, learning and partnership with service users and communities.

Priority actions that we need to consider are improving the use of data and intelligence to identify emerging risks; strengthening patient and carer involvement in service design and learning from incidents; ensuring complaints, PREMs, PALS and safety learning are triangulated; embedding a culture of compassionate leadership and continuous improvement; developing outcome measures that matter to patients; and focusing explicitly on inequalities, particularly for people with severe mental illness, learning disabilities and autism. The strategy also signals the need for trusts to prepare for increased transparency, greater use of digital tools and AI to support quality improvement, stronger Board oversight of quality outcomes, and more robust demonstration of how learning leads to measurable improvement. For EPUT specifically, much of the groundwork already exists through the Fundamentals of Care programme, PSIRF implementation, patient safety infrastructure and Quality Committee arrangements, but the opportunity is now to connect these elements within a coherent trust-wide quality management system with clear measures of safety, effectiveness and experience.

2.3 Operations – Lizzy Wells, Interim Chief Operating Officer

Despite continued operational pressure, our inpatient mental health adult average length of stay continues to decrease, staying well below the oversight framework target. In the most recently published National Oversight Framework league tables (2025/26 Q4), EPUT is ranked 5th out of 47. This evidences a period of sustained improvement because of service transformation -Time to Care and internal process control.

The new flow improvement programme has commenced and provides a strategic system review of end to end mental health care pathways, demand and capacity requirements to meet the needs of the Essex population both now and over the next 5 years; reducing the need for out of area acute beds. Progress against identified workstreams will be monitored through the refreshed Strategy Implementation Group.

Perinatal services continue to achieve access targets, ensuring timely support for women requiring specialist perinatal mental health care. The service has recently undergone its accreditation process and is currently awaiting the outcome, reflecting the team's ongoing commitment to quality improvement and delivery of care in line with national standards.

North East Essex Mental Health Care Group are a key stakeholder within the Integrated Neighbourhood Teams (INT) Early Adopter Programme. Extensive partnership working continues with system colleagues including health, social care and voluntary sector partners to support implementation, with the programme scheduled to go live on 5 October.

2.4 Finance – Jenny Davis, Interim Chief Finance Officer

Transformation Efficiency Group
The Transformation and Efficiency Group (TEG) has strengthened governance arrangements and introduced additional workforce controls to support delivery of the efficiency programme. Whilst delivery remains £1.7m behind plan year to date, Care Units and Corporate Directorates are required to identify further recurrent opportunities and present additional schemes through TEG oversight. The emphasis is increasingly shifting from short-term schemes to multi-year transformational changes. All schemes are Quality Impact Assessed (QIA) prior to their initiation.

Block Contract Deconstruction
National guidance has now been issued requiring all providers and Integrated Care Boards (ICBs) to undertake the Block Contract Deconstruction exercise during 2026/27. Whilst there is no direct financial impact in the current year, the exercise is expected to inform the future NHS payment mechanism from 2027/28.

Lampard Inquiry Costs
As at the end of June 2026 (Month 3), cumulative cash expenditure incurred by the Trust in relation to the Lampard Inquiry totals £17.1m. During 2026/27, the Trust has incurred expenditure of £1.3m, of which £0.1m has been charged to the revenue position in accordance with accounting standards, with the remainder recognised within the provision.

NHS Property Services (NHSPS) Dispute

The Trust continues to progress discussions in relation to the NHS Property Services disputes in West Essex. A pre-arbitration meeting has been agreed between EPUT, the Department of Health and Social Care (DHSC), NHS Property Services and the NHS England Regional Team.

Essex Partnership University
NHS Foundation Trust

29 July 2026

Chief Executive Office
The Lodge
Lodge Approach
Wickford
Essex
SS11 7XX

Duncan Burton
Chief Nursing Officer for England

Sarah-Jane Marsh
NHS England Chief Operating Officer

By email: england.systemcomms@nhs.net

Dear Duncan and Sarah-Jane

Re: Assurance Regarding End of Life Care, Care after Death, and Related Services within Essex Partnership University NHS Foundation Trust (EPUT)

In response to concerns raised in relation to the Fuller Inquiry and the Ockenden Report, Essex Partnership University NHS Foundation Trust (EPUT) would like to provide assurance regarding the procedures, governance arrangements, and services in place to support patients receiving end-of-life care, from recognition of deterioration through to death and bereavement.

EPUT has developed a comprehensive range of policies, procedures, and clinical guidance to support patients and their loved ones during the final stages of life. This includes CG84 Clinical Guidelines for the Care of the Deceased Patient (please see attached). These arrangements are measured against the Trust's End of Life Care Framework, which promotes best practice across the organisation. The framework encompasses all aspects of care, including communication, clinical skills and competencies, care after death, safeguarding and support for families and carers, with compassion, dignity, and respect embedded throughout.

Staff receive regular education, training, and competency assessments to support the delivery of high-quality end-of-life care. This training is led by clinical and medical leads for end-of-life care and is delivered in collaboration with local hospice education centres. Particular emphasis is placed on timely communication, symptom management, coordination of care after death, verification of expected death, and compliance with statutory requirements, while ensuring patients and families are treated with dignity and sensitivity.

EPUT does not operate any mortuary facilities. Where patients die within Trust inpatient services, transfers are generally made to mortuaries operated by local acute trusts, including:

- Basildon Hospital Mortuary (Mid and South Essex NHS Foundation Trust)
- Broomfield Hospital Mortuary (Mid and South Essex NHS Foundation Trust)
- Southend Hospital Mortuary (Mid and South Essex NHS Foundation Trust)
- Princess Alexandra Hospital Mortuary, (Princess Alexandra Hospital NHS Trust)
- Colchester Hospital Mortuary, (Essex, Suffolk and North Essex NHS Foundation Trust)

For patients who die in their usual place of residence while receiving care from community integrated teams, arrangements are typically made with funeral directors chosen by the family or identified by the patient before death.

The Trust maintains robust governance arrangements for the review and learning from deaths. Within inpatient services, both expected and unexpected deaths are reported via Datix and reviewed through the Learning from Deaths Oversight Group. Within community services, unexpected deaths are reported through Datix. In addition, all expected deaths are subject to review by the Medical Examiner service.

The Medical Examiner provides independent scrutiny of deaths not investigated by the Coroner. This includes reviewing the cause of death, engaging with bereaved families, supporting accurate certification, identifying any concerns regarding care, and ensuring appropriate referrals to the Coroner where required. This process supports transparency, patient safety, and public confidence in the certification of deaths.

Where a death is unexpected, unexplained, or otherwise meets the criteria for referral, the matter is reported to the Coroner. In such cases, the Coroner directs the subsequent management of the deceased, including transfer to an appropriate mortuary and, where necessary, post-mortem investigation. The receiving mortuary is determined by the Coroner's Service according to the circumstances and locality of the death.

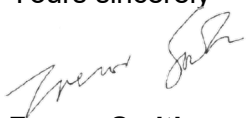
For expected deaths, verification of death is undertaken by a suitably trained and competent Registered Nurse, with certification completed by the appropriate medical practitioner. Relevant healthcare professionals, including the patient's GP, are informed, and practical guidance and support are provided to families and carers.

EPUT also recognises the importance of tissue donation as an opportunity for patients and families to leave a lasting legacy and contribute to the treatment of others. The Trust's approach is founded upon respect for patient wishes, dignity, compassion, and compliance with national legislation and guidance. Clinical teams identify potential donors where appropriate, liaise with NHS Blood and Transplant (NHSBT) Tissue Donation Services, and ensure that families receive clear information and support throughout the process.

All tissue donation activity is undertaken in accordance with the Human Tissue Act, NHS Blood and Transplant guidance, and local end-of-life and care-after-death procedures. The Trust ensures that donation processes are conducted by appropriately trained specialists and that the dignity of the deceased is always maintained.

Through these arrangements, EPUT remains committed to delivering safe, compassionate, and high-quality end-of-life care, while ensuring robust governance, transparent review processes, and appropriate support for bereaved families. Assurance regarding the Trust's compliance with the relevant requirements is provided within Annex 3 (Board Assurance Statement), which sets out the Board's assessment of governance, oversight, and arrangements in place to support this commitment

Yours sincerely



Trevor Smith
Interim Joint Chief Executive

Annex 3 - Board Assurance Statement for Essex Partnership University NHS Foundation Trust		
Please return this assurance statement to the NHS England Inquiry Team by 31 July 2026 to: england.nhsinquiryteam@nhs.net		
Assurance Statement	**Confirmed (Yes / No)**	**Additional comments or qualifications (optional)**
1. The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, mortuary and corporate services, are clear, understood and are tested on a regular basis.	NA	**EPUT does not provide mortuary services.** EPUT has in place subject matter experts and associated governance for the oversight of deaths in care and for Learning from Deaths; linking with its safeguarding procedures and oversight through the Trust Board level Quality Committee (including an annual reports for End of Life Care and Safeguarding provided to the Board of Directors). Where deceased patients are transferred to hospital trust mortuaries, responsibility sits within the governance arrangements of those organisations.
2. The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trist is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.	NA	**EPUT does not provide a mortuary service** and therefore recommendations set out for NHS Hospitals, Medical Education and training, and Ambulance Services were not applicable. Recommendation 19: sets out requirements to ensure that security and dignity of deceased people is included in safeguarding training, policies and assurance. The Trust interprets this action as applying beyond mortuary staff alone. Training, policy and assurance is associated with the roles of staff who may be involved in care after death, safeguarding, bereavement support, transfer arrangements, or oversight of contracts for services where deceased people are handled by, or on behalf of, the Trust. EPUT's Safeguarding Policies and End of Life Care Policy recognises these aspects. Action being taken: Include a specific scenario for care post death within both our Safeguarding and End of Life training programmes (by Q3 2026/27).
3. In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for safeguarding of people after they die.	Yes	EPUT's Executive Nurse has this responsibility set out under the Scheme of Delega

4. The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannon, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency.	NA	**EPUT does not provide mortuary services.**
5. For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.	NA	**EPUT does not provide mortuary services.** EPUT does undertake a PAM self-assessment annually and will ensure this is signed off by its Board of Directors prior to the submission by the 8 September 2026.

Trust Name	Trust CEO/AO Name	Date	Trust Chair Name	Date
Essex Partnership University NHS Foundation Trust	Trevor Smith	31/07/2026	Loy Lobo (Acting Chair)	31/07/2026

7. QUALITY AND OPERATIONAL PERFORMANCE

7.1 QUALITY & PERFORMANCE SCORECARD

Information Item AG/TS

REFERENCES

Only PDFs are attached

Quality and Performance Scorecard 05.08.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 August 2026

Report Title:	**Quality & Performance Scorecard**					
Executive/ Non-Executive Lead:	Alex Green, Joint Interim Chief Executive Officer Trevor Smith, Joint Interim Chief Executive Officer					
Report Author(s):	Janette Leonard, Director of ITT					
Report discussed previously at:	Finance and Performance Committee Clinical Governance & Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
This report provides the Board of Directors with: • A high-level summary of operational performance, quality indicators, safer staffing levels, finance and key NHSE metrics. • The report is provided to the Board of Directors to draw attention to the key issues that are being considered by the standing committees of the Board.	**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 97.2%, remaining above - Target <93%
- PICU Occupancy reported at 86.4%, below target - Target <88%
- Specialist Occupancy reported at 85.3%, remaining below target - Target >95%
- Older Adult Occupancy reported at 87.1%, remaining above target – Target <86%

The Flow Improvement Programme Board has been established including ICB and LA leaders and is focusing on system-wide transformation required to reduce the out of area placements and Adult Acute Care pathway bed occupancy.

Average Length of Stay:

Adult Average Length of Stay on Discharge

- Adult ALoS (Including the Assessment Unit) reported at 55.5 days continues to report below target <60 (National Oversight Framework)
- 116 discharges in June (38 Assessment Unit) – 20 long stays (60+ days) – there is a dedicated workstream in Flow Improvement now focussing on reducing long stays
- Long stay discharge breakdown:
  - **60+ days –** 15 discharges
  - **100+ days –** 9 discharges
  - **200+ days –** 6 discharges

Percentage of inpatients with over 60-day length of stay

June: 25.9%

In the most recently published National Oversight Framework league tables (2025/26 Q4), EPUT is ranked 5th out of 47 for **Percentage of inpatients with over 60-day length of stay**. (2025/26 Q1 EPUT ranked 25th out of 47, Q2 EPUT ranked 14th out of 47 and Q3 EPUT ranked 9th out of 47). This evidences a period of sustained improvement as a result of the Time to Care and Flow Improvement Programmes embedding internal operational process controls and stronger system partnerships for solutions.
Annual planning forecasts for average length of stay have been reviewed following receipt of regional feedback on our planning submission.

Older Adult Average Length of Stay on Discharge

- Older Adult ALoS reported at 86.2 days is reporting below target <90 in-month but over the last 12 months still averaging above target (National Oversight Framework) and a new workstream for OA improvement is being scoped
- 27 discharges in June – 14 long stays (60+ days)
- Long stay discharge breakdown:
  - **60+ days –** 5 discharges
  - **100+ days –** 6 discharges
  - **200+ days –** 3 discharges

PICU average length of stay

- PICU ALoS reported at 85.6 days – Target <50
- 13 discharges in June – 4 long stays (60+ days)
    - **60+ days –** 3 discharges
    - **200+ days –** 1 discharges

The work of the Flow Improvement Programme has yet to scope PICU improvement, but this will be progressed in due course.

Rates of Patients Clinically Ready for Discharge:
Patients who are clinically ready for discharge have all been reporting within target limits for the last 4 months, except for PICU. PICU had a decrease in June to 0.3%, this was caused by 1 patient that was delayed for 2 days.

Inappropriate Out of Area Placements:

- In June, a total of 41 patients were placed out of area, 13 of these were deemed "Inappropriate"
    - 11 placed in Adults
    - 2 placed in PICU
- At the end of June, **103** patients were placed out of area; **26** were deemed Inappropriate
    - Adult – 20
    - PICU - 6

From 27th March, OOA placements have been reclassified based on NHSE criteria. Where a patient is placed within EPUT boundaries, it will now be deemed Appropriate due to continuity of care principles being delivered.

The annual planning commitment has been reviewed and is now set to reduce Inappropriate Out of Area Placements to 0 by March 2029, following receipt of regional feedback on our planning submission.

Virtual Ward Occupancy:
MSE reported at 66% and West reported at 43%, both below target. The Hospital at Home Caseload Audit was completed by West Essex & Herts ICB, there were five key recommendations:

1. Continue to focus on expanding high-intensity, step-up capacity
2. Strengthen acuity-based triage
3. Embed frailty scoring into referral SOPs
4. Improve diagnostic coding using established clinical classification systems such as SNOMED CT and ICD-10
5. Address equity gaps through targeted outreach and pathway refinement

<u>Quality</u>

Cardio Metabolic (Inpatient):
Overall compliance reported at 73.48% in June and remains below target of >90%:

- Sixteen inpatient wards reported fully compliant in June (439 Ipswich Road, Gosfield, Henneage, Peter Bruff, Tower, Kitwood, Stort, Finchingfield, Ruby, The Christopher Unit, Cedar, Beech, Meadowview, Hadleigh, Poplar (CAMHS) and Byron Court)

The Inpatient & Urgent Care Unit service managers are to meet with consultants and matrons to identify and implement a standardised process for capturing cardiometabolic data across all wards. Some areas such as Chelmer and Stort have seen a vast improvement, and it has been encouraged for learning to be shared so other wards can adopt this approach.

Cardio Metabolic (Community):
Overall compliance reported at 68.08% in June and achieved target (>65%).

Mid & South have been proactively obtaining blood results from ICE/Pathology system by Productivity Team, to ensure patient file is up to date on EPR. The projected performance is for this improvement to continue.

NHS Talking Therapies:

CPR, NEE and SOS experienced an increase in referrals in June. Both the 6wk and 18wk wait to treatment are reporting 100%.

The moving to recovery indicator continues to report above the 50% target, with 55.4% reported in June.

No Harm / Low Harm Incident Rates:
June saw a continued increase in numbers reported overall with those reported as no harm/low harm also seeing an increase reflecting a positive reporting culture.

The area with the highest incident reporting rate throughout the year is the Inpatient and Urgent Care unit which is largely driven through incidents on Ardleigh, Galleywood and Hadleigh.

Workforce

Staff Sickness:
Sickness absence remained above the Trust target and increased to 6.0% in June 2026. In response, enhanced governance, oversight and accountability arrangements have been implemented to support the delivery of targeted interventions within areas experiencing the highest levels of absence. These measures are intended to strengthen management ownership, improve early intervention and support a sustained reduction in sickness absence levels over the coming months.

Vacancy Rate & Turnover:
The vacancy rate has continued to remain stable at 8.9% in June 2026. Recruitment activity remains focused on roles that directly support patient safety, including approved safer staffing establishment uplifts and the closure of longstanding vacancy gaps through targeted recruitment plans. Preparatory work is also underway to maximise the onboarding of newly registered nurses expected to commence employment in September 2026, supporting workforce stability and reducing reliance on temporary staffing.

Workforce turnover remains stable, providing assurance that retention levels are being maintained despite ongoing workforce transformation activity and recruitment challenges across the wider healthcare sector.

Workforce Plan and Temporary Staffing:
June 2026 demonstrated a modest improvement in temporary staffing utilisation compared with May 2026. However, usage remains significantly above the planned trajectory, equating to approximately 150 WTE above target, indicating that the pace of delivery of the workforce efficiency programme is not yet sufficient to achieve the required reductions.

Recognising the need to accelerate progress, enhanced oversight and targeted interventions were introduced during July 2026 across key areas including Inpatient and Urgent Care Services, Specialist Services, West Essex, Estates and Facilities, the Mid and South Essex Community Collaborative These actions are designed to strengthen accountability, improve roster management, reduce unwarranted workforce expenditure and ensure staffing levels are aligned to patient safety requirements and agreed establishment levels. Continued executive oversight will be required to provide assurance that planned workforce reductions are translated into sustainable improvements in temporary staffing utilisation and delivery of the wider workforce efficiency programme.

Ward Fill Rates:
June reported 25 wards having less than 90% fill rates against the target of <13, this remains outside of target. 2024-25 had an average of 15 wards not achieving target and in 2025-26, the average is 28 wards.

Finance

Income & Expenditure:
The Month 3 in month deficit is £1.0m, £0.2m adverse to plan. The YTD deficit is £5.6m, £1.5m adverse to plan. Adverse variances is driven by Out of Area Placement costs, Pay costs - including unfunded pay award, the impact of past industrial action, and shortfalls on efficiency programme. The position includes £1.6m of Deficit Support Funding (DSF) relating to the annual DSF entitlement of £6.3m in FY2627.

Efficiency:

The efficiency programme is £0.3m adverse to plan in Month 3 (£1.7m adverse YTD), reflecting shortfalls on temporary staffing, the ongoing need for OOA placements and locality targets not fully delivered. TEG actions to identify increased efficiency delivery have been actioned.

Cash:
Cash balances are £7.5m above plan although cash balances have reduced to £21.4m. Capital £0.3m underspent YTD against plan with £40m of YTD spend.

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

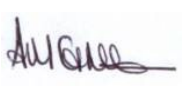
Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

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

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(s)



Alex Green
Interim Joint Chief Executive Officer

Trevor Smith
Interim Joint Chief Executive Officer

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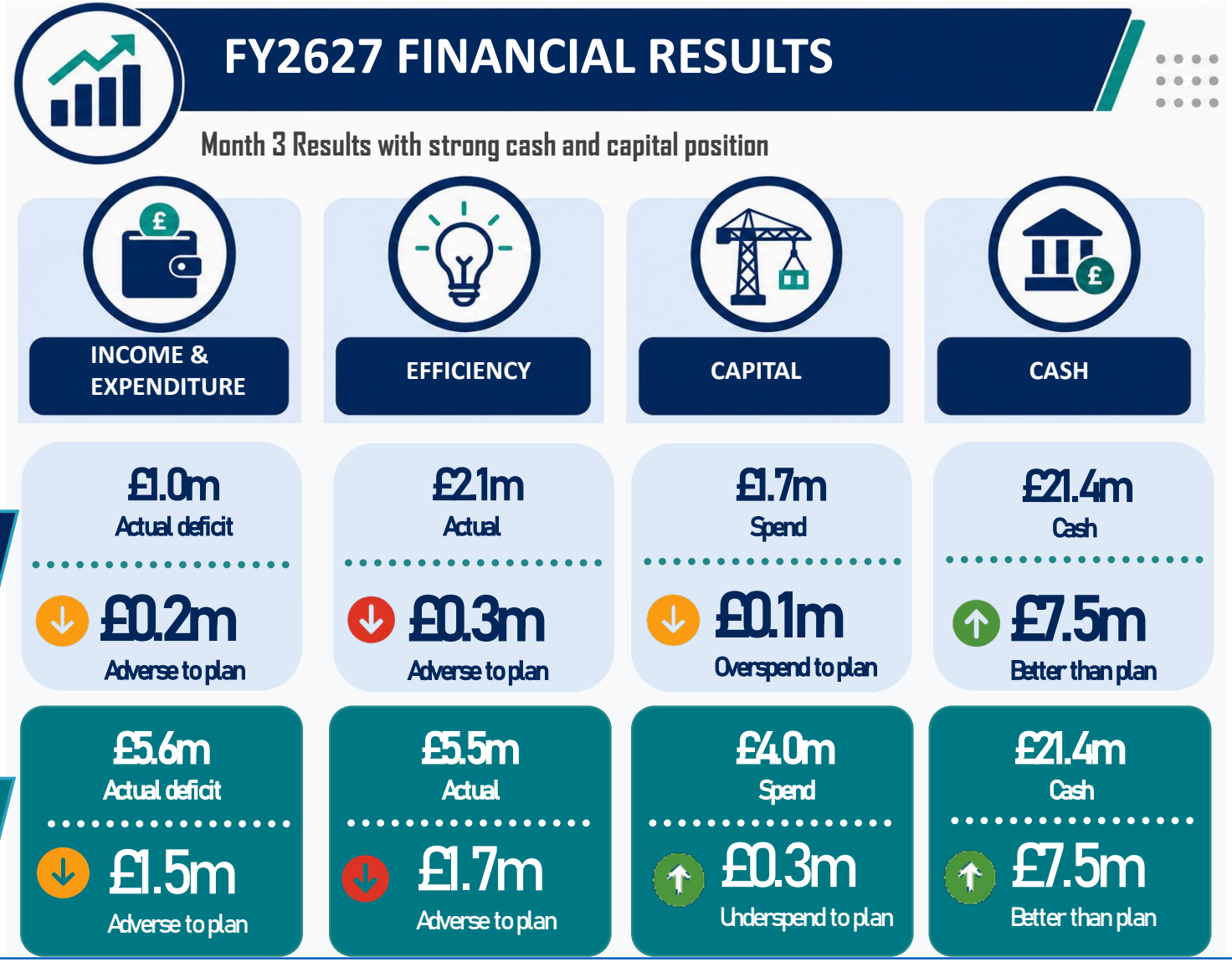
Financial Performance

Month 3 – June 2026

EPUT

FY2627 – Month 3 Financial Results



7.2 COMMITTEE CHAIRS REPORT

Information Item Chairs

• PLACE Results and Action Plan

REFERENCES

Only PDFs are attached

Committee Chairs Report 05.08.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 August 2026

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

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

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

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the report and assurance provided.
2. Note the outcome of the Patient-Led Assessment of the Care Environment (PLACE) for 2025.

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices
Committee Chairs Report Patient-Led Assessment of the Care Environment (PLACE) 2025 Report

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

2. FINANCE & PERFORMANCE COMMITTEE PART 1

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

Committee meeting held: 23 July 2026

Assurance

Financial Report

- The Committee received a report providing Month 3 2026/27 financial results.
- The Month 3 position was £0.2m adverse to plan, and the year to date deficit is £1.5m adverse to plan.
- The cash balance is £7.5m above plan, mainly impacted by efficiency shortfalls and Lampard Inquiry costs.
- Capital spend is at £4m to date - a £0.3m underspend.

Board Assurance Framework

- The Committee received an update on risks relating to the Committee on the Board Assurance Framework Strategic & Corporate Risk Register.
- Four new risks have been added to the Corporate Risk Register:
  - CRR2599 Neurodevelopmental Service Demand
  - CRR2600 Autism Spectrum Disorder Service Demand
  - CRR2659 Backlog Maintenance
  - CRR2660 Estates Workforce
- A risk relating to the target operating model for digital is being explored.

Information

Integrated Performance Report

- **NHS 111 Crisis Calls:** Meetings are being arranged with the highest performing Trusts to identify any learning from their models, and a time and motion exercise will be carried out to understand workflows, capacity and identify where pressure points exist and improvements could be made. A further update on this will be provided at the next meeting.
- **Inappropriate Out of Area Placements:** This measure has been reclassified based on NHSE criteria, resulting in a significant decrease in inappropriate out of area placements from March 2026. Visibility of both inappropriate and appropriate placements will be included from the next meeting.
- **Virtual Ward Occupancy:** The team is working with MSE and West Essex Community Care colleagues on changes to physical healthcare services. A Hospital at Home caseload audit has just been completed for the West Essex service with the outputs of this to be shared at the next meeting.

Action

No Actions for the Board.

Alert

No Alerts for the Board.

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3. PEOPLE COMMITTEE

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

Committee meeting held: 3rd July 2026

Assurance

Assurance Reports

The following assurance reports were received by the Committee:-

- Board Assurance Framework/People & Culture Risk Register
- Education, Learning and Development Update
- Equality, Diversity & Inclusion Report
- Operational Human Resources Report
- Resident Doctor 10 Point Plan Update
- Workforce Key Performance Indicators

NOVA EPR Training Plan
The NOVA EPR Training Plan was presented to the Committee, detailing timelines, staff impact, blended training approaches and operational considerations.

People Strategy Implementation Plan
The Committee received an update on the progress of the People Strategy Implementation Plan, including assurance that the single Red Rated item had been mitigated.

National Quarterly Pulse Survey Report – Quarter 1 2026
The Committee received an update on the Quarter 1 2026 Pulse Survey, noting there had been an increased response rate and improvements in most core questions. A number of targeted initiatives are underway to increase engagement further.

Information

The Mann Report
The Mann Report was published in June 2026. It is a national review into antisemitism and other forms of racism in the NHS. Recommendations will be integrated into EDI reports going forward, and an update will be presented to the Board in October 2026

Resident Doctor 10 Point Plan
The Committee received an update, noting there had been progress in a number of areas including annual leave, rotas and mandatory training, but there continue to be ongoing challenges with wellbeing, access to clean drinking water and vending machines. The Committee supported further improvements in these areas.

Action

No Actions for the Board.

Alert

No Alerts for the Board.

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4. QUALITY COMMITTEE

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

Committee meeting held: 16 June 2026 and 16 July 2026

Assurance

Assurance reports received by the Committee:

- Clinical Audit & NICE
- Mental Health Inpatient Safer Staffing
- Management of a Deteriorating Patient
- Patient Safety Incident Reporting Plan (PSIRP)
- Sexual Safety
- Learning from Deaths
- CQC and Prevention of Future Deaths
- Board Assurance Framework
- Executive Emerging Issues
- Quality of Care Performance Dashboard

The Committee received Deep Dives on the following topics:

- **Use of Contactless Patient Monitoring Technology** - The Committee noted the revised SOP and the approved 6–8-week implementation plan, and that an independent review had been commissioned. Further assurances will be provided to the Audit Committee.
- **Fundamentals of Care (FoC)** - The Committee noted the significant progress made in embedding a person-centred, quality improvement approach across services, with plans to reduce variation in practice through the 2026-28 programme, strengthening nursing leadership, improving outcome measurements, and integrating FoC principles into PSIRF investigations to further enhance patient experience, quality and safety.
- **Cherrydown Ward Ligature Reduction Learning** - The Committee noted the therapeutic patient-centred approach adopted and the significant reduction in incidents, demonstrating a sustained improvement in patient safety.

Violence & Aggression

The Committee received an update on the targeted programme of work focusing on three key areas - enhancing staff training, expanding patient education approaches and developing practical tools to support staff. Positive progress was supported with the next phase of the programme due to commence in September 2026.

Assurance

Ardleigh Ward

The Committee received an update from Ardleigh Ward team members, providing details of the positive changes that had been enacted following earlier CQC inspections. This included improvements in patient safety, staffing (including stability and leadership) and environment. The improvements had led to the CQC stepping-down monitoring and improvements were confirmed following a visit from the Regional Chief Nurse.

The meeting on the 16 July received a further update following the conclusion of a further CQC inspection, with formal feedback awaited.

Patient-Led Assessment of the Care Environment (PLACE) 2025

The Committee received a report providing details of the outcome of the PLACE assessments completed in 2025. The assessment is a nationally recognised and published assessment providing assurance regarding cleanliness, safety dignity, accessibility and patient experience within care environments. The report highlighted the following:

- The Trust had performed well, exceeding national benchmarks and showing improvement across sites.
- The key areas for improvement identified related to the older estate infrastructure, dementia and disability accessibility.

The Committee noted plans were in place to address the concerns and noted these should be targeted improvements, rather than blanket approaches. The PLACE results are attached to this report for noting.

4. QUALITY COMMITTEE

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

Committee meeting held: 16 June 2026 and 16 July 2026

Information

Approvals:
The Committee received and approved the following items:

- Committee Work Plan 2026/27
- Patient Safety Incident Response Plan 2026/28
- Safeguarding Annual Report
- EPRR Annual Report
- Complaints, PALS & Compliments Annual Report
- Health, Safety and Security Annual Report

Action

The Board of Directors is asked to receive and note the outcome of the Patient-Led Assessment of the Care Environment (PLACE) for 2025.

Alert

The Committee noted risks identified following Committee discussions, with none requiring escalation to the Board of Directors.

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PLACE 2025 Report

Patient Led Assessments of the Care Environment

PLACE Introduction

Introduction

Good environments matter. Every NHS patient should be cared for with compassion and dignity in a clean, safe environment. Where standards fall short, they should be able to draw it to the attention of managers and hold the service to account. ***Patient Led Assessments of Care Environments*** (PLACE) provide the motivation for improvement by giving a clear message, directly from patients, about how the environment or services might be enhanced. PLACE assessments focus exclusively on the environment in which care is delivered and do not cover clinical care provision (quality and safety, or ligature risk) or how well staff are doing their job. Having said that, any concerns on safety, quality, and ligature risk are highlighted on the day of assessment and picked up by the teams for immediate action.

The assessments take place every year, and results are published to help drive improvements in the care environment. The results show how hospitals are performing both nationally and in relation to other hospitals providing similar services. The PLACE collection underwent a major national review between 2018 – 2019, significantly revising the question set and guidance documentation. Annual review continues before each programme to ensure this collection remains relevant and delivers its aims.
The assessments involve local people (known as patient assessors) going into hospital 'sites' as part of teams to assess how the environment supports the provision of clinical care. Assessors rate each site out of 1-5 (1 being poor, and 5 being good) based on the following 6 domains:

1. 'Food & Hydration',
2. 'Disability',
3. 'Condition, Appearance and Maintenance'
4. 'Privacy, Dignity and Wellbeing'
5. 'Cleanliness'
6. 'Dementia Friendly'

Each patient assessor is provided with training as per the national guidance, which the patient experience team have adapted for EPUT. They also have an on-the-day orientation of the site, approach, and timings. At this point, each assessor can raise questions, and concerns if there are any. Each visit is facilitated by a member of the Patient Experience team and supported by the Estates and Facilities Team. A key learning remains that PLACE is a great opportunity for corporate services to get out and visit our care environment.

Scoring

- On the day(s) of assessment, the teams visit the various areas of the hospital and unit (e.g. wards, communal areas) filling out the relevant scorecards (paper or digital) based on observed conditions

- Results are sent to NHS England by hospital staff using the Estates and Facilities Management (EFM) online portal

- Marks awarded for each question count towards one or more domains. Domain totals are then calculated on EFM and expressed as a percentage of the maximum marks available for each domain for each organisation and site.

- National averages are calculated to take into account the variation in hospital size (and that not all areas are assessed in larger sites):

What is your immediate impression upon arriving at the hospital / health care site? How happy/confident are you that a good level of patient care and experience will be delivered within the environment?	Very Confident
	Confident
	Not Very Confident
	Not At All Confident

Table 1- overall rating score

Same question is asked upon leaving

Please Tick

Overall, how would you rate the patient meal service observed?	Good
	Acceptable
	Poor

Table 2 – overall food rating score

P	Pass = all aspects of all items must meet the definition/guidance.
Where a Pass is not appropriate, the team must decide to apply a Qualified Pass or Fail score.	
Q	Qualified Pass = a small number of items (no more than 20%) do not meet the definition/guidance.
F	Fail = more than a small number of items do not meet the definition/guidance or where blood or body fluids are present (these always result in a fail score)

Table 3- Individual domain scoring key

Summary Insights

Overall Performance

The Trust performed strongly in the 2025 PLACE assessment, with results demonstrating consistently high standards across the patient environment. Overall performance reflects a positive experience for patients and carers, particularly in relation to cleanliness, privacy, dignity and the general condition of Trust premises. Trust-wide scores compare favourably with both national and regional benchmarks, providing assurance that the quality of our estates and the environments in which care is delivered continue to support safe, respectful and person-centred care.

Sites not visited in 2025 due to the level of acuity during the visiting period and therefore not included in the reporting:

1. The Linden Centre
2. Landermere Centre
3. Kingswood Centre

Board Assurance Summary

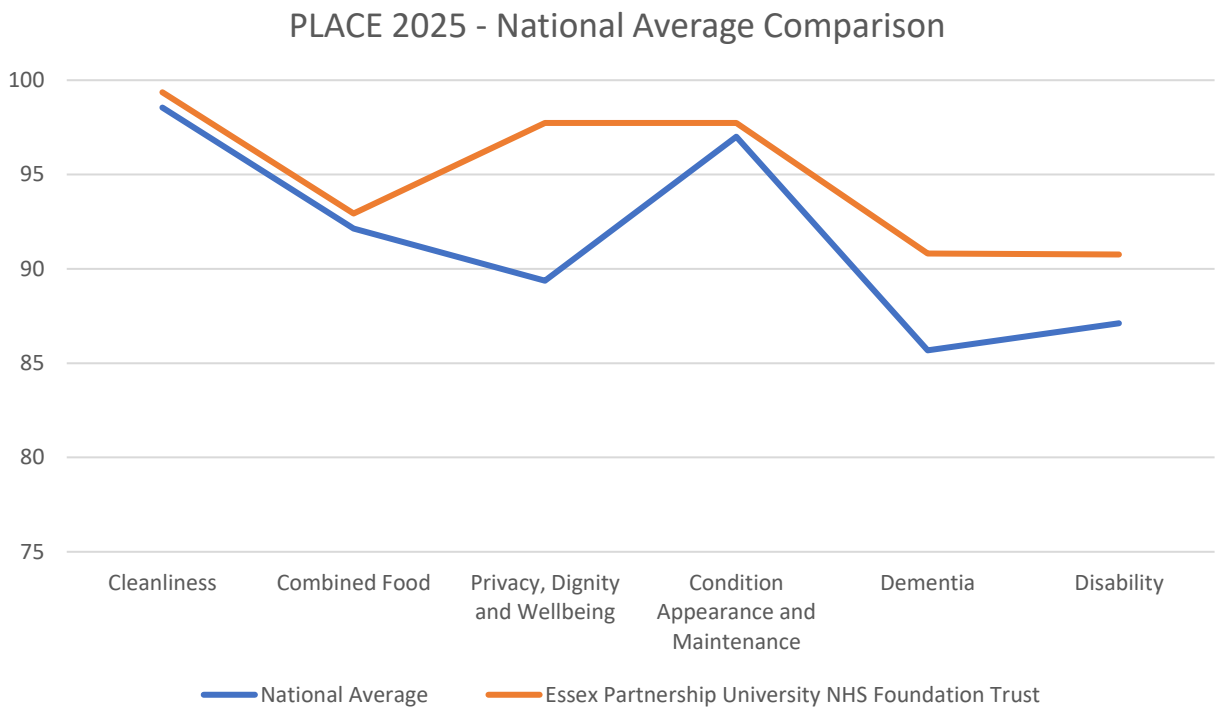
1. Overall PLACE performance is **strong**, with Trust scores **above national averages in all domains**
2. Several sites demonstrate **exceptional and improving performance**
3. **Variation is concentrated** in a small number of sites, largely driven by **estate constraints**
4. PLACE findings are being **actively used to prioritise improvement and estates planning**

National Performance

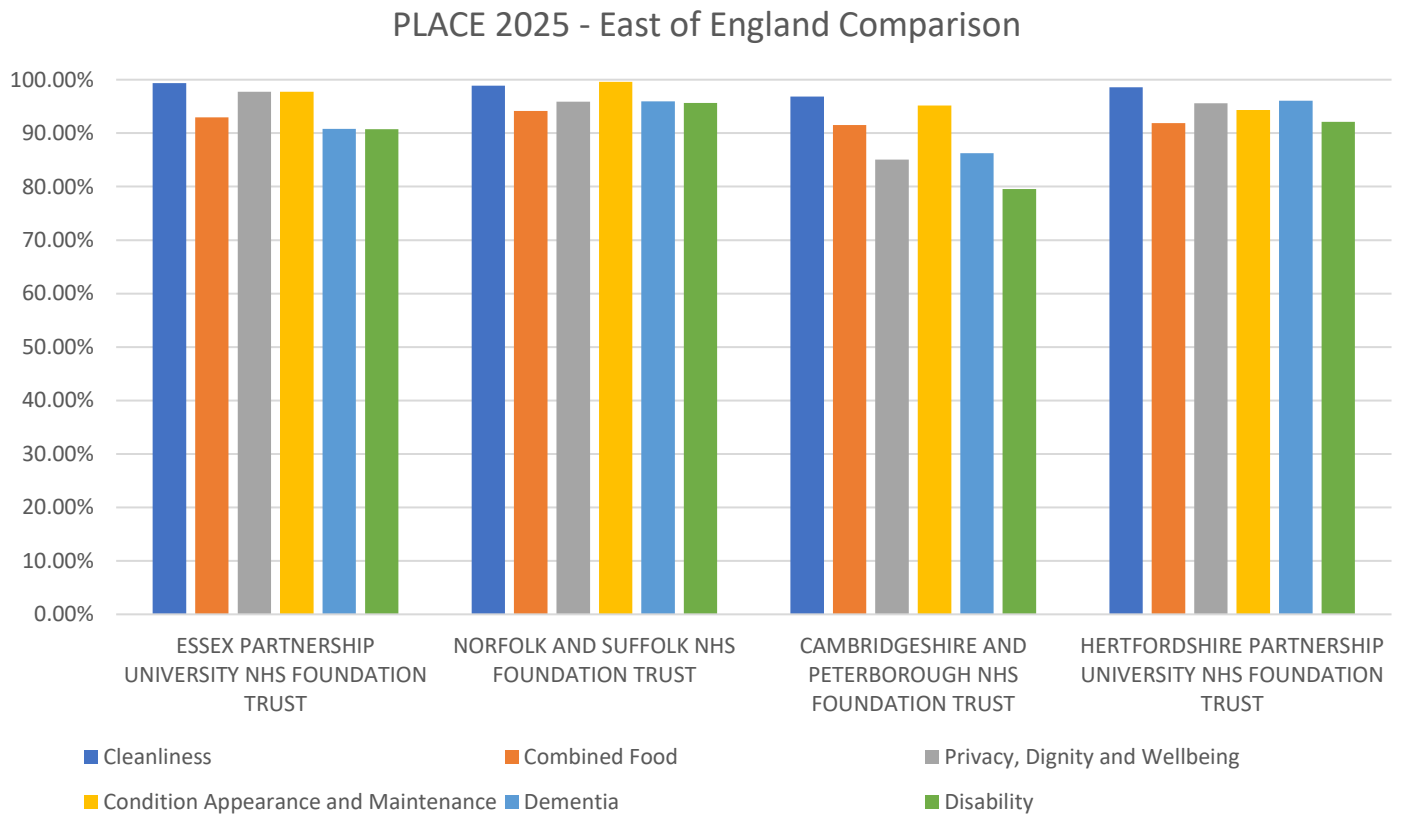
In 2025, the Trust scored above the national average across all reported PLACE domains, including Cleanliness, Privacy, Dignity and Wellbeing, Condition, Appearance and Maintenance, Dementia, and Disability.

This consistent outperformance provides external assurance that the Trust's approach to maintaining high standards across its estate is effective and well-embedded.

Areas where national performance is traditionally more variable, such as Dementia and Disability, also show the Trust performing positively overall.



Regional PLACE Scores



When compared with other mental health and learning disability providers within the East of England, the Trust continues to perform well overall.

Scores for Cleanliness and Privacy, Dignity and Wellbeing are particularly strong and compare favourably with peer organisations.

As with all providers, some variation exists across different PLACE domains, reflecting differences in estate age, service configuration and patient cohorts. The Trust's results demonstrate a solid and competitive regional position.

General Themes

PLACE 2025 results demonstrate a strong and consistent position across the core environmental domains of Cleanliness, Food, Privacy, Dignity and Wellbeing, Condition and Maintenance, Dementia, and Disability. High scores across most sites provide assurance that Trust environments are clean, well-maintained, and supportive of respectful, person-centred care.

Cleanliness, Privacy, Dignity and Wellbeing, and Condition and Maintenance remain strengths, with performance consistently exceeding national averages and showing limited variation between sites. These domains reflect well-embedded operational processes and effective estates oversight.

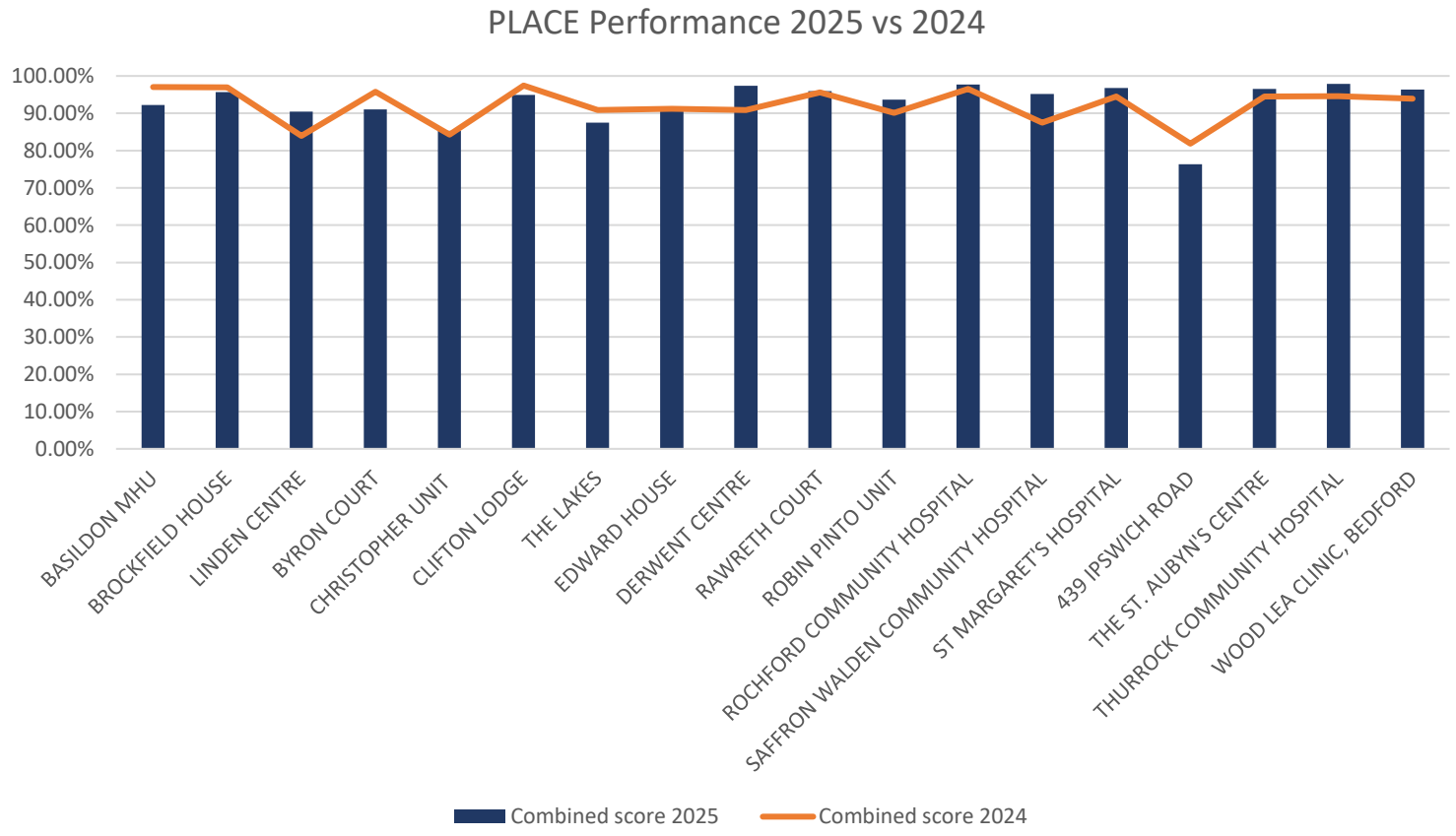
Greater variation is observed within the Food, Dementia and Disability domains, reflecting differences in site configuration, estate age, and service models rather than the quality of care delivered. PLACE findings in these areas are being used constructively to inform targeted, proportionate improvements and longer-term estates planning.

Overall, the results provide confidence that the Trust continues to deliver care in environments that are safe, welcoming, and responsive to the needs of patients, while maintaining a clear focus on continuous improvement.

Variation by Site vs 2024

PLACE 2025 continues to show some variation between individual sites, which is expected given the size and diversity of the Trust estate.

Most sites perform at a high level across all domains, with a small number of outliers clearly identified. These results provide a valuable opportunity to share good practice and focus improvement actions where they will have the greatest impact.



Highest Overall Performers

Thurrock Community Hospital

2025 score: 97.91%
Change from 2024: +3.3%

Thurrock is the Trust's highest-scoring site overall in 2025, with strong performance across all PLACE domains and clear year-on-year improvement.

Rochford Community Hospital

2025 score: 97.73%
Change from 2024: +1.2%

Rochford continues to perform at a very high level, maintaining excellence while also delivering incremental improvement on an already strong 2024 position.

Derwent Centre

2025 score: 97.33%
Change from 2024: +6.5%

Derwent Centre shows one of the most notable improvements across the Trust, moving from a good 2024 position to becoming one of the strongest performers overall in 2025.

7.3 CQC ASSURANCE REPORT

Information Item AS

REFERENCES

Only PDFs are attached

CQC Assurance Report 05.08.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 August 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 14 July 2026, Quality Committee 16 July 2026					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

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

Recommendations/Action Required
The Board of Directors is asked to: 1. Receive and note the contents of the report. 2. Note the assurance on progress against the improvement plan.

Summary of Key Issues

- EPUT continues to be fully registered with the Care Quality Commission.
- The CQC Well Led inspection of EPUT has taken place and the draft report has been received on 23rd July 2026 for factual accuracy with a response due by 6 August 2026
- The CQC undertook unannounced visits of Adult Acute and PICU Services between 7 and 9 July 2026. A data request was received and submitted within timescale. The Trust awaits the draft report.
- The CQC undertook a further unannounced visit to 439 Ipswich Road on 23 June 2026. A Data request was received and submitted within timescale. The Trust awaits the draft report.
- Following the CQC unannounced inspection of Ardleigh Ward in January 2026, the final report was published in June 2026. Improvement actions have been developed to address the CQC areas for improvement and will be monitored through the Trust CQC Improvement Plan.
- Following the CQC unannounced inspection of CAMHS in December 2025, the final report was published in June 2026 with an improved rating of 'Good'.
- Following the CQC unannounced inspection of the Mental Health Long Stay Rehabilitation Unit in November 2025, the final report was published, in April 2026, with a rating of 'Requires Improvement'. An action plan was developed to address the CQC areas for improvement, and will be monitored through the Trust CQC Improvement Plan.
- Following the CQC unannounced inspection of CHS Inpatients the final report was published in April 2026 with a rating of 'Good'
- The CQC Improvement Plan continues to be implemented. There are currently 31 CQC concerns being taken forward, 184 sub-actions have been identified for the CQC actions. This is an increase from 73 to 184 on the last reporting period as CHS Inpatients, 439 Ipswich Road and Ardleigh Ward actions have been added to the CQC Improvement Plan
- Of the 184 sub-actions
    - 4 (2%) are in recovery (Safeguarding x 2, environment x 3)
    - 5 (3%) are on track
    - 115 (63%) reported as complete and pending evidence
    - 41 (22%) Complete evidence received
    - 19 (10%) have been closed through the evidence assurance process.
- There were twelve (12) CQC enquiries raised during this reporting period.
- The overall compliance against CQC quality statements remains 'Good,' based on information available from internal compliance programme for June 2026.

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

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

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

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

Supporting Reports/ Appendices /or further reading

- CQC Assurance Report
- Appendix 1 - CQC Action Plan Update TB June 2026

Lead

Ann Sheridan

Ann Sheridan
Executive Chief Nurse

CQC Assurance Report – August 2026

1. Purpose of the report

This report provides the Board of Directors with:

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

2. CQC Registration Requirements

2.1. Registration

EPUT is fully registered with the Care Quality Commission. Five (5) Leadership updates have been registered with the CQC since the last reporting period:

- CQC Nominated Individual
- Trust Chair
- Interim Chief Executive Officers
- Interim Chief Finance Officer and
- Interim Chief Operations Officer.

3. CQC Inspections and Improvement Plans

3.1. Well Led Inspections

The Trust has received the draft report from the CQC following the Well Led inspection (Jan-March 2026) for factual accuracy with a response due by 6 August 2026.

3.2. CQC Unannounced inspections

3.2.1. Long Stay Rehab (439 Ipswich Road) (November 2025 and June 2026)

Progress has continued against the immediate actions in response to the Section 29A Warning Notice issued February 2026. The CQC published their full inspection report in April 2026 with a rating of 'Requires Improvement', an improvement plan has been developed and includes the initial actions taken to address the S29A concerns to ensure sustainability. These will be monitored through the Trust CQC improvement governance.

The CQC undertook a further unannounced visit to 439 Ipswich Road on 23 June 2026. No immediate concerns or escalations were raised by inspectors during the visit. A post-inspection information request was received and submitted within the required timescales. The Trust is awaiting formal feedback and the outcome of the inspection.

3.2.2. Community Health Inpatients (December 2025)

Following the CQC unannounced inspection of CHS Inpatients in December 2025, the final report was published on 28 April 2026, with a rating of 'Good'. No regulatory breaches were identified. Recommendations identified within the report have been incorporated into a

service improvement plan and will be monitored to ensure improvements are sustained and opportunities for further enhancement are realised.

3.2.3. Ardleigh Ward (January 2026)

Following the CQC unannounced inspection of Ardleigh Ward in January 2026, the final report was published on 11 June 2026. The overall rating for Adult Acute and Psychiatric Intensive Care Unit (PICU) Services remains 'Requires Improvement' as the inspection to Ardleigh was not rated. Improvement actions have been developed in response to the findings and recommendations. These has been added to the master CQC Improvement Plan and are being monitored through the Trust CQC improvement governance.

3.2.4. CAMHS (February/March 2026)

Following the CQC unannounced inspection of CAMHS inpatients in March 2026, the final report was published on 25 June 2026, with an improved rating of 'Good'. No regulatory breaches were identified. The service will continue to maintain compliance with CQC quality statements, continue to embed good practice identified during the inspection and monitor performance.

3.2.5. Adult Acute and PICU (July 2026)

The CQC undertook unannounced visits of Adult Acute and PICU Services between 7 and 9 July 2026. A data request was received and submitted on 24 July 2026. The Trust awaits the draft report.

3.3. CQC Improvement Plan

Progress continues against the CQC Improvement Plan. Following publication of recent CQC inspections, new improvement actions for CHS Inpatients, 439 Ipswich Rd and Ardleigh Ward have been added to the action plan which has led to sub-actions increasing from 73 to 184.

As of 29 July 2026, there are thirty-one regulatory and improvement actions, made up of 184 sub-actions.

Of the 184 sub-actions

- 4 (2%) are in recovery
- 5 (3%) are on track
- 115 (63%) reported as complete and pending evidence submission
- 41 (22%) complete evidence received
- 19 (10%) have been closed through the evidence assurance process.

See appendix 1 for further detail.

3.4. CQC Enquiries

During the reporting period (April / May 2026), the CQC raised twelve (12) 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
07/05/2026	Galleywood Ward The Linden Centre	Clinical Practice – Lack of Support
07/05/2026	Ardleigh Ward The Lakes	Clinical Practice – Poor Care on ward
12/05/2026	Cedar Ward Rochford Hospital	Clinical Practice – Diagnosis
19/05/2026	Larkwood Ward The St Aubyn Centre	Clinical Practice - Observation
19/05/2026	Cherrydown Ward Basildon Mental Health Unit (MHU)	Assault/ Abuse – Patient to Patient Physical Abuse
19/05/2026	Cherrydown Ward Basildon Mental Health Unit (MHU)	Assault/ Abuse – Patient to Patient Physical Abuse
27/05/2026	Stort Ward Derwent Centre	Systems & Procedures – Mental Health Detention
10/06/2026	Stort Ward Derwent Centre	Systems & Procedures – Transfer
08/04/2026	Roding Ward St Margarets Hospital, Mental Health Services	Clinical Practice - Medication
10/04/2026	Peter Bruff Ward The Kings Wood Centre	Clinical Practice - Disagreement with medication
24/04/2026	Hadleigh Unit (PICU) Basildon Mental Health Unit (MHU)	Assault/ Abuse – Patient to Patient Physical Abuse
24/04/2026	Christopher Unit (PICU) The Linden Centre	Assault/ Abuse – Patient to Staff Physical Abuse

3.5. CQC Notifications

All providers are required to notify the CQC of key events and during the reporting period, the Trust made nine (19) notifications to the CQC including:

- Death of a person using the service (4)
- Serious injury to a person using the service (4)
- Abuse (10)
- AWOL (1)

4. Assurance against CQC Quality Statements

4.1. Internal Assurance Programme

The Trust CQC compliance assurance framework is a key component to the Trust Quality Assurance Framework (QAF) under the Quality Assurance domain. The framework has four key areas of focus:

- Service Self-Assessment
- Internal Insight
- CQC Inspection
- Programme of joint quality assurance visits to wards and services

For those areas tested an internal assurance review for June 2026 has provided a Good review outcome, meaning that a satisfactory level of assurance has been provided by core

services during internal compliance visits, quality visits and identified through the Quality Statements Assurance Framework in the period.

4.2. Internal Assurance (Quality Statements Assurance Framework)

The Quality Statement Assurance Framework continues to be reviewed to provide Trust wide assurance of compliance with the CQC quality statements/registration 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 Quality of Care Group meetings for insight and approval. Work continues to enhance the CQC Quality Statements Assurance Framework, this has included the use of technology to improve the collection, collation and triangulation of intelligence from multiple sources. This work has included the exploration of opportunities to create an export of quality control audit outcomes (undertaken at service level on the Tendable platform) into the assurance framework.
Review in the period has focused on the Effective Domain.

4.3. Internal Assurance (Annual Assurance Visit Programme)

Delivery of the 2026/27 programme has continued and builds on the learning and progress achieved over the previous year. The programme is prioritising Safe and Well Led to further enhance assurance processes from Compliance visits by embedding consistency, strengthening impact, demonstrating measurable improvements and escalating where gaps still exist in the provision of quality care and patient experience.

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.

4.4. Quality Assurance Visits

The Quality Assurance Visit programme has continued during the reporting period. Four visits were completed and multi-stakeholder reports providing areas of good practice and areas for improvement highlighted back to the relevant service and Care Unit leadership. Also, reported through the risk and compliance reports provided to the accountability framework meetings.

The visit framework has been reviewed and updated to reflect changes within the Integrated Care Boards (ICBs), ensuring alignment with system-wide priorities and opportunities for collaborative assurance and shared learning.

5. Recommendation

The Board of Directors is asked to:

1. Receive and note the contents of the report.

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

Report Prepared by:

Nicola Jones
Director of Risk and Compliance

On behalf of
Ann Sheridan
Executive Chief Nurse

Appendix 1

CQC Action Plan Update Report

August 2026

Introduction

Level of Assurance: Level 1

NHS Essex Partnership University NHS Foundation Trust

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

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

Version 02 of the action plan includes:

- CQC report Core Services and Well Led (published July 23) – 3 actions remained open at closure of version 01 and have transferred into the new action plan
- CQC report Forensic Services (published April 2025)
- CQC report Acute Wards for Adults and PICU (published July 2025)
- CQC report Wards for people with learning disabilities or autism (published November 2025)
- CQC report for CHS Inpatients (published April 2026)

- PFD action plans open as at August 2025

Key Messages

CQC Activity

- Significant CQC activity in the period with final reports published for CAMHS Inpatients (June 2026 increased rating to Good); CHS Inpatients (April 2026 rating of Good); Ardleigh Ward (June 2026, unrated inspection), Ipswich Road (April 2026 rating of Requires Improvement)
- Draft CQC Well Led Inspection report received for factual accuracy
- Further unannounced visit to 439 Ipswich Road on 23 June 2026. No immediate concerns or escalations. Data request received and submitted within timescales. Awaiting draft report.
- Unannounced visits of Adult Acute and PICU Services July 2026. Data request received and submitted within timescales. Awaiting draft report.

CQC Action Plan v02 (2025)

Following the CQC publishing their final inspection report for LD Inpatient services (Byron Court). An action plan has been developed, approved and added to the CQC Action Plan v2

31 CQC improvements being taken forward, this includes 3 must do actions previously issued by the CQC, 10 Regulation Breach actions (RA), 6 Improvement Actions (IA) and 12 S29/Letter of intent actions. Please see slide 3 for progress.

For note,

- 4 (2%) are in recovery
- 5 (3%) are on track
- All other actions complete and awaiting evidence assurance presentation

Action monitoring is undertaken at the Quality of Care Group which holds action owners to account for delivery. The meeting is chaired by the Executive Chief Nurse. Evidence assurance is undertaken by the Learning Oversight Group before CQC concerns are closed.

Next Steps

Take evidence through Evidence Assurance process for approval of closure.

CQC Action Progress Update

Essex Partnership University NHS Foundation Trust

Summary of implementation status

Overview as of 27 July 2026:

- 184 sub-actions made up from 5 carried forward from the 2022 improvement plan, 73 Regulatory and Improvement actions from inspection reports, 58 letter of Intent actions and 48 Section 29a actions have been developed to address the improvements required.

- Of the 184 sub-actions
  - 4 (2%) are in recovery
  - 5 (3%) are on track
  - 115 (63%) reported as complete and pending evidence
  - 41 (22%) Complete evidence received
  - 19 (10%) have been closed through the evidence assurance process.

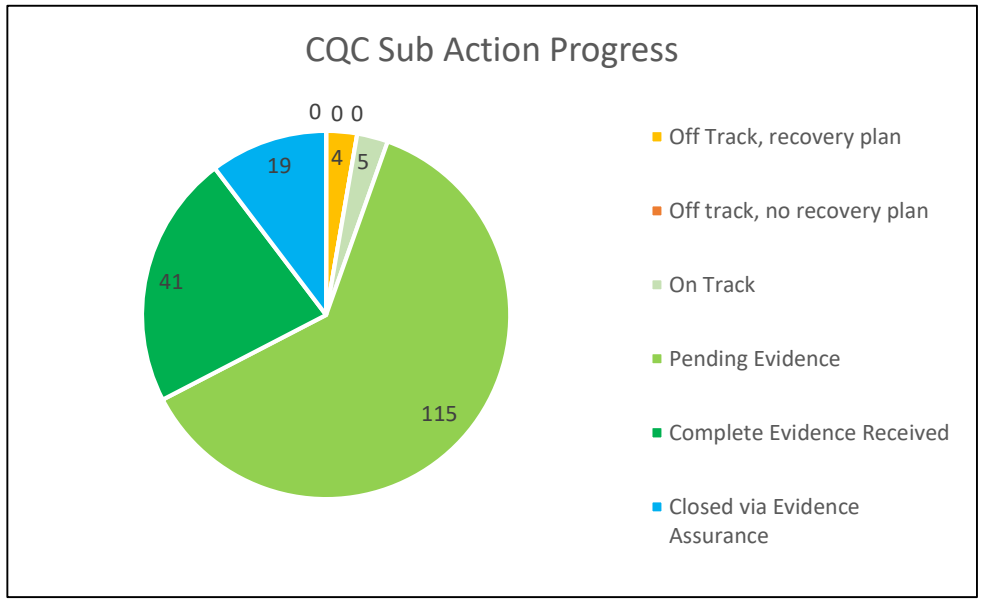
Summary of key improvements made in the reporting period

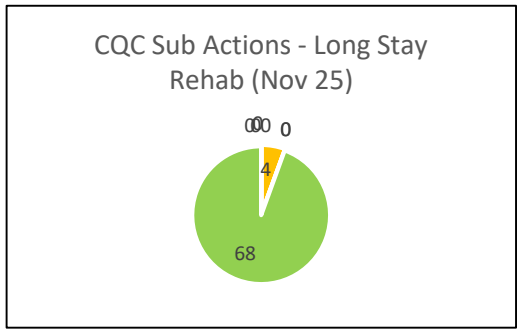
Personalised Care Planning LD

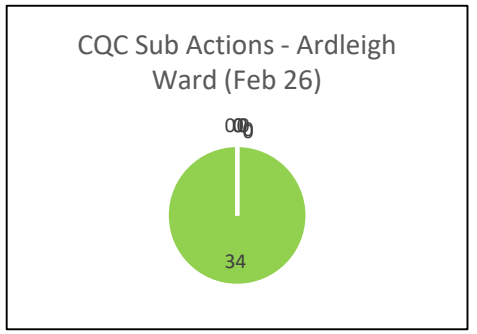
- Care plans were reviewed through 1:1 support sessions, resulting in improved personalisation and greater focus on patient involvement.
- Audit findings used to identify and address gaps in care planning quality.
- Patient forum agendas were revised to strengthen opportunities for patient feedback and involvement in service development.

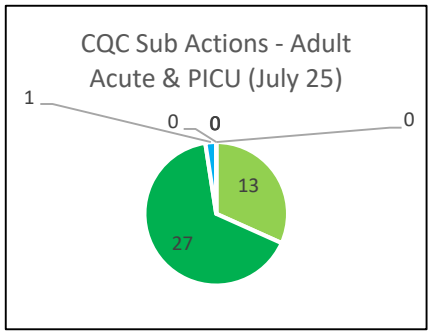
Governance LD

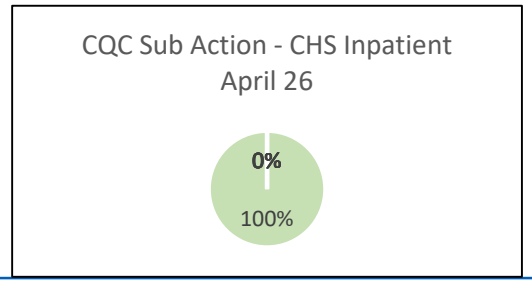
- Staff knowledge and consistency in documentation delivered through Care plan training and focused teaching sessions delivered awareness and comprehension of policy requirements, supporting improved clinical governance.
- Policy requirements were reinforced through the sharing of key policy extracts and delivery of focused micro-teaching sessions, supporting improved governance and compliance.











All actions for Forensic Services (April 25) and LD Services (Nov 25) have been completed with evidence provided, next step Evidence Assurance Presentation

CQC Action Recovery Plan

Action Recovery Plan – Ipswich Road					
Action Ref.	**CQC Concern**	**Sub-Action past timescale**	**Current Position**	**Recovery Plan**	**Lead**
S29 1.5	Staff failed to report safeguarding incidents appropriately	Safeguarding Team rep to attend a MDT meeting to review safeguarding with the team (Action 6 of 7)	The delay was caused by the unforeseen absence of the local Safeguarding Lead which meant they were not able to attend an MDT meeting. There has been significant work undertaken to strengthen safeguarding processes.	The Safeguarding Team continues to provide support to the service during the absence of the Safeguarding Lead. The deadline for completing the action has been extended until August 2026.	Marina Laing
S29.2.2	Staff failed to report safeguarding incidents appropriately	HR coaching to be undertaken with new leadership team at Ipswich Road (Action 7 of 7)	The action was intended to utilise the learning from a HR investigation into safeguarding processes. The investigation took longer to complete than expected, which had an impact on the timescale for this action.	Investigation now complete and learning identified. The coaching is now scheduled to take place by the end of August.	Marina Laing
S29 14.5	Concerns relating to the health and safety of the environment were not effectively actioned, putting patients at risk of avoidable harm b) 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.	Review of lighting outside Ipswich road to be undertaken (Action 6 of 6)	The concern raised by the CQC was due to a patient covering their window, creating a fire risk, due to a outside light directed at their window. The issue was resolved through the patient being moved and no further patients being admitted to the room until the lighting issue is resolved. The action was agreed as an additional action to review the lighting to allow the room to be	Estates are due to attend the site and provide options following review. This has been scheduled to be reviewed by the end of August.	Marina Laing

CQC Action Recovery Plan

Action Recovery Plan – Ipswich Road					
Action Ref.	**CQC Concern**	**Sub-Action past timescale**	**Current Position**	**Recovery Plan**	**Lead**
S29 15.5	Concerns relating to the health and safety of the environment c) 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 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.	Estates to review current contracts to enhance garden maintenance (Action 5 of 5)	The issues identified by the CQC regarding the ligature risks in the garden have been resolved. The remaining action relates to general tidy-up of the garden area. The garden has been maintained on an as required basis.	Estates exploring a more structured and regular maintenance schedule to support ongoing environmental standards. This will be completed in August 2026	Marina Laing

7.4 LEARNING FROM DEATHS Q4 2025/26 REPORT

Information Item AS

REFERENCES

Only PDFs are attached

Learning From Deaths Q4 Report 05.06.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 August 2026

Report Title:	**Learning from Deaths Q4 2025/26 Report**					
Executive Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Michelle Bourner, Mortality Senior Project Lead					
Report discussed previously at:	Learning from Deaths Oversight Group / Learning Oversight Sub-Committee / Quality of Care Group / Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
This report provides the Board of Directors with an overview of mortality data and learning for the Quarter 4 period 2025/26.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

The Quarter 4 2025/26 overview of mortality learning and data report has been presented to the Learning from Deaths Oversight Group, Learning Oversight Sub-Committee, Quality of Care Group and Quality Committee, and approved for submission to the Board of Directors.

To maximise capacity for other key mortality priorities and to progress the development of new processes for automating the production of mortality data into the future, a reduced data process was undertaken for Q4. This reduced process has focused predominantly on Q4 and the mandated data reporting requirements under the national guidance. As a result, the full data dashboards and progress with historic reviews have not been completed this quarter. It is intended to retrospectively prepare this information in the Q1 2026/27 data process.

The draft report sets out:

- Mortality data (as at 01/05/26) mandated for reporting to the Board of Directors in support of mortality surveillance under the Learning from Deaths process. Statistical process control analysis of the data indicates that there are no matters of concern relating to the data.
- A summary of deaths occurring in previous periods for which the review was closed in this quarter.
- Examples of learning emerging from reviews of deaths undertaken during this quarter under Stage 1 and Stage 2 of the Learning from Deaths process, and actions being taken in response.

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**	

Acronyms/Terms Used in the Report			
LDOG	Learning from Deaths Oversight Group	PSIRF	Patient Safety Incident Response Framework
LOSC	Learning Oversight Sub-Committee	SMI	Severe Mental Illness

Supporting Reports/ Appendices /or further reading

Learning from Deaths Q4 2025/26 Report

Executive Lead

Ann Sheridan
Executive Nurse

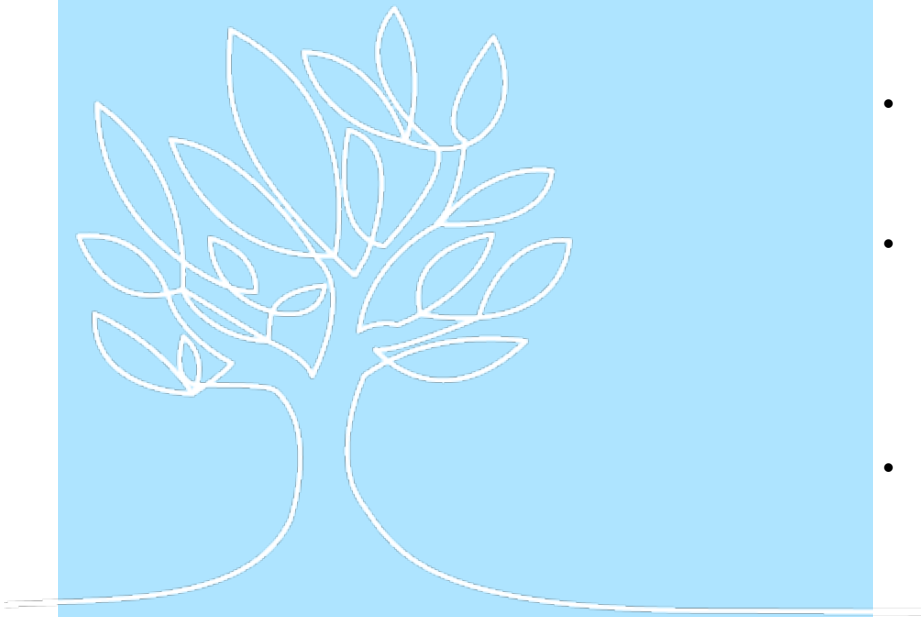
NHS
Essex Partnership University
NHS Foundation Trust

QUARTERLY OVERVIEW OF LEARNING AND DATA

Learning from deaths

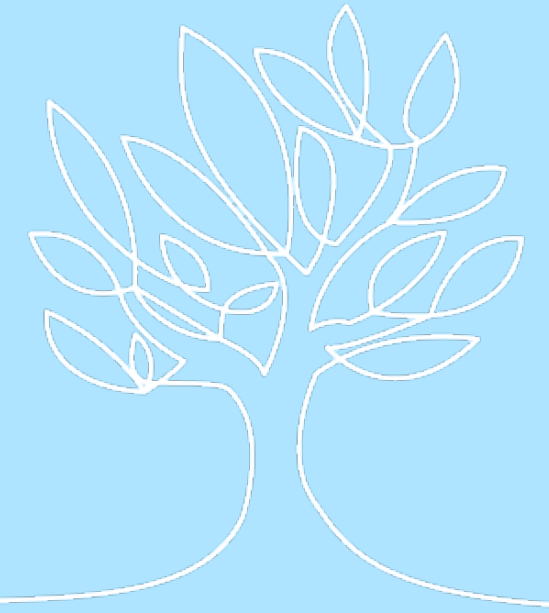
QUARTER 4 - 2025/26

Summary of Quarter 4 2025/26 mortality data (as at 01/05/26) (Page 1)



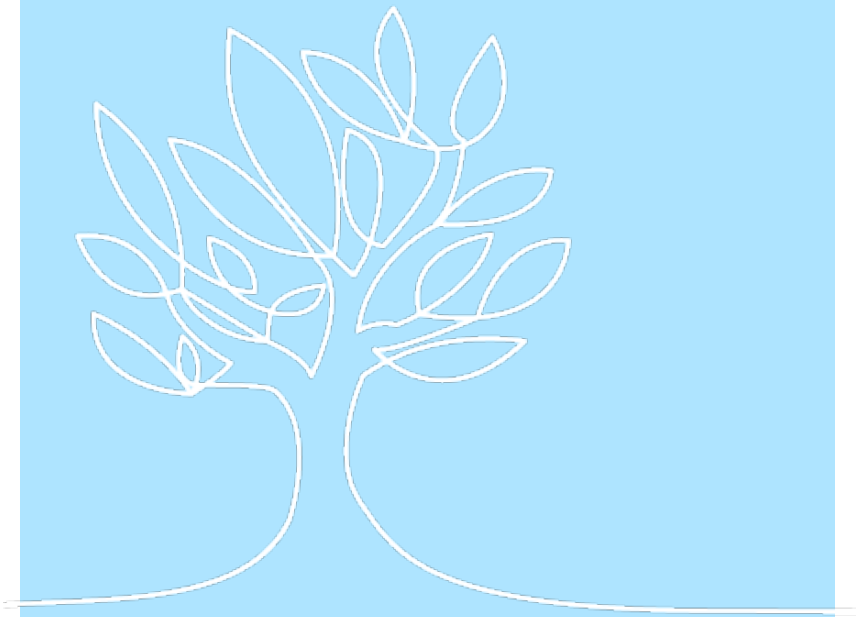
- **Total number of deaths reported:** There were a total of 205 reports of deaths made on Datix (the Trust's incident management system), relating to 197 deaths for Q4 2025/26 (these include those not falling within the scope for mandatory reporting).
- To date, a total of 40 have been deemed as meeting one of the categories for mandatory review under Learning from Deaths arrangements and thus in scope for mandated reporting under the Learning from Deaths Policy.
- The breakdown for certain key categories of deaths is as follows:
  - 6 deaths were inpatient deaths and 8 were nursing homes deaths (see below).
  - 7 deaths were Learning Disability / Autism client deaths (see below).
  - 7 deaths were Essex Drug and Alcohol Partnership (EDAP) client deaths.
  - 5 deaths were deaths 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 Q4 are within usual parameters.
- **Inpatient / Nursing Homes deaths:** Of the 197 deaths reported in Q4, 5 were EPUT community health services inpatient deaths, 1 was an EPUT mental health services inpatient death and 8 were EPUT nursing home deaths. All these deaths have been confirmed as expected natural causes deaths, with the exception of the one mental health inpatient services death for which the cause of death is under determination.
- **LeDeR reporting validation:** All of the 7 reported Learning Disability / Autism deaths have been confirmed as reported to the national LeDeR programme – a programme aimed at learning from the lives and deaths of people with a learning disability and autistic people.

Summary of Quarter 4 2025/26 mortality data (as at 01/05/26) (Page 2)



- **Stage 1 (Datix) reviews:** To date, a total of 150 Stage 1 learning from deaths reviews have been conducted by a local service manager in respect of the Q4 deaths. A total of 33 Stage 1 reviews are recorded as outstanding for deaths occurring in Q4. Targeted work continues to ensure timely completion of Stage 1 reviews, monitored weekly by the Emerging Incidents Review Group. Only 1 Stage 1 reviews remain outstanding from previous quarters (which relates to a Q3 death).
- **Stage 2 (clinical case note) reviews:** A total of 0 deaths in Q4 have been identified to date for Stage 2 mortality clinical case note review / thematic review.
- **Decision Monitoring Tools (DMT):** The number of deaths referred for Stage 2 review is low as Care Units will often commission immediate completion of a DMT (Decision Monitoring Tool) or SWARM by the service which is designed to assist a decision in terms of any PSIRP review required (see below). A completed DMT enables identification of learning and actions; and thus, where a comprehensive DMT has been completed it is often deemed that completion of a Stage 2 review in addition would be unnecessary duplication.
- 18 DMTs have been commissioned to date for deaths occurring in Q4. A total of 4 deaths occurring in Q4 have so far been closed at DMT stage.
- **Stage 3 (Patient Safety Incident Response Framework - PSIRF) reviews:** A total of 5 deaths in Q4 have been identified to date for PSIRF review. All are still underway.
- Where deaths have been deemed via a Stage 1 or Stage 2 review as being potentially more likely than not to have been due to problems in care by EPUT, they will be referred on for a Stage 3 PSIRF review. To date, no Q4 deaths reviewed under Stage 1 or Stage 2 have met this criteria. As stated above, 5 deaths in Q4 have been referred directly for a Stage 3 PSIRF review all of which are underway. A determination as to whether these deaths were more likely than not to have been due to problems in care by EPUT will be made at the point of approval of the review report.

Summary of reviews closed for deaths occurring in Q4 2025/26 (as at 01/05/26)



Level of closure	Total	As a %	Summary
Stage 1 - out of scope	5	4%	Stage 1: 95%
Stage 1 - expected death no concerns	50	45%	
Stage 1 - unexpected / unknown but no criteria for further review met	51	46%	
Decision Monitoring Tool	4	4%	DMT: 4%
Stage 2 - individual mortality case note review	0	-	Stage 2: 0%
Stage 2 - unexpected death of inpatient in last 30 days	0	-	
Stage 2 - thematic review	0	-	
Care Unit SWARM	1	1%	Local PSIRF: 1%
Care Unit Multi-disciplinary Team Review (MDTR)	0	-	
Stage 3 PSIRP	1	1%	Stage 3: 1%
Essex Drug and Alcohol Partnership multi-agency collaborative review	0	-	EDAP: 0%
TOTAL Q4 DEATH REVIEWS CLOSED (AS AT 01/05/26)	112	**101%**	**101%**

Type of death	Total	As a %
Expected Natural	56	50%
Unexpected Natural	15	13%
Unexpected Unnatural	4	4%
Unknown	37	33%
TOTAL	**112**	**100%**

Please note, this analysis only includes those deaths reported on Datix (the Trust's incident management system). Only deaths within scope of the Learning from Deaths Policy are mandated for report onto Datix, with those scope categories being predominantly unexpected deaths. Staff may report other deaths onto Datix (for example, where there may be learning) but this is not mandatory.

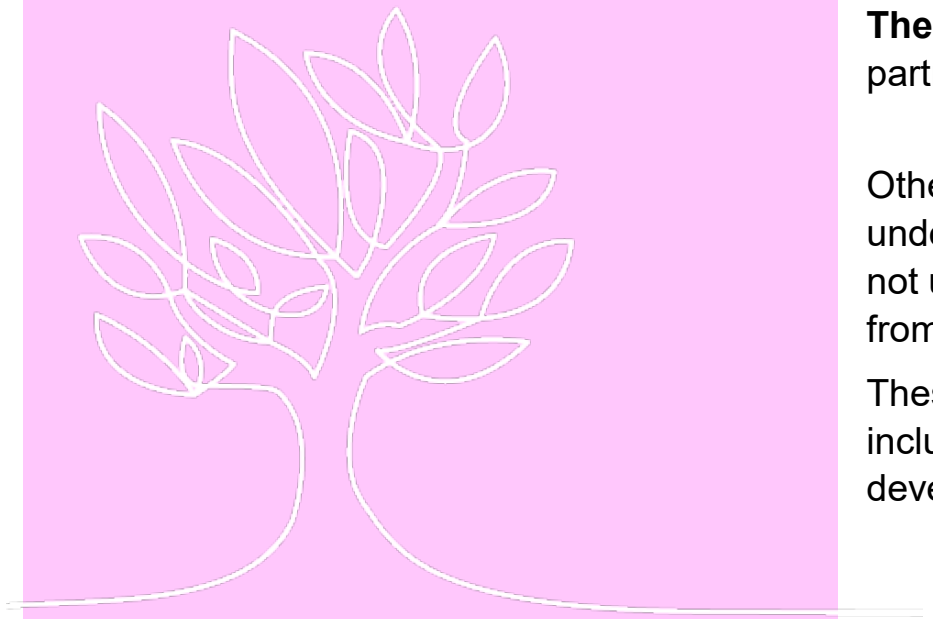
Summary of deaths occurring in previous periods closed in Q4 2025/26

Level of closure	Total	As a %	Summary
Stage 1 - out of scope	9	5%	Stage 1: 65%
Stage 1 - expected death no concerns	40	23%	
Stage 1 - unexpected / unknown but no criteria for further review met	65	37%	
Decision Monitoring Tool	19	11%	DMT: 11%
Stage 2 - individual mortality case note review	1	1%	Stage 2: 1%
Stage 2 - unexpected death of inpatient in last 30 days	0	-	
Stage 2 - thematic review	0	-	
Care Unit After Action Review (AAR)	0	-	Local PSIRF: 2%
Care Unit Multi-disciplinary Team Review (MDTR)	3	2%	
Stage 3 PSIRP	10	6%	Stage 3: 6%
Essex Drug and Alcohol Partnership multi-agency collaborative review	9	5%	EDAP: 5%
LEDER review (Note: This figure is higher than normal due to a data exercise using Southend, Essex and Thurrock LEDER programme data)	21	12%	LEDER: 12%
TOTAL DEATH REVIEWS CLOSED 2025	**177**	**102%**	**102%**

Type of death	Total	As a %
Expected Natural	50	28%
Unexpected Natural	47	27%
Unexpected Unnatural	46	26%
Unknown	34	19%
TOTAL	**177**	**100%**

Please note, this analysis only includes those deaths reported on Datix (the Trust's incident management system). Only deaths within scope of the Learning from Deaths Policy are mandated for report onto Datix, with those scope categories being predominantly unexpected deaths. Staff may report other deaths onto Datix (for example, where there may be learning) but this is not mandatory.

Key learning themes emerging from Stage 1 and Stage 2 reviews completed in Q4



The most common themes emerging from Stage 1 reviews of deaths completed in Q4 are as follows:

Theme 1: Death expected / of patient receiving end of life care – this amplifies the importance of the work being undertaken by the Trust's End of Life Care workstream to continually strengthen the quality of this care.

Theme 2: Clinical care learning – including assessments, risk and care / safety planning, co-ordination of services involved, timely patient follow up, and management of patients whilst on waiting list. This learning is fed into the Trust's programme of Safety Improvement Plans (SIPs)

Theme 3: Death related to physical health issues – again this amplifies the importance of the work being undertaken by the Trust to strengthen the Trust's contribution to physical healthcare

Theme 4: Communication - including with patients, families, within or across teams and with partner agencies.

Other themes identified included no cause of death being available to EPUT at point of undertaking review, record keeping, deaths of patients awaiting ADHD assessment / care, patient not under the care of an EPUT service at the date of death and learning relating to discharge from acute Trust care to EPUT services.

These are consistent with themes identified in previous quarters and are subject to Trust action including incorporation into Safety Improvement Plans, thematic review or facilitated developmental multi-agency discussion.

QUESTIONS TAKEN FROM THE GENERAL PUBLIC

8. ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL

8.1 BOARD ASSURANCE FRAMEWORK

Decision Item AG/TS

REFERENCES

Only PDFs are attached

BAF Report 05.08.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 August 2026

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

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

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

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

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

2. 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.
- Four new risks have been escalated to the Corporate Risk Register (see at a glance summary below)
- 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:
    - **SR4 Demand and Capacity** – Two actions past timescales action 7 (model out of area bed capacity/demand to inform terms of unification project with ICBs including appropriate level of resource transfer) and action 13 (Flow improvement programme – internal). The Full Business Case with investment and modelling of CIP trajectories to reduce OOAP has been presented and approved by Executive Team and Finance and Performance Committee in July and is in the final stages of approval through the Executive Team (final review) and Board of Directors.
    - **SR6 Cyber Security** – DSPT/CAF received overall High Internal Audit assurance rating (April 26). The final DSPT submission Paper was submitted to Finance and Performance Committee (June 2026) to assure the committee of EPUT's compliance to DSPT and confidence in achieving "standards Met). Final submission of the assessment is complete, with Finance & Performance Committee advised of the outcome. New action developed for the 26/27 DSPT-CAF submission in June 2027.
- 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. For note:
    - **New risk CRR2599 – Neurodevelopmental (ND) Service Demand**
      There is a continued risk that demand for ND services will exceed commissioning capacity due to rising referral volumes. This may lead to increased backlogs, extended waits, and negative impacts on patient outcomes, safety, complaints, and Trust performance and reputation. The Initial Risk Score of 20 (C4×L5) has reduced to 16 (C4×L4). Initial controls and actions have been established to further reduce the risk.
    - **New risk CRR2600 – Autism Spectrum Disorder (ASD) Service Demand**
      Demand for ASD services is similarly projected to exceed commissioned capacity due to rapidly increasing referrals. Consequences include growing backlogs, extended waits, and associated impacts on patient experience, quality, and organisational reputation. The Initial Risk Score of 20 (C4×L5) has reduced to 16 (C4×L4). Controls and actions are in place.
    - **New risk CRR2659 – Backlog Maintenance**

Work is underway to complete a stratified review of the current maintenance backlog to understand the level of risk, in terms of locality (localised / trustwide) and severity (compliance / complexity). This will allow the development of further actions. The initial risk score of 16 (C4xC4) has been set and controls and assurances identified.

- **New risk CRR2660 – Estates Workforce**
  Options appraisal completed and due to be presented to the Board of Directors, with the outcome impacting identified actions relating to the delivery of the options. Other identified actions relating to the review of business continuity plans, the uploading of the asset register and researching alternative technical solutions are on track. The initial risk score of 20 (C4xC5) has been reduced to 16 (C4XL4) and controls and assurances identified.

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

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

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

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

Supporting Reports/ Appendices /or further reading
• Board Assurance Framework Dashboard • Strategic Risk Register • Corporate Risk Register

Lead
Denver Greenhalgh **Executive Director of Corporate Governance**

NHS
Essex Partnership University
NHS Foundation Trust

Board Assurance Framework

July 2026

EPUT

NHS
Essex Partnership University
NHS Foundation Trust

Risk Dashboard

Jul-26

EPUT

Strategic Risk Register at a Glance

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

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

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

% Risks with Controls	% Risks with Assurances	Actions Overdue	Extended Actions
100%	100%	0	6

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
SR3	All	Finance & Resources Infrastructure	TS	Safety, Experience, Compliance, Service Delivery, Reputation	5x3=15	15 15 15	Capacity and adaptability of support service infrastructure including Estates & Facilities, Finance, Procurement & Business Development/ Contracting to support frontline services.	ERIC and PAM oversight continues, with scheduled meetings to confirm progress and forward plans; no high or significant risks are currently identified. ERIC submission completed for 2026 and PAM submission underway for August 2026
SR4	All	Demand and Capacity	LW	Safety, Experience, Compliance, Service Delivery, Reputation	5x3=15	15 15 15	Long-term plan. White Paper. Transformation and innovation. National increase in demand. Need for expert areas and centres of excellence. Need for inpatient clinical model linked to community. Socioeconomic context & impact. Links to health inequalities.	Action 7 and 13 now overdue extended timescale (Full business case with investment and modelling of CIP trajectories to reduce OOAP has been presented and approved by Executive Team and Finance and Performance Committee in July and is in the final stages of approval through the Executive Team (final review) and Board of Directors. Action 13b discontinued as work is now being undertaken through Reset Flow Improvement Programme. Action 14 complete with community demand and capacity workstream now initiated.
SR5	All	Statutory Public Enquiry	CO	Compliance, Reputation	4x4=16	16 16 16	Statutory Public Inquiry into Mental Health services in Essex (Lampard Inquiry)	The intensity of work is likely to continue between now and the end of the evidence gathering phase of the Inquiry, aligned to the published forward view on the Lampard Inquiry website. A substantial programme redesign has been undertaken to strengthen the oversight and capacity in the team. Inquiry requests continue to be managed through additional resource within the team, and trajectory planning is progressing as planned.

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
SR6	All	Cyber Security	ZT	Safety, Experience, Compliance, Service Delivery, Reputation	5x3=15	15 15 15	The risk of cyber-attacks on public services by hackers or hostile agencies. Vulnerabilities to systems and infrastructure.	Paper submitted to F&P (June 2026) to assure the committee of EPUT's compliance to DSPT and confidence in achieving "standards Met). Final submission of the assessment complete. Action is closed and new action (see action 15) preparation for the 26/27 DSPT-CAF submission in June 2027. National guidance for cyber risk management due to be released imminently. It is EPUTs intention to use this guidance to review the risk/threat level that modern cyber security threats represent. Internal auditors (TIAA) proposing an assessment of threat response readiness for AI. to be approved though audit committee. Following F&P support, National training for boards has been recommended and supported, this is being agreed within the Board Development Programme for 2026/27
SR7	All	Capital	TS	Safety, Experience, Compliance, Service Delivery, Reputation	5x4=20	20 20 20	Need to ensure sufficient capital for essential works and transformation programmes in order to maintain and modernise	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. In addition the Trust is in the process of bidding for additional sustainability funding from NHSE Work continues to identify additional external funding opportunities. Opening capital plan for 2026/27 is £24.1m, plan approved during planning process. The Trust continues to progress with estates disposals/rationalisation to release additional CDEL and support mitigation of capital pressures. At month 3 Cash balances remain stronger than planned at £21.4m, which is £7.5m above plan, although the balance has reduced during the year. Capital expenditure is £0.3m below plan year to date, with total capital spend of £4.0m against plan.
SR8	All	Use of Resources	TS	Safety, Experience, Compliance, Service Delivery, Reputation	5x4=20	20 20 20	The need to effectively and efficiently manage its use of resources in order to meet its financial control total targets and its statutory financial duty	For Month 3 the Trust reported an in-month deficit of £1.0m which is £0.2m adverse to plan. The year-to-date (YTD) deficit is £5.6m, representing a £1.5m adverse variance against plan. This is less than a 1% variance to plan YTD and is anticipated to maintain the financial rating in NOF to a 3. The adverse position is primarily driven by continued pressure from Out of Area (OOA) placement costs, pay expenditure (including the impact of the unfunded pay award and residual costs associated with previous industrial action), and shortfalls in delivery of the efficiency programme. The most significant risk to financial sustainability continues to be the delivery of the £47 million efficiency programme. Robust oversight is maintained through the Trust Executive Group (TEG), which continues to support the identification and delivery of savings opportunities. However, achieving the full value of planned efficiencies remains a key delivery risk and is critical to improving the Trust's financial position.
SR9	All	Digital and Data Strategy	ZT	Safety, Experience, Compliance, Service Delivery, Reputation	5x3=15	15 15 15	The risk of not being a digitally and data enabled. Resulting in poor and/or limited implementation of systems and technologies, with reduced quality and safety of care and lack of data intelligence to inform change / transformation	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. Nova risk now tracked as CRR 2598 and supersede action 12 which has been closed. Action 11 - Note the action for the Digital Target operating model implementation phase 2 has been further extended. This was raised at F&P Committee requesting further detail on the challenges with the Nova Operating Model. This will be taken forward by the Nova Programme leads through F&P and updated in this action as appropriate.

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
SR10	All	Workforce Sustainability	AM	Staff Morale Skills Gap Workforce Sustainability	4x3=12	12 12 12	The risk of not being able to recruit and retain staff. Resulting in associated skills deficit, reliance on temporary staffing, impact on staff morale and quality of care provided to our service users.	The People Strategy implementation continues, with bi-monthly updates to the People Committee. As at month 3 we are 2% above workforce plan and continuing with monthly meetings with NHS England. Enhanced controls and measures have been established for recruitment and targets set for care units to reduce non clinical roles by 10%. Workforce targets are being overseen by TEG. Action 6 complete, People strategy approved by the Board of Directors
SR11	All	Staff Retention	AM	Staff Morale Skills Gap Workforce Sustainability	4x3=12	12 12 12	The risk of not being able to recruit and retain staff. Resulting in associated skills deficit, reliance on temporary staffing, impact on staff morale and quality of care provided to our service users.	Local and Corporate Induction Reform proposals were signed off by Executive Team and a delivery group is now working towards implementation date of September 2026. There will be quarterly staff experience reports into People Committee. An External Provider has been agreed to deliver our Starter and Leaver experience surveys (Great with Talent) this will provide better understanding of staff experience. Action 11 complete. Alongside the staff networks, engagement and co-creation of a new model of engagement with staff is being developed through 'staff cafes' starting in July 2026, 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. This will act as a precursor to what is likely to be a new workforce ambassador/engagement champion model in 2027-28
SR12	All	Organisational Development	AM	Staff Morale Skills Gap Workforce Sustainability	4x4=16	16 16 16	The risk of not addressing cultural development and management of change, then we may not achieve a positive impact, resulting in suboptimal outcomes for staff and patient care.	Action 11 complete. The OD & Culture team has now identified talent across 3 years with a focus on the new EPUT Leadership Programme by working with Care and Corporate Units. The King's Fund/BRAP service specification is currently in development, supported by an internal steering group. Nomination and talent mapping have identified the first cohort, set to begin in Autumn 2026.
SR13	All	Quality Governance	AS	Safety Effectiveness Experience Regulator	5x3=15	15 15 15	Government Led Inquiry; Trust and Confidence in our services; Adverse regulatory inspection outcomes.	All actions have been completed, next steps are to review impact of new controls and assurances and reassess the risk score

Corporate Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
2	4	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				2598, 2659 2599, 2660 2600	
5					

% Risks with Controls	% Risks with Assurances	Actions Overdue	Extended Actions
100%	100%	0	1

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
CRR11	All	Suicide Prevention	KS	Safety	4x3=15	12 12 12	Implementation of suicide prevention strategy	Suicide prevention strategic plan continues to be overseen by the Quality Committee Work continues to shift from risk stratification to personalised safety planning in line with NHS England guidance, supported by updated clinical tools and documentation. STORM training capacity has increased and plan in place to full out to all services by December 2027.
2598	All	Nova Programme	ZT	Safety, Quality, Service Delivery, Reputation	4x4=16	16 16 16	Potential for implementation delays, system integration issues, technical challenges	Adoption and embedding controls continue to progress through the Change and Engagement, Training and Nova Readiness pillars, supported by the transformation strategy, training approach and service readiness criteria aligned to go-live requirements. Oversight remains in place through CODA, Nova Implementation Group, Nova Joint Programme Board and Nova Joint Steering Board, with DHA assurance partner oversight. A Nova Director of Operations has been appointed following interviews in June 2026, with onboarding progressing in line with recruitment processes. The Transformation Plan (New action 6) remains in development and will support change management, training, engagement, benefits realisation and post go-live sustainability arrangements, with completion due by 31 July 2026.
2599	All	ND Services, ADHD, MSE NE and West	LW	Safety, Quality, Service Delivery, Reputation	4x4=16	16 16	Demand for Neurodevelopmental (ND) services will continue to exceed commissioning capacity	New Risk. There is a continued risk that demand for ND services will exceed commissioning capacity due to rising referral volumes. This may lead to increased backlogs, extended waits, and negative impacts on patient outcomes, safety, complaints, and Trust performance and reputation. The Initial Risk Score of 20 (C4×L5) has reduced to 16 (C4×L4). Initial controls and actions have been established to further reduce the risk.
2600	All	Service demand exceeding capacity for ND services, Autism South & NE	LW	Safety, Quality, Service Delivery, Reputation	4x4=16	16 16	ASD service demand will continue to exceed capacity	New Risk. Demand for ASD services is similarly projected to exceed commissioned capacity due to rapidly increasing referrals. Consequences include growing backlogs, extended waits, and associated impacts on patient experience, quality, and organisational reputation. The Initial Risk Score of 20 (C4×L5) has reduced to 16 (C4×L4). Controls and actions are in place.

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
2659	All	Increasing Backlog Maintenance Requirements	JD	Safety, Quality, Service Delivery, Reputation	4x4=16	16 16	Backlog Maintenance requirements from ageing Estate & infrastructure continue to increase, despite the multiple millions of capital and revenue investments in recent years.	New Risk. Work is underway to complete a stratified review of the current maintenance backlog to understand the level of risk, in terms of locality (localised / trustwide) and severity (compliance / complexity). This will then allow the development of further actions.
2660	All	Failure to maintain a safe, compliant and resilient estate due to insufficient Estates workforce capacity	JD	Safety, Quality, Service Delivery, Reputation	4x4=16	16 16	Workforce shortages in specialist Estates roles, increasing statutory requirements, and contractor reliance may result in non-compliance, infrastructure failures, reduced resilience, increased costs, staff burnout, and harm to patient safety and organisational reputation.	New Risk. Options appraisal completed and due to be presented to the Board of Directors i, with the outcome impacting identified actions relating to the delivery of the options. Other identified actions relating to the review of business continuity plans, the uploading of the asset register and researching alternative technincal solutions are on track.

Strategic Risk Register

July 2026

SR3- Finance and Resources Infrastructure (2135)

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

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

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

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

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

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
EPUT Strategy	EPUT Strategy (approved Jan '23) Estates Strategy (Board approved)	Finance and Performance Committee Report (update 2 x year)	
Operational Target Operating Model	Care Unit Leadership in place Procurement Team restructured to align with TOM	Accountability Framework	
Estates and Facilities, Contracting and Business Development, Finance Teams	Established Support services	PMO support in place reporting to Executive Restructure fully recruited to	IA Estates & Facilities Performance (Moderate/Moderate Opinion)
Range of corporate, finance policies	Policy Register and procedures in place	Accountability Framework	
PMO, Capital Programme, E-expenses system,	Capital Steering Group	Capital Planning Group	
Audit Programme and ISO		Audit Committee	
Premises Assurance	Operational meetings for PFIs ERIC and PAM Groups Established	Premises Assurance Model in place with assessment	
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. ERIC submission completed for 2026 and PAM submission underway for August 2026

SR4- Demand and Capacity (2136)

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 C5 x L4 = 20	*Current Risk Score* C5 x L3 =15	*Target Score* C5 x L3 = 15	**Note 1**: Previous reported completed actions 1-6, 8-12 and 14 have been removed from the report. **Note 2:** Undertaking analysis of Trend over time for length of stay occupancy, OOA placements and proportion of metal health act detainees - this will inform the assessment of current risk and that of intended action impact to control / mitigate the risk (informing the target score)

Executive Responsible Office: Executive Chief Operating Officer
Director Lead: Director of Performance and Improvement
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 - Inpatient		Performance Reporting Published alongside EPUT Strategy One year touch points and monitoring through accountability	
Community First Transformation Programme 4 key work streams			
Flow improvement programme		IPUC Steering group reporting to Accountability Framework to IPUC System Implementation Group (SIG)	

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 June 26	SC/DC	Control	The Trust awaits ICB analysis of confirm FY25/26 outturns and has put forward a Q1 deadline to agree a resource transfer value. In addition the Trust has undertaken a Flow Away Day which has identified a number of workstreams to support Out Of Area reductions. Full business case with investment and modelling of CIP trajectories to reduce OOAP has been presented and approved by Executive Team and Finance and Performance Committee in July and is in the final stages of approval through the Executive Team (final review) and Board of Directors.
13	Flow improvement Programme - Internal (EPUT)	Extended June 26	DC	Control	Full business case with investment and modelling of CIP trajectories to reduce OOAP has been presented and approved by Executive Team and Finance and Performance Committee in July and is in the final stages of approval through the Executive Team (final review) and Board of Directors.
13b	Demand and Capacity Length of Stay Programme (System) EPUT to hold the system to account for delivery	Discontinued	DC	Mitigation	This action has now been marked as discontinued, as the work is being progressed through the Reset Flow Improvement Programme, (Action 13), which provides the appropriate governance and delivery framework for implementation.
14	Community demand and capacity work stream initiated	Complete	AS	Control	The workstream has been initiated, next steps are to review the initial findings and confirm next steps. New actions will be added in the next reporting cycle.
15	Deliver Community First Programme	Sep-26	KS	Control	Review underway to consider if there should be a separate risk associated with the 'community first programme'. The programme involves offer for assertive outreach patients and a proposal for patients with complex emotional needs and was presented to the Executive Team in May 2026, with agreement to commence implementation where operations were ready and noted that resource gaps needed to be assessed and associated business case to be developed for commissioner discussions.

SR5 - Statutory Public Inquiry (2140)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5 x L4 = 20	*C4 x L4 = 16*	*C4 x L2 = 8*	**Note 1:** Previous reported complete actions 1-7, 9 & 10 have been removed from the Board report. **Note 2:** a) reviewing the financial plan to ensure it both captures the direct costs and also the exit strategy within the financial framework. b) Inquiry information requests continue to be managed through additional resources, and trajectory planning is progressing as planned. risk remains on track to achieve its delivery objectives. Inquiry requests continue to be managed through additional resource within the team, and trajectory planning is progressing as planned.

Executive Responsible Office: Executive SRO for the Inquiry Board Committee: Audit Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Exchange portal in place to safely transfer information to the inquiry	Data protection impact assessment and reporting in place.		
Inquiry Team (Resource with skills and capacity to meet the needs of EPUT response to the Inquiry).	Executive SRO (Catherine O'Connell) Project Director 2 Associate Directors 1 Head of PMO Browne Jacobson Essex Chambers	Trust Board of Directors	S21 Notice issued in respect of eight Rule 9s request from the Lampard Inquiry (negative assurance) - All Section 21 requests have been met
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 eight Rule 9s 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 (practical support and signposting) Here for You Provision (psychological support) Browne Jacobson (legal support) Executive & Leadership Team	Trust Board of Directors	Internal audit.
Support for families	Contract with HPFT	Trust Board of Directors	Internal audit. No referrals made to date
Communications Plan	Multi-disciplinary Project Working Group Multi-disciplinary Communications Group	Trust Board of Directors	Internal audit.
Management Development Programme (Inquiry Module)	Led by Inquiry Team - sessions ongoing		

Actions (to modify risks)		By When	By Who	Gap	Update
8	Rule 9 progress	Ext June 27	CBD	Assurance	The intensity of work is likely to continue between now and the end of the evidence gathering phase of the Inquiry, aligned to the published forward view on the Lampard Inquiry website.
11	Review and refocus of Project Inquiry resource to align with the skill set required to respond to the latest Rule 9's.	Extended July 26	CO	Control	A substantial programme redesign has been undertaken to strengthen the oversight and capacity in the team. This has included: The appointment of a dedicated Senior Responsible Officer; several staff secondments and transfers; increased legal, programme and clinical support; and development of a more structured Programme Management Office approach with further external support commissioned.
12	Ensure staff receiving individual Rule 9 requests form 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.	Jun-27	CBD	Control	Operational recovery remains key focus. Additional resources and restructure of roles within the team is expected to create greater stability moving forward Inquiry requests continue to be managed through additional resource within the team, and trajectory planning is progressing as planned.

SR6- Cyber Security (2141)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5 x L4 = 20	*C3 x L5 = 15*	*C4 x L3 = 12*	**Note 1:** Previous reported completed actions 1 - 10 and 12 have been removed from the report. **Note 2:** Action 13 has been developed to provide further assurance and to identify any additional controls required to strengthen the mitigation of AI-related risks.

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

Key Controls	Controls Assurance		
	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
Cyber Essentials Accreditation	Certification achieved	Monitor controls through IGSSC	Accreditation certified
MSE ICS DSPT & Cyber Maturity Baseline	Completed	Audit Committee	DSPT/CAF Action plan Implementation following TIAA audit **Received an overall High Internal Audit Assurance rating April 26**

Actions (to modify risks)		By When	By Who	Gap	Update
11	Deliver against DSPT CAF assurance plan to reach standards met.	June 2026 Completed	AW	Assurance	Paper submitted to F&P (June 2026) to assure the committee of EPUT's compliance to DSPT and confidence in achieving "standards Met). Final submission of the assessment complete. Action to closed and new action (see action 15) preparation for the 26/27 DSPT-CAF submission in June 2027
13	Engage with NHSE National cyber team to identify advice on new controls for AI cyber threat management and make recommendation to the IGSSC group for consideration.	Sep-26	AW	Assurance	National guidance for cyber risk management due to be released imminently. It is EPUTs intention to use this guidance to review the risk/threat level that modern cyber security threats represent. Internal auditors (TIAA) proposing an assessment of threat response readiness for AI. to be approved though audit committee.
14	Board Cyber security assurance training	TBC	AW	Assurance	Following F&P support, National training for boards has been recommended and supported, organisation of the training underway.
15	New action (July 26) Preparation for the 26/27 DSPT-CAF submission in June 2027, acknowledging new directives and expectations to build on the 25/26 baseline.	Jul-27	AW	Assurance	New action. Planning underway for 2026/27 submission.

SR7- Capital (2142)

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 activates

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note 1:** Previously report completed actions 2 -7 have been removed from the report.
C5 x L4 = 20	*C5 x L4 = 20*	*C5 x L3 = 15*	

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

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
	Controls Assurance		
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 2026/27	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 2026/27 in place and prioritisation undertaken		
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. In addition the Trust is in the process of bidding for additional sustainability funding from NHSE Work continues to identify additional external funding opportunities.
8	Delivery Capital Plan 2026/27	31-Mar-27	JD	Control	Opening capital plan for 2026/27 is £24.1m, plan approved during planning process. The Trust continues to progress with estates disposals/rationalisation to release additional CDEL and support mitigation of capital pressures. At month 3 Cash balances remain stronger than planned at £21.4m, which is £7.5m above plan, although the balance has reduced during the year. Capital expenditure is £0.3m below plan year to date, with total capital spend of £4.0m against plan.

SR8 - Use of Resources (2143)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note 1:** Previous reported completed actions 1,2,3 - 5,6,7-13 has been removed from the report.
C5 x L4 = 20	*C5 x L4 = 20*	*C5 x L3 = 15*	

Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: Finance and Performance Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Finance Team (Response to new resource bids and financial control oversight)	Team 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
14	Deliver Financial Efficiency Target 26/27	End March 2027	TS	Control	The Trust is focusing on FY26/ 27 schemes with a newly formed Transformation and Efficiency Group. The target efficiency for FY26/27 is £43.1m with 7 key themes identified for delivery. These are being monitored within TEG and via AF meetings. The efficiency programme is £0.3m adverse to plan in Month 3 and £1.7m adverse year to date. The variance reflects under-delivery across key schemes, including temporary staffing reductions, OOA placement savings and locality-based efficiency targets. Actions agreed through the Transformation and Efficiency Group (TEG) to increase the level of efficiency delivery have been implemented and continue to be monitored.
15	Deliver Financial plan for 26/27	End March 2027	TS	Control	For Month 3 the Trust reported an in-month deficit of £1.0m which is £0.2m adverse to plan. The year-to-date (YTD) deficit is £5.6m, representing a £1.5m adverse variance against plan. This is less than a 1% variance to plan YTD and is anticipated to maintain the financial rating in NOF to a 3. The adverse position is primarily driven by continued pressure from Out of Area (OOA) placement costs, pay expenditure (including the impact of the unfunded pay award and residual costs associated with previous industrial action), and shortfalls in delivery of the efficiency programme.

SR9 - Digital and Data Strategy (2144)

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. **Note 2:** Action 12 (Datix action 17765) - This action is close on the basis that the associated risk is now captured and actively managed through a separate risk entry, specifically focused on the monitoring and tracking of the NOVA risk to EPUT, thereby maintaining appropriate oversight and assurance.

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

Controls Assurance

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

Actions (to modify risks)		By When	By Who	Gap	Update
11	Digital Target operating model implementation - phase 2	Extended Oct'27	AW	Control	The programme timelines for Nova have previously been agreed by the Board and there are regular updates to the Board on the Nova programme. The update to the timeline for the Digital Target Operating model has been updated to bring it in line with the agreed Nova programme timelines. This was raised at F&P Committee requesting further detail on the challenges with the Nova Operating Model. This will be taken forward by the Nova Programme leads through F&P and updated in this action as appropriate.
12	Implementation of new UEPR	Closed	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. Nova risk now tracked as CRR and supersede this action This action is recommended for closure on the basis that the associated risk is now captured and actively managed through a separate risk entry, specifically focused on the monitoring and tracking of the NOVA risk to EPUT, thereby maintaining appropriate oversight and assurance.

SR10: Workforce Sustainability (2145)

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4 = 16	*C4 x L3 = 12*	*C4 x L3 = 12*	**Note 1:** Previously reported completed actions 1 - 5 and 7-8 have been removed from the report.

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

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
People Strategy	People Strategy Implementation Plan overseen by Chief People Officer and People & Culture Group.	Approved by Board of Directors January 2024 with revised draft developed for ratification in June 2026.	
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
People strategy implementation plan 2025/26	People and Culture Group	Executive Team	
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	Complete	Executive Director of People and Culture	Assurance	The People Strategy has been approved by the Board of Directors and has been included as a control.

Actions (to modify risks)		By When	By Who	Gap	Update
9	Adherence to the Workforce Plan for 26/27 as part of the overall Operational Planning process.	Mar-27	Executive Chief People Officer	Assurance	Action is associated to the substantive workforce and the temporary workforce plans. The People Strategy implementation continues, with bi-monthly updates to the People Committee. As at month 3 we are 2% above workforce plan and continuing with monthly meetings with NHS England. Enhanced controls and measures have been established for recruitment and targets set for care units to reduce non clinical roles by 10%. Workforce targets are being overseen by TEG. Monitoring via weekly and monthly workforce reporting.
10	Developing a five year plan with professional leads for staff development.	Jan-27	GB / Professional Leads	Assurance	Facilitated discussion to take place in the summer with all professional leads. This will be reported to the Board in September and that the rollout remains on track. Model reviews are progressing as planned.

SR11: Staff Retention (2146)

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4 = 16	*C4 x L3 = 12*	*C4 x L3 = 12*	**Note 1:** Previously reported completed actions 1 - 7 have been removed from the report. **Note 2:** Action 11 is now complete and will be removed from future reporting

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

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Staff Experience Team (aligned with Retention Strategy and priority areas)	Director of OD & Culture to oversee alignment and development of strategy aligned to oversight of recruitment plan overseen by Associate Director of People - Resourcing.	Operational Workforce Group and oversight and assurance at People Committee.	
People strategy implementation plan 2025/26	People and Culture Group	Executive Team	
People and Education Strategy	People Strategy Implementation Plan overseen by Chief People Officer and People & Culture Group.	Approved by Board of Directors January 2024 with revised draft developed for ratification in June 2026.	
People Promise investment by NHS England	This is supported by retention and well being plan undertaken by OD & Culture team.	People & Culture Indicators in IPR with oversight at People Committee with emphasis on turnover rates and trends. This also includes oversight of exit interview analysis.	Workforce Key Performance Indicators oversight at System People Board

	Actions (to modify risks)	By When	By Who	Gap	Update
8	Delivery of People Promise objectives with an emphasis on new starter experience.	Extended Oct 26	Director of OD & Culture	Assurance	Local and Corporate Induction Reform proposals were signed off by Executive Team and a delivery group is now working towards implementation date of September 2026. There will be quarterly staff experience reports into People Committee. An External Provider has been agreed to deliver our Starter and Leaver experience surveys (Great with Talent) this will provide better understanding of staff experience. Request to extend timescale to October to align with new induction programme and Great with Talent coming on line.

Actions (to modify risks)		By When	By Who	Gap	Update
9	To complete and publish the outcome from the Cultural Review being undertaken by BRAP/Kings Fund.	Sep-26	Director of OD & Culture	Assurance	The cultural review is nearing completion with an expectation that feedback is provided to the Board in the first instance alongside areas of focus and possible development. It is then intended to be shared across the organisation alongside action to support cultural development. The full Cultural review report will be submitted to July Week 3 Executive Team and then publicised to stakeholders
10	To commence the new senior leadership programme from September 2026 and to develop a mid manager and aspirant leadership programme.	Mar-27	Director of OD & Culture & Director of Education	Assurance	The curriculum for the senior leadership programme will be informed by the outcome of the cultural review. Nominations have been requested from Care Unit and Corporate teams with programme to be initiated in September 2026. 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 Angla Ruskin University. 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 Angla Risking University. The Talent Map to identify leadership cohorts is complete and currently being reviewed. The course content has been agreed and delegates will shortly receive their formal invitations and calendar holds for 6 formal sessions interspersed with short coaching group sessions.
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.	Complete	AD of OD & Culture	Assurance	Action complete: Alongside the staff networks, engagement and co-creation of a new model of engagement with staff is being developed through 'staff cafes' starting in July 2026, 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. This will act as a precursor to what is likely to be a new workforce ambassador/engagement champion model in 2027-28

SR12: Organisational Development (2147)

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- 9 have been removed from the report. **Note 2:** New actions 15: Absence Management Plan **Note 3:** Employee relations IA findings added to the controls assurance

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

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
OD Team	The new Director of OD & Culture	Oversight will be provided and sought by People committee by Director of OD & Culture.	
People and Education Strategy	Oversight by Learning & Education Group	Oversight by People committee and approved by Board of Directors January 2024	
Key performance indicators.	Workforce Efficiency Group	Oversight by People Committee and Board within the Integrated Performance Report	Oversight by system People Board. Audit of Employee Relations received reasonable assurance (Feb 2026)
OD Practitioners Partnership			

	Actions (to modify risks)	By When	By Who	Gap	Update
10	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. 70 delegates identified from talent mapping will commence the new leadership programme in late September 2026. RAG reflects extended timescale
11	Develop 3 year development plans that highlights talent mapping and support succession plans for each Care Unit as well as corporate teams.	Complete	Director of OD & Culture	Assurance	Action Complete: The OD & Culture team has now identified talent across 3 years with a focus on the new EPUT Leadership Programme by working with Care and Corporate Units.
12	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 with an assurance report to July People Committee. Further detailed plans will be shared with August People Committee and then signed off at October Trust Board which has an EDI Focus.

Actions (to modify risks)		By When	By Who	Gap	Update
13	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. All Cohorts across the next 3 years have been mapped.
14	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.
15	NEW ACTION: The development of an Absence Management Plan which reflects reactive and proactive measures and interventions based on People Promises to reduce absence levels and improve staff experience	Oct-26	Director of OD & Culture	Assurance	Sickness Absence Management Plan is in draft form with OD&C providing Proactive elements.

SR13 - Quality Governance (2353)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5 x L4 = 20	*C5 x L3 =15*	*C5 x L2 = 10*	**Note 1:** Previously reported completed actions 1-8 have been removed from the report. **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 - with reduction to C5 x L2 = 10.

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

Key Controls	Controls Assurance		
	Level 1 (Management)	**Level 2 (Oversight)**	**Level 3 (Independent)**
Lead roles and subject matter experts	Nursing and Quality Structure Medical Directorate Structure Care Unit Leadership Triumvirate (Including DDQS)		IA Safeguarding (outcome detail to be added) 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 (outcome detail to be added)
Clinical (Quality) Governance Structure	Each meeting annual work plan, annual report and effectiveness reviews.		CQC inspection report for Adult MH Inpatient Wards and PICU (July '25) identified a breach in governance as a consequence of not having adequate oversight of the breaches within the Safe domain. IA reviewed CG structure process - Reasonable assurance received 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

Corporate Risk Register

July 2026

EPUT

CRR11 - Suicide Prevention (2285)

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

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note 1:** Previous reported completed actions 1 - 5 have removed from the report for CRR11.
C4x L4 = 16	*C4 x L3 = 12*	*C4 x L2= 8*	

Executive Responsible Office: Executive Medical Director
Director Lead: Interim Deputy Medical Director Mental Health Urgent & Impatient Services
Leads: Alan Hewitt, Deputy Director of Quality and Safety
Board Committee: Quality Committee

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

Actions (to modify risks)		By When	By Who	Gap	Update
6	Implementation of the Suicide Prevention Framework (as aligned to the Quality of Care Strategy	Dec '26	GW	Control	Q4 report presented to Quality Committee May 2026. The Trust has maintained zero inpatient deaths by suicide for over two years. However, 12suspected suicides were reported this quarter, all occurring within community and urgent care pathways, reflecting both local and national trends where suicide risk is higher outside inpatient settings. A weekly executive-led emerging incident review, chaired by the Chief Nurse, has been implemented improving triangulation, learning and timely oversight of all deaths and serious incidents across care units. The Trust is continuing to progress a major transition from risk stratification to personalised safety planning, fully aligned with NHS England's Staying Safe from Suicide guidance. Key foundations are now in place, including updated self-harm clinical guidelines and revised assessment and safety formulation templates. There has been a 17% reduction in self-harm incidents this quarter and a 4% reduction year-on-year, supported by targeted ward-level quality improvement work, particularly in CAMHS and adult inpatient services. STORM training capacity has expanded significantly, with additional facilitators now trained. Compliance currently stands at 85% in urgent care services, with a clear plan in place to reach 95% Trust-wide, alongside the launch of a mandatory suicide prevention module for all staff.

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:** Previous reported completed action 1 has been removed from the report

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 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
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 though 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
First-of-Type	Established Mental Health, Community Care and Community & Mental Health PAS workstreams Unification Governance and dependencies with Acute work streams. Design Authorities CODA and TDRA Weekly Nova Change Control Group Weekly Nova Configuration Change Group Nova Implementation Group	Nova Joint Programme Board and Nova Joint Steering Board	DHA assurance partner oversight Strategic Delivery Partner engagement

Key Controls	Level 1	Level 2	Level 3
Clinical Digital Safety	Clinical Safety Officers (CSOs) engaged in workstream development Ongoing training for additional CSOs to help ensure the system remains safe Regular review of robust Hazard Log Nova Clinical Safety Officer Working Group Design Authority CODA CCIO/CNIO oversight of workflow assurance Nova Implementation Group	Nova Joint Programme Board and Nova Joint Steering Board	DHA assurance partner oversight
Adoption and Embedding	Change and Engagement, Training and Nova Readiness Pillars in place to support adoption Transformation strategy and training approach established Defined service readiness criteria aligned to go-live requirements Design Authority CODA Nova Implementation Group Monitoring of system usage and uptake	Nova Joint Programme Board and Nova Joint Steering Board	DHA assurance partner oversight
Change and Engagement	Change and Engagement Pillar governance Communication Strategy and plan in place System partners and GP engagement Regular communications across the Trusts including regular slot on All Team Briefing and Senior Leader meetings Design Authority CODA Nova Implementation Group	Nova Joint Programme Board and Nova Joint Steering Board	DHA assurance partner oversight
Resourcing	Clear forward planning for operational staffing identifying required roles, skills and backfill Nova Implementation Group	Weekly Exec forums for escalations and concerns including resourcing Nova Joint Programme Board and Nova Joint Steering Board	Regional Team oversight DHA assurance partner oversight Strategic Delivery Partner support
Nova Strategy and Planning	Pillar strategies approved with delivery objectives in plan Domain plan assurance into 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
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	Extended 31/07/2026	PD	Control	A successful candidate was appointed to the Nova Director of Operations role following interviews conducted in June 2026. Onboarding is progressing in line with the recruitment process. The action has been extended and will remain open until the onboarding process is fully completed.
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 Weekly reviews are planned to commence to further strengthen oversight and progress tracking.
6	Develop and implement a Transformation Plan to support adoption and embedding of new ways of working, including change management, training, engagement, benefits realisation and post go-live sustainability arrangements.	31/07/2026	PD	Control	In development

CRR 2599 - ND Services, ADHD, MSE NE and West

Risk Description: There is a risk that that demand for Neurodevelopmental (ND) services will continue to exceed commissioning capacity; this is caused by rapidly rising referrals and limited workforce and resources, and would result in growing backlogs and extended waits, leading to an impact upon patient outcomes, safety, complaints, and the Trust's performance and reputation

Initial Risk Score C4x L5 = 20	*Current Risk Score* C4 x L4 = 16	*Target Score* C4 x L2= 8	**Note 1:** Risk approved by the Executive Team in June 2026 for escalation onto Corporate Risk Register. **Note 2:** Operational actions 16905-16909 been removed from report

Executive Responsible Office: Chief Operating Officer
Director Lead: Director of Psychology Services
Leads: Deputy Clinical Director for Psychology Services and Lead Psychologist
Board Committee: Finance and Performance

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Commissioned ND Service	Establishment	Commissioner Meetings	
Discussion with MSE ICB about some further FTC additional prescribing resource to address the meds waiting list which people are not being taken off currently due to managing shared care challenge resulting from the GPs decision	Clinicians identified for role and starting approx. June 2026		
Report to NE/NW ICB highlighting Demand and Capacity (March 2023)			
Regular updates to MSE ICB around volume of referrals received and emails/contact to pursue a business case and discussion around service structure.			
Monthly meetings as of Sept 24 to review contracts and KPI's. Gap in control as these meetings have been postponed in light of changes in ICB			

	Actions (to modify risks)	By When	By Who	Gap	Update
1	Demand & Capacity Modelling and Harms review	Milestone 1 - May 26 Milestone 2 (TBC)	RT/ GW	Control	Michelle Bourner has recently completed a stage 1 deaths review in relation to ADHD which was presented at the LDOG May 2026. Team capacity mapping being shared by ICBs DDQS West Essex taking forward this workstream and is dependent on the outcome of stage 1 deaths review and team capacity mapping.
2	Explore triage models - Review combining services and referrals	Dec-26	SA/AO	Control	The impact of this measure is anticipated to improve efficiency in the use of current resources while not influencing referral volumes or the existing workforce capacity. Working on this currently, dependent on exploring the use of Psyomics and digital solutions. Front door request underway.

Actions (to modify risks)		By When	By Who	Gap	Update
3	Engage with Pharmacy to manage medication related pressure	Complete	SA/AO	Control	As described above - Current issue re medications (Melatonin and Clonidine) which the GP Feds do not prescribe and the GPs do not either if they relate to someone's ADHD. No further action to be taken
4	Consider temp staffing or Locum support	May 26 - ongoing	SA/AO	Control	Implemented and stabilizing the situation, preventing further deterioration. Any new agency or locum support would require lead time and additional funding due to current cost pressures. Nursing post have been approved at cost pressure for 6 month intervals. May 26 - one last member of staff returning from maternity leave in a graded way in July/August for ADHD services in NE/West and the cover for her post contract ends at the end of June. Whilst it is positive to have the mat leave member of staff returning, the NE/West service continues to remain under pressure from general revels, the GPs decision around SCA and the fact that paediatric refls have returned to the service from April this year having been diverted to another service for the last year. Both services are struggling with the impact of the GPs decision on our specific services but also on the wider EPUT MH services where we are being asked to support/pick up prescribing for those with ADHD in AMH services in the community.
5	Digital solution to waiting list – (Psyomics bid)	Dec-26	AW/ JL	Control	This initiative has the potential to support services in multiple ways and may positively influence the score once waiting lists are reviewed, validated, and a new referral management process is implemented with Psyomics input. Awaiting funding coming through and in the process of completing a Front Door request to support in establishing a project group for this.
6	Complaints data review/ FOI/ Inquest review	Sep-26	SA/AO	Assurance	Service has met in May 2026 with the complaints and PALS team to look at a different way to manage the volume coming through and have a plan in place to trial through June 2026 Still awaiting progression with the plan for a regular report to send out to FOI requests but haven't had any for a short time, this links to publication scheme project (aim Sept 2026). Have had SAR requests increasing though.

CRR 2600 - Service demand exceeding capacity for ND services, Autism South & NE

Risk Description: There is a risk that ASD service demand will continue to exceed capacity; this is caused by rapidly rising referrals and limited workforce and resources, and would result in growing backlogs and extended waits, leading to an impact upon patient outcomes, safety, complaints, and the Trust's performance and reputation.

Initial Risk Score C4x L5 = 20	*Current Risk Score* C4 x L4 = 16	*Target Score* C4 x L2= 8	**Note 1:** Risk approved by the Executive Team in June 2026 for escalation onto Corporate Risk Register. **Note 2:** Operational actions 17042-17047 have been removed from report

Executive Responsible Office: Chief Operating Officer Director Lead: Director of Psychology Services Leads: Deputy Clinical Director for Psychology Services and Lead Psychologist Board Committee: Finance and Performance	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
ASD Service	Establishment	Commissioner Meetings	
Monitoring of waiting list length and referral times	This is ongoing and we are working through validating the WL as part of the process of the WL initiative and the transfer of some of our longest waiters to the accredited providers.		
Prioritisation/triage process in place for urgent and high-risk cases – we don't offer this as it is not possible to do.	As noted we are not able to offer this.		
Signposting to interim support resources where available	This information is given in acknowledgement and WL letters.		
Regular performance reporting and meetings with/to management and commissioners	We were having monthly meetings with the ICBs (combined) as part of a process to look primarily at the ADHD services but also at wider ND services. Meetings postponed in light of ICB changes		
Digital System	We are exploring funding for a digital option for triage using Psyomics but are currently awaiting further confirmation. (see action 5)		
Action plan and Business Case			
T&FG to look at ASD and ADHD across MSE established			
Neurodiversity Steering Group gap analysis			
Reviewed and streamlined referral and diagnostic pathways – data on referrers.			

Actions (to modify risks)		By When	By Who	Gap	Update
1	South Autism Service Pilot to be further run from March 2026 (Pilot launched Nov 24 which offers people a 'clinical opinion' rather than a full diagnostic assessment.)	Sep-26	SA	Control	Pilot being run starting March 26 Pilot paused
2	Recruitment and training of additional specialist staff	Complete - Ongoing	SA	Assurance	Staff on maternity leave agreed replacement at cost pressure Agreed cost pressure of an additional trainee CAP in the south Autism service, this is replacing/instead of a band 4 AP post
3	Signposting (regularly when contact with individuals) and offering training and consultation. Onward referrals for those who have some additional needs in terms of MH concerns, housing/social care needs. Supportive letters for individuals on the WL or who have had a diagnostic assessment for employers/benefits/further education around reasonable adjustments	Complete - Ongoing	SA	Assurance	Signposting information is included on service letters. Service offers training and consultation to other services (recent training for GPs was completed in March 2026). Supportive letters for individuals on the WL or who have had a diagnostic assessment around reasonable adjustments for example is given on a case by case y case basis.
4	Review and streamline referral and diagnostic pathways – data on referrers.	Complete	SA	Control	This has been done in the South Autism service. Introduction in the South Autism service of a referral clinic for those where we have additional concerns about level of need/MH challenges and/or lacking information in the referral. In the NE service referrals come through the SPA team. Review and streamlining exercise complete, awaiting Psyomics which could potentially further support Completed in the South Autism Service. We are awaiting further confirmation on the funding for Psyomics to start this process.
5	Digital solution to waiting list – (Psyomics bid?)	Dec-26	AW/JL	Control	This initiative has the potential to support services in multiple ways and may positively influence the score once waiting lists are reviewed, validated, and a new referral management process is implemented with Psyomics input. Awaiting funding coming through and in the process of completing a Front Door request to support in establishing a project group for this.
6	Regularly review service pressure and escalation protocols	Complete / ongoing	SA/GW	Assurance	T&F with ICBs - currently postponed. Have all age pathway meeting in place, MSE focused QCPM, Stage 1 reviews flagged at senate - Complete Planning for additional service requirements
7	Review commissioning options or temporary capacity uplift	Sep-26	SA	Control	MSE ICB (prior to 1 April) agreed temporary funding to validate our longest waiters in the MSE ADHD and South Autism Services to transfer them across to a list of accredited providers. This funding is to run to the end of September 2026 but the transfers are to happen to the end of June 2026, allowing for further validation of the waiting lists in the interim period. There is also funding for a 1yr FTC for a NMP to start to see those people on our existing meds WL which we have not been able to address due to the impact of the GPs decision around shared care.
8	Seek additional funding or partnership opportunities	Sep-26	SA	Control	see action 7 Prescriber post - have identified the clinicians for this role and one of them will start in late June the other start date TBC

CRR: 2659 Increasing Backlog Maintenance Requirements

Risk Description: If Backlog Requirements from Ageing Estate & infrastructure continue to increase, despite the multiple millions of capital and revenue investments in recent years and our supplementary capital applications this year. Then this could compromise regulatory compliance, safety and the ability to repair, or service the functionality and efficiency of EPUT's estates infrastructure. Resulting in potentially leading to critical service failures or disruption, increased maintenance cost, inadequate asset replacement causing suboptimal working conditions and an impact on patient and staff safety.

Likelihood based on: The current backlog liability of £117 million which indicates a significant shortfall in the funding needed to address the estate's Backlog maintenance program.
Consequence based on: Inadequate investment in maintaining the NHS estate can lead to several serious issues. These include increased risk of asset failure, compromised patient safety, infection control breaches, reduced healthcare capacity, higher long-term costs, diminished staff morale, loss of public trust, regulatory violations, and a negative impact on care quality.

Initial Risk Score C4 x L4= 16	*Current Risk Score* C4 x L4= 16	*Target Score* C4 x L 2= 8	**Note 1:** Risk approved by the Executive Team in June 2026 for escalation onto Corporate Risk Register.

Executive Responsible Office: Executive Chief Finance & Resources Director
Director Lead: Director of Estates and Facilities
Board Committee: Finance & Performance Committee

Controls Assurance

Key Controls	Level 1	Level 2	Level 3
PPM's currently in place for maintainable assets	PPM data reviewed and lists placed onto backlog for replacement	Estates Assurance Groups reporting into Health Safety and Security Committee	
Six facet and M&E maintainable asset registers	monitored and inform backlog program for replacement based on risk		
Capital and Backlog tie in with the Estates Strategy	Regular meetings held with teams and lists shared between the two ensuring investment prioritised where needed	Capital Programme Board	
Backlog PM and utilising consultants for support	Delivering Backlog maintenance program on time		
Ensuring call off orders agreed with firms			
Any available Capital contingencies prioritised where possible for Backlog maintenance.	Working alongside the capital team to ensure collaborative approach when it comes to investment across the Estate linked to Estates Strategy and reducing backlog liability		
Short circuiting our non-pay controls			
Ensure bids are placed in good time for external monies, ensuring investment into the right areas of the Estate	Regular reporting and review		
Continue prioritisation approach reviewing significant high risk items			

Actions (to modify risks)		By When	By Who	Gap	Update
1	Review of the current BCP	Jul-26	MM	Control	In progress. BCP reviewed and comments provided. These now to be incorporated and finalised.
2	Better data reporting via 6 facet surveys, asset condition surveys, progress reports etc.	Ongoing	MM	Control	Control. Update each month at assurance meeting

Actions (to modify risks)		By When	By Who	Gap	Update
3	Undertake new 6 facet survey in 2026	Oct-26	MM	Control	This has not yet been commissioned due to a vacancy for Associate Director of Estates and will be taken forward once this position has been filled. Recruitment process underway.
4	Look at and bid for other options available to us for additional investment such as CIR and SALIX funding etc.	Mar-27	TT	Control	Estates funding for 2026/27 confirmed and in process of bidding for sustainability funding.
5	Completion of the (ERIC) Estates Return information Collection	Complete	MM	Assurance	Completed and submitted.
6	Explore the options for another backlog project manager	Mar-27	ST	Control	Under review.
7	Asset disposal plan	Complete	MW	Control	This will remain under continued review for new opportunities.
8	Estates strategy implementation	Mar-27	MM	Control	The Estates Strategy has been established, with updates provided bi-monthly to F&P, alongside a dedicated task and finish group.
9	To review the operating model	Dec-26	MM	Control	In progress.
10	Complete Estates recruitment/restructure (Core services team)	Complete	MM		The Core Services has been developed and are in place. Complete.
11	Ongoing exploration of Commercial financing options	Mar-27	MM	Control	In progress.
12	Complete a stratified review of the current maintenance backlog to understand the level of risk, in terms of locality (localised / trustwide) and severity (compliance / complexity)	Oct-26	JD	Control	In progress.

CRR: 2660 Failure to maintain a safe, compliant and resilient estate due to insufficient Estates workforce capacity

Risk Description: There is a risk that the Trust is unable to deliver a safe, compliant and resilient estate due to insufficient in-house workforce capacity, difficulty recruiting to specialist Estates roles, increased statutory requirements, and reliance on contractors leading to non-compliance with statutory and HTM requirements, infrastructure failure, reduced service resilience, increased operational costs, staff burnout, and potential adverse impact on patient safety and organisational reputation

Likelihood based on: The current insufficient in-house Estates workforce capacity and difficulty recruiting to specialist/technical roles to meet statutory and operational demands across the expanding Estate

Consequence based on: Non compliance with statutory requirements, infrastructure failures, increased operational costs, staff burnout and reduced morale, and potential adverse impact on patient safety and organisational reputation

Initial Risk Score C4 x L5= 20	*Current Risk Score* C4 x L4= 16	*Target Score* C4 x L 2= 8	**Note 1:** Risk approved by the Executive Team in June 2026 for escalation onto Corporate Risk Register.

Executive Responsible Office: Executive Chief Finance & Resources Director
Director Lead: Director of Estates and Facilities
Board Committee: Finance & Performance Committee

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Utilisation of contractors to supplement workforce	Contractor performance monitoring and periodic review reports		
CAFM system used to monitor performance against KPIs	Regular KPI reports and variance analysis from CAFM		
Asset management and compliance oversight	Internal audit of asset data and statutory maintenance compliance		
Workforce and recruitment processes	HR recruitment updates and workforce planning review		
Governance oversight of Estates performance		Committee reporting (HSSC, Quality, or Estates Committee)	

	Actions (to modify risks)	By When	By Who	Gap	Update
1	Draft and submit an options paper to the Board for approval.	Aug-26	MM	Control	The options paper has been completed and is due to be presented to the Board of Directors in August.
2	Review and adjust the work plan to reflect reduced staffing levels and the operational impact under BCP	Jul-26	MM	Control	In progress
3	Following Board decision, implement the preferred option: either outsource the department or undertake large-scale recruitment to meet service demand.	Mar-27	MM	Control	Dependant on the outcome of the Board paper.
4	Continue utilising contractors temporarily to reduce the backlog of outstanding tasks recorded on the CAFM system.	Ongoing	MM	Control	Timescale will be revised on the outcome of Board discussion on the paper.
5	Upload the verified asset data from the completed asset survey into the CAFM system and align PPM schedules to each asset	Dec-26	MM	Control	In progress
6	Review current practices, research potential alternative technical solutions to maintenance tasks	Mar-27	MM	Control	In progress

Risk Movement

July 2026

EPUT

Risk Movement and Milestones

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

Risk ID	Initial Score	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	Apr 26	May 26	June 26	July 26
SR1	20	15	15	15	15	Closed																				
SR3	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15
SR4	20	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	15	15	15	15	8	8	8	16	16	16	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
SR7	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
SR8	15	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
SR9	20	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	12	12	12
SR11	16				New	16	12	12	12	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	16	16	16
SR13	20					New	15	15	15	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 (July 24 – July 26)

Risk ID	Initial Score	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	Apr 26	May 26	June 26	July 26
CRR11	16	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
CRR45	12	12	12	12	12	12	12	16	12	12	12	12	12	12	12	12	Closed									
CRR77	16	16	16	16	16	8	Closed																			
CRR81	12	12	12	12	12	12	Closed																			
CRR92	20	12	12	12	12	12	12	12	12	12	12	12	12	12	Closed											
CRR93	15	15	15	15	15	10	Closed																			
CRR94	16	20	20	20	20	10	Closed																			
CRR98	20	12	12	12	12	12	12	12	12	12	12	12	12	Closed												
CRR2598	16																					New	16	16	16	16
CRR2599	20																							New	16	16
CRR2600	20																							New	16	16
CRR2659	16																							**New**	**16**	**16**
CRR2660																								**New**	**16**	**16**

8.2 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ANNUAL REPORT 2025-26

Decision Item LW

REFERENCES

Only PDFs are attached

EPRR Annual Report 05.08.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 August 2026

Report Title:	**Emergency Preparedness, Resilience And Response Annual Report 2025-26**					
Executive Lead:	Lizzy Wells Interim Executive Chief Operating Officer (Interim)					
Report Author(s):	Amanda Webb, Emergency Planning and Compliance Manager					
Report discussed previously at:	Health Safety & Security Committee Quality of Care Committee Quality Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report	None – provides assurance regarding emergency preparedness, resilience and response arrangements.		
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure		✓
	SR4 Demand/ Capacity		✓
	SR5 Statutory Public Inquiry		
	SR6 Cyber Attack		✓
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data		
	SR10 Workforce Sustainability		
	SR11 Staff Retention		
	SR12 Organisational Development		
	SR13 Quality Governance		
Does this report mitigate the Strategic risk(s)?	No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors with assurance that EPUT has effective organisation resilience measures in place to respond to a Major Incident, Critical Incident or Business Continuity issue. The report provides evidence of the Trusts achievements and continued commitment to the organisational resilience during 2025-26 in order to meet the requirements of the Civil Contingency Act 2004 and NHS England's Emergency Preparedness, Resilience and Response Framework 2022.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Receive and note the content of the report.

Summary of Key Issues

Essex Partnership University NHS Foundation Trust (EPUT) continues to demonstrate strong organisational resilience and full compliance with its statutory duties as a Category 1 responder under the Civil Contingencies Act 2004. During 2025–26, the Trust maintained robust Emergency Preparedness, Resilience and Response (EPRR) arrangements, providing assurance that it is well positioned to respond to major incidents, critical incidents and business continuity disruptions while maintaining safe and effective patient care.

The Trust achieved 100% compliance with the NHS England EPRR Core Standards following the annual self-assessment and confirm and challenge process led by the Mid and South Essex Integrated Care Board. This reflects sustained improvement from previous years and strong governance, planning, training and exercising arrangements. Areas of good practice identified through the assurance process included comprehensive major incident planning, effective risk assessment and tracking processes, and mature EPRR governance.

Throughout the year, EPUT successfully managed several complex business continuity incidents, including disruption to catering supply and periods of resident doctors' industrial action, without escalation to critical or major incidents. Command and control arrangements were activated promptly and operated effectively, supported by trained Gold and Silver commanders and a resilient on-call and loggist model. Learning from incidents and exercises was systematically captured and embedded into EPRR arrangements to support continuous improvement.

The Trust delivered a comprehensive training and exercising programme, meeting and in many areas exceeding national requirements. Participation in local, regional and national exercises—including pandemic preparedness and communication cascade testing—provided further assurance of readiness and highlighted improvements in responsiveness and system coordination.

Business Continuity Management arrangements continued to strengthen, with improved compliance across services and a risk-based approach adopted to plan review cycles. Central oversight and close engagement with Care Groups supported sustained improvement throughout the year.

EPUT remained fully engaged in system-wide and multi-agency partnership working, with consistent representation at the Essex Local Health Resilience Partnership, Integrated Care System EPRR forums and resilience meetings. This ensured alignment with partners during a period of significant NHS reform and emerging system risks.

Overall, the Trust can provide strong assurance that Emergency Preparedness, Resilience and Response arrangements are effective, compliant and continuously improving. The foundations established during 2025–26 place EPUT in a strong position to sustain resilience, respond to emerging risks and protect patient safety into 2026–27 and beyond.

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			
EPRR	Emergency Preparedness Resilience and Response	BCP	Business Continuity Plans
ICS	Integrated Care Systems	NHSE/I	NHS England and NHS Improvement
LRF	Local Resilience Forum	ICB	Integrated Care Boards
ICC	Incident Control Centre	LHRP	Local Health Resilience Partnership
BAU	Business as usual		

Supporting Reports/ Appendices /or further reading

Emergency Preparedness, Resilience And Response Annual Report 2025-26

Executive Lead

Lizzy Wells
Executive Chief Operating Officer (Interim)

NHS
Essex Partnership University
NHS Foundation Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ANNUAL REPORT 2025-26

EPUT

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ANNUAL REPORT

30 March 2026


NHS

Contents

INTRODUCTION

PURPOSE

The purpose of this annual report is to provide assurance that EPUT has robust and effective organisational resilience arrangements in place to respond to a Major Incident, Critical Incident, or Business Continuity event.

The report also highlights the Trust's achievements throughout 2025-26 and demonstrates its ongoing commitment to strengthening organisational resilience.

RELEVANT GUIDANCE

This report confirms that the Trust is compliant with its statutory duties under the Civil Contingencies Act 2004, the associated Cabinet Office guidance, and all other relevant legislation and standards, including:

1. The NHS Act 2006
2. The NHS Constitution
3. The Emergency Preparedness, Resilience and Response (EPRR) requirements set out in the NHS Standard Contract(s)
4. NHS England EPRR guidance and supporting materials, including:
5. NHS England Core Standards for Emergency Preparedness, Resilience and Response
6. NHS England Business Continuity Management Framework (Service Resilience)
7. Additional national guidance published by NHS England: http://www.england.nhs.uk/ourwork/eprr/
8. National Occupational Standards for Civil Contingencies
9. BS ISO 22301: Societal Security – Business Continuity Management System

CIVIL CONTINGENCIES ACT 2004

The Civil Contingencies Act (CCA) 2004 sets out a single, coherent framework for civil protection across the United Kingdom. Part 1 of the Act establishes clear roles and responsibilities for all organisations involved in emergency preparedness and response at a local level.

Under Section 1 of the CCA 2004, an **"emergency"** is defined as:

> **(a) An event or situation that threatens serious damage to human welfare in the United Kingdom**
> **(b) An event or situation that threatens serious damage to the environment in the United Kingdom**
> **(c) War or terrorism that threatens serious damage to the security of the United Kingdom**

Within the NHS, incidents are categorised as:

- **Business Continuity Incident**
  An event or situation that disrupts, or may disrupt, an organisation's normal service delivery below predefined acceptable levels, requiring temporary special arrangements until services can be restored. This may include surges in demand requiring resource redeployment.
- **Critical Incident**
  A localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services. Patients may have been harmed, or the environment may be unsafe, requiring special measures and support from partner agencies to restore normal operations.
- **Major Incident**
  An event or situation with serious consequences requiring special arrangements by one or more emergency responder agencies. For the NHS, this includes any event meeting the CCA definition of an "emergency."
- **High Profile Incident (EPUT - specific)**
  An incident requiring executive-level oversight that does not meet the criteria for a Business Continuity, Critical, or Major Incident.

Under the CCA 2004, organisations are designated either **Category 1 responders** (primary responders) or **Category 2 responders** (supporting agencies).

Category 1 responders, including NHS Trusts, are subject to the full range of civil protection duties and must:

1. Assess the risk of emergencies occurring and use this to inform contingency planning

2. Develop and maintain emergency plans
3. Develop and maintain business continuity management arrangements
4. Maintain arrangements to make information available to the public on civil protection matters, and to warn, inform and advise the public during emergencies
5. Share information with other local responders to support coordination
6. Cooperate with other local responders to enhance coordination and efficiency

This report provides assurance of how the Trust meets its obligations as a Category 1 responder**,** demonstrating compliance with the statutory duties set out in the Civil Contingencies Act 2004.

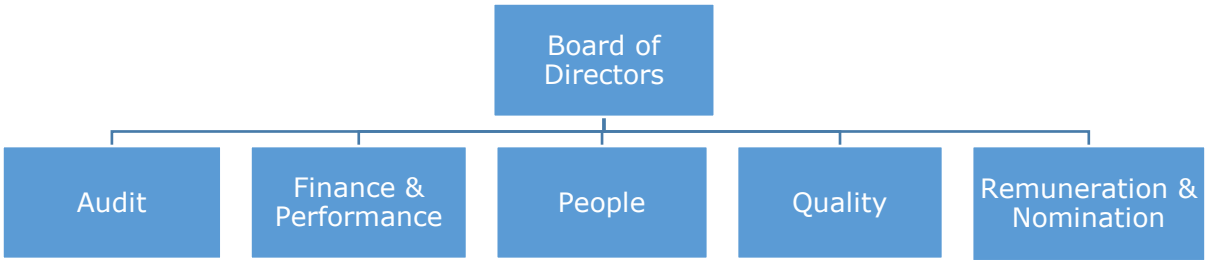
GOVERNANCE AND ACCOUNTABILITY

EPRR GOVERNANCE STRUCTURE

The Health, Safety & Security Committee is responsible for overseeing delivery of the Trust's annual Emergency Planning, Resilience and Response (EPRR) work plan.

The Committee is chaired by the Director/Associate Director of Risk & Compliance and includes representation from all Care Units. The Committee meets bimonthly, with progress against the EPRR work plan reviewed as a standing agenda item on a quarterly basis.

A quarterly EPRR report is also submitted to the Trust Quality Committee, a standing committee of Trust Board, to provide additional assurance.



Throughout 2025-26, identified EPRR risks were escalated to the appropriate risk registers and incorporated into the Board Assurance Framework that is presented to the Trust Board of Directors.

Both the Executive Director and the designated Non-Executive Director with responsibility for EPRR have been actively engaged in the programme of work during 2025-26, offering guidance and support to the EPRR Team.

EPRR ROLES AND RESPONSIBILITIES

The NHS Act 2006 (as amended) requires relevant service providers to appoint an individual responsible for discharging their duties under Section 252A. This role is designated as the Accountable Emergency Officer (AEO). For EPUT, the AEO is Alex Green**,** Deputy CEO &

Executive Chief Operating Officer who took over the role from Nigel Leonard in September 2025.

Overall accountability for Emergency Preparedness, Resilience and Response (EPRR) rests with the Chief Executive Officer, Paul Scott.

The Trust also has a dedicated EPRR Team, led by Comfort Sithole, Head of Compliance and Emergency Planning, and supported by Amanda Webb, Emergency Planning and Compliance Manager, who is responsible for day-to-day operational delivery and coordination of EPRR activities.

NHS ENGLAND EPRR CORE STANDARDS 2025-26

As part of the NHS Emergency Preparedness, Resilience and Response (EPRR) Framework, NHS England requires annual assurance that NHS-funded services are able to respond effectively to emergencies and remain resilient in delivering safe patient care. The national EPRR assurance process concludes with a submission to the NHS England Board, with subsequent assurance provided to the Department of Health and the Secretary of State for Health.

The NHS England Core Standards for EPRR set out the minimum expectations for all providers of NHS-funded services. These standards are structured across ten domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Cooperation
9. Business continuity
10. Chemical Biological Radiological Nuclear (CBRN)

All providers are required to complete and submit an annual self-assessment against these core standards, demonstrating compliance and providing supporting evidence on request.

Following the Trust's 2025–26 self-assessment and the subsequent "confirm and challenge" process led by the Mid and South Essex Integrated Care Board (MSE ICB), the Trust has been assessed as fully compliant, achieving 100% against the NHS England Core Standards for EPRR.

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

The 2025–26 EPRR assurance process did not include an annual deep dive as part of the Core Standards assessment.

During the assurance process, the following areas of good practice were identified:

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

EPRR ACTIVITIES THIS YEAR

EPRR EVENTS

MAJOR / CRITICAL INCIDENTS

During the reporting period, the Trust did not experience any major or critical incidents. This reflects the continued effectiveness of our preparedness arrangements, robust escalation processes, and ongoing commitment to organisational resilience.

BUSINESS CONTINUITY INCIDENTS

Electronic Patient Record – July 2025

An electronic patient record (EPR) system used by the Health & Justice Service was owned by an external party and hosted in the cloud by a third-party company.

On 2 July 2025, EPUT was informed by the external party that their relationship with the third-party company had broken down. The third-party advised that, as a result, they intended to switch off the cloud hosting environment on 4 July 2025, later extended to 11 July 2025, placing the availability and integrity of patient data at immediate risk.

Immediate actions were taken by EPUT to safeguard continuity of care and protect patient records:

- Stood up Silver and Gold Command (watching brief).
- Enacted the relevant Business Continuity Plan
- Ceasing all new data entry onto Excelicare.
- Implemented electronic manual record-keeping processes to maintain service operations.
- Extracted historic patient records to ensure continuity of access to essential information.
- Completed a full system back-up with support from the external party.
- Changed the system to read-only mode to prevent accidental further data entry prior to shutdown.
- Sought urgent legal advice to protect patient data.
- Prepared contingency plans to host the EPR system independently should this be required.

Incident Learning

- All requests for legal advice during incidents must be channeled through the Trust's Legal Team to ensure appropriate governance, consistency and timely escalation.

Industrial Action (IA)

During the reporting period, the Trust managed three periods of Resident Doctors' Industrial Action: 25–30 July 2025, 14–19 November 2025, and 17–22 December 2025. All three periods were handled safely and effectively, with no significant impact on service delivery.

Two learning points emerged from this first period of action. These related to:

1. Inconsistent on-call handover processes and
2. Delays in receiving NHSE communications issued directly to Chief Executives.

Both issues have since been resolved through requirements for shadow rota staff to be present on site and improved internal communication processes via the EPRR inbox.

The subsequent periods of industrial action in November and December 2025 were managed without concern. Gold Command implemented a consistent set of Silver-level mitigations, including Consultant-led review and rescheduling of clinics, restrictions on new annual and study leave, increased staffing for Crisis Response and Hospital Liaison Teams, enhanced support for high-observation areas, activation of shadow on-call rotas, and additional senior medical on-call cover. Resident Doctor's participation in the strike action was monitored twice daily and averaged 30–40%.

Formal after-action reviews were held, which highlighted several strengths, including effective activation of command structures, strong engagement across Care Groups and Business Units, productive partnership working with BMA representatives, streamlined sit-rep reporting, and clear communication for staff and patients. Shadow rota coordination through Medical Staffing and the Medical Director's Office also supported a well-managed response.

Overall, the Trust demonstrated strong organisational resilience, reliable command structures, and effective partnership working throughout all periods of industrial action.

Food Supply (September 2025 - ongoing)

The Trust's main food supplier via the NHS Supply Chain Framework, was identified as failing to meet contractual obligations, including missed deliveries and delivery of incorrect or incomplete food items. Minor issues had been observed over several months, escalating in the week prior to incident declaration when several scheduled deliveries were missed.

On 2 September 2025**,** a Situation, Background, Assessment and recommendation (SBAR) report was submitted to MSE ICB declaring a Business Continuity Plan (BCP) incident.

Risk Identified: Failure by the supplier to meet delivery obligations created a significant risk to the Trust's ability to provide safe and nutritious meals to patients.

Mitigation Measures:

- Use of takeaways, local shopping and mutual aid from neighbouring providers to ensure all patient meals could be delivered.

Actions Taken:

- Regular engagement with NHS Supply Chain regarding supplier concerns.
- Financial checks undertaken on the supplier.
- Mutual aid secured from ELFT for Bedford sites.
- Additional mutual-aid food providers utilised.
- BCP enacted, allowing facilities to source food through approved mutual-aid routes.
- Preparation for emergency cold-chain processes, including procurement of frozen containers.
- Issue flagged to the local system and partner providers for situational awareness.

On 24 October 2025**,** the supplier was formally removed from the NHS Supply Chain Framework**.** As a result, the Trust implemented temporary catering arrangements:

- A new food supplier now supplies the main patient food for approximately six facilities: Rochford, St Margaret's, Basildon MHU, Thurrock and Brockfield House.
- A separate food supplier, supplies plated meals to the remaining Trust sites.
    - The suppliers bulk-cook model is suited to larger sites (50+ patients).
    - The spplier provides complete meals tailored for smaller sites with lower capacity.

Both suppliers have been sourced through the NHS Supply Chain Framework with Procurement support, providing assurance regarding commercial viability, compliance, and suitability for NHS catering provision.

During this six-month temporary arrangement, the Facilities and Procurement Teams have been exploring long-term catering options. Following this review, they will make recommendations to the Trust to secure a sustainable permanent solution.

This incident remains ongoing and, once resolved, an After-Action Review will be completed alongside a full review of the Facilities BCP.

EPRR EXERCISES

National guidance sets out the minimum requirements for NHS organisations to regularly test their emergency preparedness arrangements. As a minimum, organisations must undertake:

- **Communications Exercise** – at least every six months
- **Table-top Exercise** – at least annually
- **Live-play Exercise** – at least every three years
- **Command Post Exercise** – at least every three years
- **Incident Coordination Centre (ICC) Equipment Test** – at least every three months

Regular exercising is essential to ensuring that the Trust can respond efficiently and effectively during emergencies. Testing plans through a variety of formats—including table-top discussions, communication cascades, command-and-control simulations and live-play scenarios—enables staff to practise key skills, build confidence and reinforce the knowledge required to lead and support a real incident response.

The Trust participated in external multi-agency exercises led by Integrated Care Boards (ICBs) and NHS England. Wider Trust participation is encouraged to strengthen organisational preparedness, promote cross-system collaboration and ensure alignment with partner response arrangements.

Following each exercise, a debrief is undertaken to capture early learning and identify any urgent issues. A full exercise report is produced thereafter, with all findings,

recommendations and required actions incorporated into the routine EPRR reporting governance.

Where significant or time-critical risks are identified, a briefing is escalated to the Executive Team to ensure timely oversight, decision-making and implementation.

COMMUNICATIONS EXERCISE

Exercise Toucan – May 2025

Exercise Toucan tested the organisation's ability to respond to no-notice notification cascades issued via the EPRR single point-of-contact email system. The exercise was delivered without prior warning to ensure a realistic assessment of responsiveness. EPUT responded promptly to all notifications, and the exercise successfully achieved its aims and objectives. No concerns or gaps were identified, demonstrating strong organisational readiness and effective communication pathways.

Exercise Eagle – July 2025

On 16 July 2025, Suffolk & North East Essex (SNEE) ICB delivered Exercise Eagle 2025, a live EPRR stimulation exercise designed to test system-wide responsiveness to a mass-casualty major incident. The core objective was to rapidly convene Strategic Commanders from all partner organisations to assess real-time positions and coordinate an initial strategic response.

During office hours, the EPUT Emergency Planning Team acts as the single point of contact (SPOC) for EPRR. The Trust received notification at 10:59 for an 11:35 Strategic call, providing a realistic test of short-notice mobilisation.

Organiser and EPUT Feedback:

The organiser noted:
"We were able to get through to the Director on call; however, he did not know what he was there to do. Crucially, he was present and would have been able to take actions."
This highlighted gaps in understanding of the exercise purpose and what is expected of the Director on call in an EPRR role.

The Director on Call identified several learning points:

- No prior awareness of Exercise Eagle or the expectation for Director on calls to participate in EPRR exercises, as this was not included in the On-Call training or handbook.
- The 15-minute mobilisation time was insufficient without baseline knowledge of the scenario, expectations or required information.
- Lack of clarity about who else would be on the call, and no supporting EPUT colleagues present.
- No agenda provided, and EPUT was asked to present its position first.
- No access to real-time operational information.
- Pando data was found to be significantly out of date, with no alternative source identified for current Trust status information.

Following a feedback and escalation report to the Executive Committee on 22 July 2025, the following actions were agreed and progressed:

- The Trust's AEO and EPRR Team jointly issued communication to all Director on calls outlining EPRR responsibilities, key actions during an incident, and contact details for the EPRR Team. .
- Review of the On-Call Handbook to explicitly include EPRR responsibilities, expectations for system-wide exercises, and the Director on Call's Gold Commander role. This work is ongoing.
- Planned Director on call training programme: two sessions scheduled for 2026, with the intention to offer this training every six months. Sessions will include theoretical input and a tabletop exercise to test decision-making.

Exercise Red Alert

Exercise 'Red Alert', coordinated by the MSE ICB, is designed to test the effectiveness and reliability of emergency communications between the ICB and NHS providers. The exercise ensures that, in the event of a real incident, critical information can be shared securely and within appropriate timeframes.

EPUT participated in all scheduled exercises throughout 2025–26, demonstrating progressively strong response times:

Date of Contact	Response
June 2025	45 minutes
July 2025	9 minutes

September 2025	16 minutes
October 2025	5 minutes
January 2026	7 minutes
February 2026	11 minutes

The significant improvement following June's exercise reflects strengthened internal processes and greater familiarity with communication pathways.

Learning from the first exercise highlighted two key issues for EPUT to address:

- Contact Centre staff were not fully familiar with the escalation process for on-call support
- It was not immediately clear that a Director on call was available when requested.

These insights have been incorporated into subsequent training and internal guidance, contributing to the consistently improved response times seen in later exercises. EPUT's continued participation demonstrates an ongoing commitment to strengthening emergency communication and organisational readiness.

Throughout 25/26; communication was tested internally and by the ICB's however these are not formally documented. In the event the ICB encounters any issues, an email is sent to the EPRR team to review. No issues were encountered within the reporting period.

TABLETOP EXERCISES

Exercise Solaris - April 2025

Exercise Solaris was a local multi-agency pandemic tabletop exercise designed to test collective preparedness and strengthen local system readiness. It forms a key component of wider multi-agency pandemic planning and will directly inform preparations for Exercise Pegasus.

EPUT participated with three specialist representatives — EPRR, Infection Prevention and Control (IPC), and Communications — allowing multiple aspects of the Trust's pandemic plans to be tested within a single exercise. Initial on-the-day feedback was positive, with valuable learning identified across agencies which was taken forward for Exercise Pegasus.

Exercise Pegasus

A future pandemic remains one of the highest-rated risks on the National Risk Register, with national experts consistently emphasising that it is a case of *when*, not *if*, the UK will experience another significant infectious disease event. In response, the National Security Secretariat has tasked the Department of Health and Social Care (DHSC) with leading a Tier 1 national pandemic preparedness exercise; "Exercise Pegasus", the largest exercise of its kind ever undertaken in the UK. The UK Health Security Agency (UKHSA) is acting as a key delivery partner.

The overarching aim of Exercise Pegasus is "To assess significant elements of the UK's preparedness, capabilities and response arrangements in the context of a pandemic arising from a novel infectious disease."

The programme was delivered in multiple phases across Autumn 2025 and into early 2026. Phase 1 took place on 22 September 2025, attended by the EPRR Lead and Communications representative. Subsequent phases occurred during Q3 as face-to-face multi-agency events, again with EPUT representation from EPRR and Communications. Throughout the exercise period, Integrated Care Boards (ICBs) issued requests via EPRR for Trust action. For example, on 23 September the Trust was required to provide indicative PPE stock levels as part of scenario planning.

A final exercise phase will take place with a comprehensive national report anticipated in Q1 2026/27. This report will outline key findings, recommendations and required actions for participating organisations. At this stage, no specific recommendations or actions have been identified for EPUT, but learning from earlier phases is expected to inform future preparedness planning.

Exercise Pegasus represents a significant opportunity for the Trust to benchmark its pandemic readiness against national expectations, strengthen inter-agency coordination, and ensure that our emergency response arrangements remain robust, evidence-based and aligned with evolving national standards.

COMMAND POST

The Trust maintains robust processes within the Emergency Preparedness, Resilience and Response (EPRR) team to ensure that the Incident Control Centres (ICCs) at both The

Lodge and the Hawthorn Centre remain in a constant state of readiness for activation during a major incident.

Throughout 2025-26 the Trust continued to operate a virtual ICC, with strategic and tactical command functions delivered via Microsoft Teams. Incident logging was supported by a cohort of trained Loggists, who maintained comprehensive electronic records with oversight from the EPRR team as required.

During the reporting year, virtual command arrangements were activated to manage five business continuity incidents. On each occasion, the virtual command post was established promptly and provided effective coordination of the Trust's response. This consistently demonstrated the robustness, effectiveness, and resilience of the Trust's current EPRR infrastructure.

ICC EQUIPMENT TEST

The Trust has robust processes in place within the EPRR Team to ensure that the Incident Control Centres (ICCs) at The Lodge and The Hawthorn Centre are fully prepared for activation in the event of a major incident. Both ICC locations undergo quarterly readiness checks to ensure they are operational and equipped for immediate use.

These checks cover:

- Room suitability and layout
- Functionality of telephone and communication lines
- Availability of major incident documentation
- Stock levels of the stationery box
- Completeness of loggist folders

All checks are documented and retained for audit and assurance purposes, ensuring continued compliance with national EPRR expectations.

TRAINING 2025-26

An EPRR Training Framework has been developed and implemented within the EPRR Team to monitor compliance with the Minimum Occupational Standards required for

Emergency Preparedness, Resilience and Response. This framework supports a consistent, competency-based approach to training across the organisation.

During the year, a number of Organisational Resilience training courses have been delivered and completed by EPUT staff, including:

INTERNAL TRAINING

General Awareness Training

Online resources relating to organisational resilience, emergency response, and Business Continuity Plans are available on the Trust's intranet. Introduction to these topics is also included within the Risk Management module of the mandatory staff induction programme, with compliance monitored by the Workforce Development Team.

Loggist Training

The Trust delivers Loggist training aligned to national standards to ensure effective decision logging during major incidents. Loggists provide accurate, real-time records of decisions and actions, supporting post-incident reviews and legal scrutiny.

A trained Loggist is required for all Gold Command activations, so maintaining a sufficient and competent pool is essential. Due to limited national training capacity, the Trust has developed an internal course that meets Minimum Occupational Standards and supports ongoing Loggist development.

The Trust currently has:

- 16 fully trained and in-date Loggists
- 6 Loggists requiring refresher training
- 24/7 on-call coverage, supported by senior staff within the Risk and Compliance Team to provide out-of-hours provision

The Emergency Planning and Compliance Manager has completed the NHSE Train-the-Trainer programme, allowing all training materials to be updated to national standards and strengthening the Trust's decision-logging capability.

EXTERNAL TRAINING

Principles of Health Command Training (Gold)

This NHS England (East of England) programme provides staff who may be involved in a major incident response with the knowledge and skills required to undertake key roles effectively. A significant proportion of directors and senior staff remain trained and in date.

Training compliance for 2025–26 is as follows:

- 89% Executive Team – Increase from 80% from 2024-25
- 84% Director on Call – Remained the same as 2024-25
  A further 3 are scheduled to attend in April 2026, bringing compliance to 94%
- 100% EPRR Leadership – Remains the same as 2024-25

These figures demonstrate strong organisational readiness and ongoing commitment to maintaining a competent and well-prepared major incident response capability.

Level 4 Award in Health Emergency Preparedness, Resilience and Response

The Health Emergency Preparedness, Resilience and Response (EPRR) Programme includes three qualifications — Award, Certificate and Diploma. The Level 4 Award provides a strong entry-level grounding for staff new to Emergency Planning. In April 2025, the second Compliance Administrator successfully completed the course.

These qualifications strengthen the EPRR function by enhancing core capability, improving operational readiness and ensuring more robust support for compliance, incident response and assurance processes.

BUSINESS CONTINUITY MANAGEMENT

BUSINESS CONTINUITY PLANS

The Trust's Business Continuity Plans (BCP) supports the Major Incident Plan and ensures that critical services can be maintained or restored quickly following disruption. As a core element of the Trust's Organisational Resilience framework, the BCP enables effective response to events such as severe weather, industrial action, pandemic pressures and other interruptions.

All EPUT services maintain local Business Continuity Plans that:

- Prioritise service activities across five levels, from restoration within 1 hour to seven working days
- Set out strategies and contingencies to maintain or recover essential functions

In 2025–26, significant work was completed to review and update local plans and ensure secure, centralised storage across inpatient and non-critical sites.

BCP compliance for year-end 2025–26 is shown in the table below.

	% in date (2025-26)	2024-25	Comparison to last year	Overdue	Total
Corporate	56%	50%	↑	4	9
Corporate – Local Teams	83%		↑	2	12
Urgent Care & Inpatient Services	87%	78%	↑	8	60
Specialist Services	100%	57%	↑	0	32
Community Delivery Mid & South Essex	77%	77%	–	21	89
Community Delivery West Essex	97%	97%	–	4	48
Community Delivery North Essex	100%	100%	–	0	13
Psychological Services	71%	44%	↑	10	34

The EPPR team continues to work closely with Care Groups to ensure timely updates of Business Continuity Plans (BCPs). Targeted follow-up with services due their review has resulted in a sustained improvement in compliance across the Trust.

A recent Trust-wide review of services; reflecting ongoing transformation programmes and team restructures, has increased the number of BCPs required within each Care Unit. Despite this expanded scope, compliance levels have continued to improve.

In addition, a comprehensive policy review was completed to assess BCP requirements by priority level. This work has confirmed which services must retain an annual review cycle, in line with existing policy, and which can move, with ICB agreement, to a bi-annual review schedule. This risk-based approach supports a more proportionate and sustainable programme of BCP maintenance across the Trust.

Risk, Resilience & Organisational Learning

KEY EPRR RISKS

The Civil Contingencies Act (CCA) 2004 places a legal duty on Category 1 responders to undertake risk assessments and to contribute to the publication of Community Risk Registers (CRRs). EPUT fulfils this responsibility through active membership of the Essex Resilience Forum (ERF), which coordinates this work across local partners.

The purpose of the Community Risk Register is to provide assurance to the public that the risks affecting communities in Essex have been formally assessed, and that appropriate preparedness arrangements and response plans are in place.

The top five risks currently identified on both the national and local Community Risk Registers are:

- Influenza-type disease (pandemic) / major outbreak
- Emerging infectious diseases
- Malicious attacks
- Chemical, Biological, Radiological, Nuclear and Explosive (CBRNE) incidents
- Low temperatures and snow

The Trust's approach to emergency planning ensures it is well-positioned to respond to incidents arising from any of these significant risks. This includes alignment with the ERF's risk assessments and multi-agency plans.

In addition to the community-level risks, the Trust employs its standard risk management framework to identify and manage local risks specific to business continuity and organisational resilience. These risks are managed in line with established Trust processes and are escalated through the appropriate risk registers where required.

The Trust maintains a suite of detailed emergency and business continuity plans that address the major risks identified within the Local Resilience Forum's Community Risk

Register. Where appropriate, these plans are aligned to the corresponding multi-agency plans developed by the Local Resilience Forum.

CYBER SECURITY

The Trust's position on Cyber associated risks is report to the Finance & Performance Committee on a monthly basis by the Information Governance and Cyber Risk Teams. The report provides assurance that the Trust has the appropriate protection and controls in place to prevent theft, loss or damage to secure data, devices, services and networks via manual or electronic means.

The overall trust Cyber BAF risk rating of **15** has not changed.

"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 the prevalence of cyber alerts that are relevant to EPUT systems. Consequence based on assessed impact and length of downtime of our systems

Initial risk score	Current risk score	Target risk score
C5 x L4 = 20	C5 x L3 = 15	C4 x L3 = 12

PARTNERSHIP WORKING

Under the Civil Contingencies Act (CCA) 2004, cooperation between local responder organisations is a legal duty. Effective emergency planning and response rely on strong joint working arrangements across agencies. It is therefore essential that, in addition to coordinated planning within individual NHS organisations, incident preparedness is aligned across the wider health system and at a multi-agency level with partner organisations.

Throughout 2025-26, EPUT has continued to work collaboratively with NHS England, Integrated Care Boards (ICBs), and partner NHS Trusts through both strategic and operational local resilience health forums. The EPRR Team has provided consistent representation at these meetings, contributing to shared planning, joint exercising, and coordinated response arrangements.

Local Resilience Forums

Local Resilience Forums (LRFs) are multi-agency partnerships comprising representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency, and other organisations designated as Category 1 Responders under the Civil Contingencies Act (CCA) 2004.

LRFs are responsible for planning and preparing for localised incidents and major emergencies. Their work includes identifying potential risks, developing and maintaining emergency plans, and coordinating joint preparedness arrangements to prevent or mitigate the impact of incidents on local communities.

EPUT is represented at the Essex Resilience Forum through an NHS England representative, alongside all other NHS providers. Two-way communication and feedback between LRFs and NHS organisations are facilitated through the Local Health Resilience Partnerships (LHRPs), ensuring alignment between multi-agency planning and health sector preparedness.

Local Health Resilience Partnerships (LHRP)

The Essex Local Health Resilience Partnership (LHRP) continued to provide strategic oversight and assurance of Health Emergency Preparedness and Response across Essex

during the reporting period. Co-chaired by the Accountable Emergency Officer for Mid and South Essex ICB and the Director of Public Health at Essex County Council, the LHRP brought together senior leaders from NHS organisations, local government, NHS England and resilience partners. During the reporting period, the Trust maintained full engagement with the Local Health Resilience Partnership (LHRP), with consistent full attendance at all scheduled meetings.

The LHRP maintained clear governance relationships with the Essex Resilience Forum (ERF), Local Incident Lessons Identified Log (LILL) and NHS England (East of England).

During the reporting period, key areas of focus included assurance on NHS transition and system reform, the implications of organisational change for EPRR leadership and arrangements, pandemic preparedness, and ongoing risk and horizon scanning. The LHRP also received regular updates on system learning through the Essex LILL, emerging health protection risks, and multi-agency resilience activity across Essex.

The Partnership provided a strategic forum for aligning NHS and local authority approaches to emergency preparedness, supporting collaboration with the ERF, and ensuring that risks requiring escalation were identified and managed effectively. Throughout a period of significant system change, the Essex LHRP continued to play a critical role in maintaining senior oversight, assurance and coordination of the health response to major incidents and emergencies.

ICB and Regional Collaboration

The Mid and South Essex (MSE) Integrated Care System (ICS) EPRR Forum provided system-wide oversight and coordination of emergency preparedness, resilience and response throughout the year. Chaired and supported by the MSE Integrated Care Board (ICB) EPRR team, the Forum brought together NHS providers, NHS England and key partners to ensure effective assurance against EPRR Core Standards and to support collective preparedness.

During the period, attendance remained consistent by EPUT. The Forum provided a key mechanism for information sharing, challenge and escalation into the Local Health Resilience Partnership and Essex Resilience Forum where required.

Key areas of focus included risk and horizon scanning, planning and preparedness, training and exercising, and the review of recent incidents and lessons identified. Risks discussed included seasonal pressures, infectious disease, cyber security, infrastructure resilience, public disorder and the impact of NHS reform and organisational change. The Forum also supported oversight of business continuity incidents, mass casualty and CBRN preparedness, pandemic planning and winter resilience.

Training and exercising activity was extensive, with partners participating in a range of local, regional and national exercises. Learning from exercises and live incidents was routinely shared and tracked, supporting continuous improvement and system learning.

Overall, the EPRR Forum played a critical role in maintaining system readiness during a period of significant operational pressure and change, strengthening collaboration across partners and supporting the system's ability to respond effectively to emergencies and major incidents.

EPRR WORKPLAN

The EPRR Work Plan for 2025–26 was developed to incorporate all actions required to achieve full compliance with the NHS EPRR Core Standards, alongside additional development actions identified by the EPRR Lead; following development, actions were progressed through EPRR governance and reported to the Health, Safety and Security Committee (HSSC).

It should also be noted that during 2025-26, the EPRR team delivered several significant achievements, including:

- Full compliance with the NHS England Core Standards for EPRR
- Successful completion of the Award in Health Emergency Preparedness, Resilience and Response by the second Compliance Administrator
- Successful completion of the NHSE Train-the-Trainer programme by the Emergency Planning and Compliance Manager in order to strengthen the Trust's decision-logging capability
- Continued partnership working with the three ICB EPRR Leads
- Involvement in regional and national exercises
- Effective management of EPRR BCP incidents to prevent escalation to Critical Incidents
- Strengthened relationships with local authorities, emergency services, NHS partners and voluntary sector groups.
- Represented the Trust effectively in LHRP/ICS planning groups and multi-agency exercises.
- Support of incidents including preparation and organisation of Gold and Silver Commands.
- Updated the Business Continuity Management Plan

CONCLUSION

Essex Partnership University NHS Foundation Trust continues to maintain robust, effective and compliant Emergency Preparedness, Resilience and Response (EPRR) arrangements. The Trust has met all statutory duties as a Category 1 responder under the Civil Contingencies Act 2004 and achieved an impressive full compliance against the NHS England EPRR Core Standards, providing strong assurance regarding its ability to respond to, manage and recover from emergencies and major incidents.

Throughout the year, the Trust effectively managed a number of complex Business Continuity incidents, including supply chain disruption and industrial action, without escalation to critical or major incidents. These events evidenced the strength of command and control arrangements, mature escalation processes and effective partnership working across services and with system partners. Learning from incidents and exercises has been systematically captured and used to strengthen preparedness, governance and operational resilience.

The Trust remains actively engaged in system-wide and multi-agency resilience arrangements through full participation in the Essex Local Health Resilience Partnership, Integrated Care System EPRR Forum and regional and national exercises. Consistent attendance and contribution have ensured alignment with partner organisations during a period of significant NHS reform and organisational change.

Looking ahead, the Trust will continue to build on the solid foundations established during 2025–26, focusing on sustaining compliance, strengthening workforce capability, embedding organisational learning and enhancing preparedness for emerging and evolving risks. This ongoing commitment will ensure the Trust remains resilient, responsive and ready to protect patient safety and service continuity under all circumstances.

Essex Partnership University NHS Foundation Trust

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8.3 PATIENT SAFETY INCIDENT RESPONSE PLAN

Information Item AS

REFERENCES

Only PDFs are attached

PSIRP Report 05.08.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 August 2026

Report Title:	**Patient Safety Incident Response Plan**					
Executive Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Lucy Beach, Director of Safety & Patient Safety Specialist					
Report discussed previously at:	Quality of Care Group and Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	The PSIRP identifies a coherent risk profile centred on three overarching system risks: • Delivery Risk – capacity, capability, and consistency of incident response • Translation Risk – converting learning into measurable, sustained improvement • Reliability Risk – ensuring consistent delivery of fundamental care and safe systems These risks are interdependent and require: • Strong governance (LOSC to Board line of sight) • A shift from investigation to improvement • Embedding QI capability and local ownership • Better triangulation of intelligence	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Statutory Public Inquiry	✓
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	✓
	SR9 Digital and Data	✓
	SR10 Workforce Sustainability	
	SR11 Staff Retention	
	SR12 Organisational Development	✓
	SR13 Quality Governance	✓
Does this report mitigate the Strategic risk(s)?	N/A	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk		
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	N/A	
	Finance		
	Estates		
	Other		

Purpose of the Report		
The report provides the Board of Directors with the Trust's Patient Safety Incident Response Plan (PSIRP) for 2026–2028.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

The Patient Safety Incident Response Plan (PSIRP) 2026–2028 sets out how the Trust will respond to patient safety incidents in line with the NHS Patient Safety Incident Response Framework (PSIRF). The Plan adopts a learning-focused, systems-based approach to improving patient safety, ensuring that learning from incidents is translated into sustainable improvement actions. It is informed by patient safety intelligence and aligned to the Trust's quality priorities, providing clear governance and oversight arrangements for patient safety learning and improvement.

The PSIRP has been reviewed by the Quality of Care Group and approved by the Quality Committee, which was assured that the plan meets national requirements and provided an appropriate framework for strengthening patient safety learning oversight and improvement across the Trust. The Board of Directors is asked to note the report.

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**

Acronyms/Terms Used in the Report			
PFD	Prevention of Future Death	DoC	Duty of Candour
CQC	Care Quality Commission	PSII	Patient Safety Incident Investigation

MDT	Multi-Disciplinary Team	LOSC	Learning Oversight Sub-Committee
FoC	Fundamentals of Care	ICB	Integrated Care Board

Supporting Reports/ Appendices /or further reading

Patient Safety Incident Response Plan 2026-2028

Executive Lead

Ann Sheridan
Executive Nurse

Patient Safety Incident Response Plan

Effective date: August 2026

Estimated refresh date: August 2028

	NAME	TITLE	SIGNATURE	DATE
Author	**Lucy Beach**	**Director of Safety and Patient Safety Specialist**		
Reviewer	**Quality of Care Group** **Quality Committee**			**09 June 2026** **16 July 2026**
Authoriser	**Board of Directors**			

Contents

Foreword

This Patient Safety Incident Response Plan (PSIRP) sets out how Essex Partnership University NHS Foundation Trust (EPUT) will respond to patient safety incidents in a way that supports learning, improvement, and safer care.

The introduction of the Patient Safety Incident Response Framework (PSIRF) represents a significant shift in how organisations respond to patient safety events. It moves away from a focus on investigation alone, towards a proportionate, systems-based approach that prioritises learning and sustainable improvement.

At EPUT, we are committed to:

- Creating a just and learning culture
- Supporting staff to report and learn from incidents without fear of blame
- Ensuring that learning leads to measurable improvements in care delivery and patient outcomes

This PSIRP reflects our ambition to be a safety-conscious organisation, one that continuously learns, adapts, and improves.

Introduction

This plan is based on NHS England's Patient Safety Incident Response Framework (PSIRF) 2022 as per the NHS Standard Contract and sets out Essex Partnership NHS Trust (EPUT) approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety over the 24 months. Key elements are

- compassionately engaging and involving those affected by patient safety incidents,
- applying a range of system-based approaches to patient safety learning,
- providing considered and proportionate responses,
- and providing supportive oversight, focused on strengthening response system functioning and improvement.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management. Effective patient safety management and response rely on having a positive learning culture where staff are keen to learn from incidents and events, has an effective incident reporting process and where robust and shared investigation and learning take place.

A PSIRP is a requirement of each provider or group/network of providers delivering NHS-funded care. This document should be read alongside our Patient Safety Incident Response Framework (PSIRF) Policy and associated Standardised Operating Procedures and our Quality Account.

Governance, Approval and Publication

This Patient Safety Incident Response Plan (PSIRP) has been developed in alignment with the work to review our data and develop our Quality priorities and Safety improvement plans for 2026/28.

Therefore, it has been:

- Developed through engagement with internal stakeholders, including Care Unit leadership teams, patient safety specialists, quality and governance functions, and clinical teams
- Informed by patient, family, and carer insight where available
- Reviewed in collaboration with system partners, including the Integrated Care Boards (ICBs)
- Formally agreed with the relevant commissioning bodies

The PSIRP will be:

- **Approved through Trust governance structures**, including the appropriate Quality of Care and Quality Committee and ratified by Trust Board (or delegated executive committee)
- **Published on the Trust's external website**, alongside the Patient Safety Incident Response Framework (PSIRF) Policy, in line with NHS England requirements
- Shared with system partners to support cross-organisational learning and alignment

Governance oversight of the PSIRP and its delivery sits with:

- **Learning Oversight and Sub Committee (LOSC)**– for oversight of learning, themes
- **Fundamentals of Care Steering Group** - for oversight of system-wide improvement

- **Quality of Care Committee** – for assurance of quality, safety and improvement delivery

- **Trust Board** – for strategic oversight and organisational accountability

This governance structure ensures that the PSIRP is not a static document but is actively used to drive learning, improvement and assurance across the Trust.

Review, Refresh and Version Control

This PSIRP is a living document, designed to remain responsive to emerging intelligence, organisational learning and system priorities.

The Trust will adopt a dynamic review approach, consisting of:

Routine Review

- The PSIRP will be formally reviewed at least annually, in line with NHS England expectations
- A more comprehensive review will be undertaken at a point not exceeding 18 months, or earlier if significant changes occur

Triggered Review

The PSIRP will be updated at any point where:

- New or emerging risks are identified (e.g. through incident data, PFDs, complaints, thematic reviews)
- There is evidence that existing priorities are no longer relevant or have been mitigated
- There are significant changes to services, pathways, or commissioning arrangements
- National guidance or regulatory expectations are updated

Continuous Intelligence Monitoring

The Trust will:

- Monitor emerging themes through Daily Incident Review, Care Unit Incident Review Group and our Learning Oversight Sub-Committee
- Use triangulated intelligence (incidents, patient safety reviews, complaints, Prevention of Future Deaths) to assess whether priorities remain appropriate
- Balance effort between new learning responses and implementation of improvement actions

Any updates to the PSIRP will:

- Be agreed through established governance processes
- Be communicated to staff and stakeholders
- Replace previous versions on the Trust's external website

Scope

This PSIRP applies to all patient safety incidents occurring within Trust services and is focused solely on learning and improvement.

Patient safety incident response under PSIRF:

- Adopts a systems-based approach, recognising the interaction between people, processes, environment and organisational context
- Does not seek to establish blame, liability, or individual fault
- Is separate from other processes including:
    - HR investigations
    - Claims and legal processes
    - Coroner's inquests
    - Safeguarding or regulatory investigations

The purpose of the PSIRP is to ensure that learning is identified, shared, and translated into improvement, reducing the risk of recurrence

Our Services

EPUT provides community health, mental health, learning disability and social care services to a population of over 3.2 million people across the East of England in Bedfordshire, Luton, Essex, Southend, Thurrock, and Suffolk. More than 7,500 staff work across more than 200 sites delivering the Trust services. At any one time, we care for more than 100,000 people.

EPUT has organised its clinical services into a care unit model which allows closer alignment to the needs of the local populations and represents a multidisciplinary approach.

The West Essex Community care unit provides adult primary and community mental health services alongside community physical health services across Epping, Harlow and Uttlesford.

The Northeast Essex Community care unit provides primary and community mental health services across Colchester and Tendring districts, urgent care services as well as three trust-wide services: perinatal mental health; children's learning disability services (CLDS); and Allied Health Professional (AHP) services.

The Urgent Care and Inpatients care unit provides urgent and emergency and inpatient mental health services across Essex, Southend and Thurrock. The Trust provides adult (18+) and older adult (70+) inpatient services from 23 wards across Chelmsford, Colchester, Rochford, Harlow, Clacton, Basildon, Thurrock and Epping. There are also a Trust-wide rehabilitation unit and two nursing homes. Urgent care services include mental health liaison teams based within the five acute hospitals in Essex, crisis response services and home treatment teams.

The Mid and South Essex Community care unit provides adult primary and community mental health services in Mid and South Essex alongside community physical health services across Southeast Essex. This Care Unit is part of The Mid and South Essex Community Collaborative, which was formed in September 2020 to review how best community physical health services can best meet the needs of local communities.

Specialists Services Care Unit provide a varied range of specialised services and serves a large population of many diverse communities across Essex and the wider East of England region. EPUT is the lead provider of forensic psychiatric services, as well as community and Tier 4 secure inpatient services. Specialist Services also provide inpatient Children and Adolescent Mental Health Services (CAMHS) as part of the East of England Provider Collaborative. It also provides drug and alcohol misuse services across Essex and the Veterans Service for the whole of the East of England, inpatient and community learning disability services as part of the Essex Learning Disability Partnership with Hertfordshire Partnership University NHS Foundation Trust, as well as Adult Psychiatric Morbidity Survey (AMPS), health outreach services for Suffolk health inequalities, inpatient perinatal and health and justice services.

Psychological Services Care Unit works collaboratively across the other five care units through participation in multidisciplinary service teams. It also provides Essex-wide services across Mental Health and Community Health across Essex and Hertfordshire. These include Eating Disorders, At Risk Mental State (ARMS) for Psychosis, Maternal Mental Health, Parent Infant Mental Health, Personality Disorder & Complex Needs services, Clinical Health Psychology Services, Cancer & Palliative Care Services, a Step 4 direct therapy service, and two large Talking Therapy (formerly IAPT) services. The Care Unit is assisting in leading the Trust towards to provide Trauma Informed Care and to develop psychologically informed practices.

Our Patient Safety Culture

EPUT is committed to improving health and care outcomes for local people and to fostering a workplace culture that is responsive, supportive, and restorative. We seek to create an organisational environment in which staff feel valued and empowered, good practice is actively shared, and continuous learning is embedded at all levels of the Trust.

Central to this ambition is the development of a restorative, fair, and learning culture founded on openness and transparency. Staff are encouraged to report patient safety incidents and near misses without fear of blame or punitive response. When incidents occur, the focus is on understanding what happened, why it happened, and what can be learned, so that improvements can be made locally and shared across services to prevent recurrence.

EPUT aims to be a safety-conscious organisation, one that is receptive to adverse events and able to learn, adapt, and improve practice. We actively promote the reporting of incidents and near misses as essential sources of intelligence for improving safety and quality. Patient safety incident responses are viewed as key drivers for learning and improvement, supporting the reduction of risk and harm to patients, service users, families, and staff.

We work collaboratively with staff to embed the principles of the Patient Safety Incident Response Framework (PSIRF), ensuring that responses to incidents are proportionate, compassionate, and focused on learning and improvement rather than solely on investigation.

The Trust recognises that effective delivery of the PSIRP requires sufficient capacity, capability and competence across patient safety functions.

Workforce and Roles

The Trust has established:

- A Patient Safety Incident Management Team providing expert support to Care Units
- Learning Response Leads (LRLs) role within Care Units
- Access to subject matter experts (clinical, human factors, safeguarding, safeguarding adults/children, etc.)
- Dedicated roles supporting patient and family engagement, including Family Liaison Officers

Training and Competence

All staff involved in patient safety incident response are expected to:

- Complete training aligned to the National Patient Safety Syllabus (Levels 1 and 2)
- Be trained in systems-based approaches to learning, including application of tools such as SEIPS or equivalent

Learning Response Leads will:

- Have appropriate seniority and independence from the incident being reviewed
- Receive ongoing professional development
- Be supported with protected time to undertake learning responses

Capacity Management

The Trust will:

- Regularly assess its capacity to deliver learning responses in line with PSIRP priorities
- Adjust the number and type of responses to ensure they are proportionate and focused on learning and improvement
- Avoid over-investigation where sufficient learning already exists, redirecting effort towards improvement activity

Where gaps in capacity or capability are identified, a development plan will be implemented to ensure compliance with PSIRF standards.

Mechanisms to Support and Strengthen Our Safety Culture

The Trust has established the following structures and support mechanisms to enhance patient safety culture and oversight:

- Daily Incident Review Meeting (Monday to Friday)
  Chaired by the Patient Safety Team, these meetings provide timely review of newly reported incidents of moderate harm and above, to ensure immediate risks are identified, appropriate actions are taken, and early learning is captured.
- Weekly Emerging Incident Review Group
  Chaired by the Chief Nurse, this group reviews learning, trends, and themes emerging from daily incident reviews. It agrees actions and response plans as

required. Representation includes Human Resources, Complaints, Inquests, and Safeguarding to ensure a coordinated, system-wide response.

- Care Unit Incident Response Group (CIRG)
  Held weekly and chaired by one of the triumvirates, CIRG reviews incidents graded as moderate harm and above. The group oversees the use of decision-making tools, commissions appropriate learning responses, monitors progress, and formally signs off completed reviews.
- Patient Safety Incident Management Team
  The Team provides advice and guidance to care units and staff involved in patient safety incidents, including signposting to information on the incident response process and access to appropriate support services.
- Freedom to Speak Up Guardian
  A confidential independent service available to staff who have concerns about patient safety or the organisation's response to a patient safety incident.
- Support for Staff Involved in Incidents
  Practical and emotional support is available from Learning Response leads, Line managers and Here for You, our Trust resources for staff
- Chaplaincy Services
  Chaplaincy support is available for staff and others affected by patient safety incidents, as needed.

Addressing Health Inequalities

The Trust recognises its important role in reducing health inequalities by improving access to services and ensuring that care is inclusive, equitable, and responsive to the diverse needs of the local population. Addressing health inequalities is core to the Trust's approach to quality improvement, quality assurance, and patient safety.

Health inequalities can have a direct impact on patient safety. Individuals and communities with protected characteristics may experience disparities in access to care, quality of treatment, and safety outcomes. Where people have multiple protected characteristics, these inequalities may be compounded, increasing the risk of harm. The Trust is therefore committed to identifying and addressing any disproportionate risks experienced by specific population groups.

Through robust data collection, analysis, and triangulation of patient safety, demographic, and population health data, the Trust will seek to identify variations in safety outcomes that may indicate health inequalities. This intelligence will inform proportionate and appropriate patient safety incident responses under PSIRF, ensuring that learning and improvement activities take account of unequal risk and experience.

When undertaking patient safety incident responses, learning reviews, and associated improvement actions, consideration will be given to whether health

inequalities or protected characteristics have contributed to risk, harm, or barriers to safe care. This includes consideration of all protected characteristics under the Equality Act (2010). Key findings will be used to inform Trust-wide improvement and transformation workstreams, supporting system-level learning and change.

As part of the ongoing review and refinement of the Patient Safety Incident Response Plan, the Trust will routinely consider population-level and patient safety data to identify variations that may signal emerging or persistent inequalities. This insight will inform the development of future iterations of the PSIRP and associated priorities.

To support meaningful involvement and engagement, the Trust will ensure that patient safety incident response processes, reports, and plans are accessible. This includes the use of appropriate communication and support tools such as easy-read materials, translation and interpretation services, and other reasonable adjustments, to maximise involvement and ensure that the voices of all those affected are heard.

Engaging and involving patients, families and staff following a patient safety incident

PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

The trust is committed to creating a culture of openness with patients, families and carers particularly when clinical outcomes are not as expected or planned. There is a responsibility as well as a statutory requirement under CQC regulation 20, Duty of candour for all healthcare organisations to be open and transparent with patients and their families when things go wrong with treatment or care delivery. In accordance with the trust's Being open policy (incorporating the duty of candour), investigators will involve the patients, their family or carers in the investigation process unless there is an identified and documented reason not to do so.

When engaging after a patient safety incident, all patients and families will be treated with respect, dignity, openness, and transparency at all times. The term engagement describes everything an organisation does to communicate with and involve people affected by a patient safety incident in a learning response. This may include the Duty of candour notification or discussion. PSIRF emphasises the need for compassionate engagement which prioritises and respects the needs of people who have been affected by a patient safety incident.

Those affected by patient safety incidents will be:

- provided with a named main contact with whom to liaise about any learning response and support
- communicated with in a way that takes account of their needs
- fully informed about what happened
- given the opportunity to provide their perspective on what happened
- given an opportunity to raise questions about what happened and to have these answered openly and honestly
- helped to access counselling or therapy where needed
- given the opportunity to receive information from the outset on whether there will be a specific learning investigation and what to expect from the process
- signposted to where they can obtain specialist advice and, or advocacy and, or support from independent organisations regarding learning response processes
- allowed to bring a friend, family member or advocate of their choice with them to any meeting that is part of the learning response process they are involved in
- informed who will conduct any learning investigation and of any changes to that arrangement
- given the opportunity to input to the terms of reference for the investigation, including being given the opportunity to request the addition of any questions especially important to them (note this does not mean that their requests must be met, but they must have any decision not to meet their request explained to them)
- given the opportunity to agree a realistic timeframe for any investigation
- informed in a timely fashion of any delays with the investigation and the reasons for them
- updated at specific milestones in the investigation should they wish to be
- given the opportunity to review the learning report with a member of the investigation team while it is still in draft and there is a realistic possibility that their suggestions may lead to amendments, note this does not mean that their suggestions must be incorporated but any decision not to incorporate their suggestions must be explained to them
- invited to contribute to the development of safety actions resulting from the learning report
- given the opportunity to feedback on their experience of the learning response and report (for example, timeliness, fairness, and transparency).

The Trust has a patient advice and liaison service (PALS). People with a concern, comment, complaint or compliment about care or any aspect of the trust services are encouraged to speak with a member of the Care team. Should the Care team be unable to resolve the concern then PALS can provide support and advice to patients,

families, carers, and friends. PALS is a free and confidential service and the PALS team act independently of clinical teams when managing patient and family concerns. The PALS service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions.

PALS can help and support with the following:

- advice and information
- comments and suggestions
- compliments and thanks
- informal complaints
- advice about how to make a formal complaint

If the PALS team is unable to answer the questions raised, the team will provide advice in terms of organisations which can be approached to assist.

We recognise that there might also be other forms of support that can help those affected by a patient safety incident and will work with patients, families, and carers to signpost to their preferred source for this.

To monitor our effectiveness a post learning response questionnaire will be issued to patients and, or their families affected by patient safety incidents.

Defining our patient safety incident profile

The Trust undertook a systematic review of patient safety intelligence to develop an evidenced patient safety incident profile and inform priorities within this Patient Safety Incident Response Plan (PSIRP). The methodology was designed to ensure that incident responses are proportionate, learning-focused, and aligned with the Patient Safety Incident Response Framework (PSIRF), rather than driven by automatic investigation or volume of reporting.

The review aimed to:

- Understand the nature, frequency, and themes of patient safety incidents
- Identify areas of highest risk, persistent harm, and emerging concerns
- Assess the effectiveness and sustainability of previous learning and improvement actions
- Inform local and trust-wide incident response priorities
- Support ongoing quality improvement and risk mitigation activity

While this PSIRP defines priority areas, the Trust recognises that additional risks and incidents will emerge that require timely consideration.

A structured decision-making process is applied to all incidents to determine whether a learning response is required.

This includes consideration of:

- Severity and potential for harm
- Recurrence and pattern
- Novelty and emerging risk
- Opportunity for system learning
- Impact across services or vulnerable groups

Decision-making is undertaken through:

- Daily Incident Review processes
- Care Unit Incident Review Groups (CIRG)
- Escalation to Trust-level governance where required

Where a learning response is indicated, an appropriate and proportionate method (e.g. swarm, MDT review, PSII) will be commissioned.

Where learning is already well established, the focus will shift to implementation and assurance of improvement, rather than further investigation.

This ensures the Trust remains responsive, proportionate and improvement-focused.

Scope and Data Period

The review covered the period 1 November 2023 to 30 November 2025, providing sufficient data to:

- Identify trends and patterns over time
- Include learning from the embedding of PSIRF
- Assess whether previous improvements have been sustained

All Trust services were included, encompassing:

- Community services
- Specialist services
- Acute mental health and urgent care
- Primary mental health services

Data Sources

Multiple sources of patient safety intelligence were reviewed to enable triangulation and avoid reliance on any single data set. These included:

- Incident reporting data, covering all harm levels (near misses, no harm, low, moderate, severe harm and deaths), extracted from the Trust's Patient Safety Dashboard
- Prevention of Future Deaths (PFD) reports issued by HM Coroners and associated Trust responses, including assurance statements and actions taken
- PSIRF-aligned patient safety learning responses, including MDT reviews and Patient Safety Incident Investigations (PSIIs) where learning was identified
- Action plans arising from reviews, with consideration of completion and impact
- Complaints and PALS data, to capture patient, family and carer experience and concerns related to safety

Data was extracted from incident reporting systems, coroner correspondence, quality and patient safety databases, and complaints management systems.

Analytical Approach

- Both quantitative and qualitative approaches were used.
- At a Trust-wide level, quantitative incident data (numbers, categories and severity) was reviewed to understand scale and distribution; however, it was recognised that high-level counts alone provided limited insight into underlying safety risks. Detailed quantitative analysis is therefore intended to be used primarily at Care Unit and service level to support locally owned improvement and measurement.
- To strengthen understanding of systemic issues, a qualitative thematic analysis was undertaken. This included analysis of free-text incident descriptions, reviews, complaints and PFD material. The use of AI-enabled analysis supported the identification of themes beyond traditional category counting. Emerging themes and codes were sense-checked with the Patient Safety Team and validated through stakeholder engagement.

Triangulation and Decision-Making

Findings were triangulated across all data sources to:

- Identify recurring issues appearing across incidents, complaints and PFDs
- Avoid disproportionate response to isolated events
- Focus on broad, systemic themes linked to risk and harm
- Use insight from action plans and coroner responses to inform meaningful and sustainable improvement, rather than transactional fixes

Where relevant, complaint themes will be fed into the Care Unit improvement planning, recognising significant overlap with patient safety concerns. The Trust also acknowledged that not all improvement activity would be delivered through Safety

Improvement Plans (SIPs) alone, with links required to wider transformation and pathway redesign programmes.

Stakeholder Engagement and Socialisation

Findings from the data review were shared and tested through structured engagement, including:

- A multidisciplinary stakeholder workshop with representation from frontline staff, people with lived experience, managers, system partners and regulators
- Presentations and briefings at Trust Board, Board of Governors, leadership forums, quality governance meetings and clinical conferences

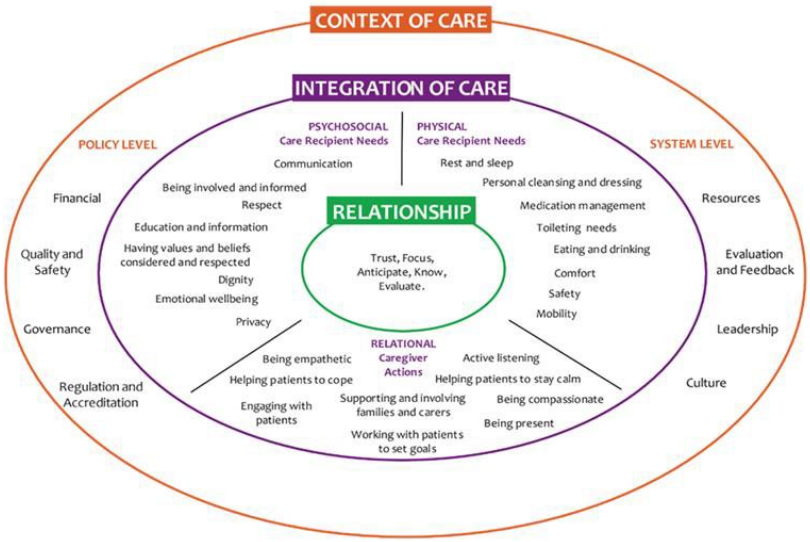
This engagement informed refinement of themes and ensured shared understanding of risk, learning and priorities.

Defining our patient safety improvement profile

Over recent years, the Trust has progressed a number of quality related initiatives, including Time to Care, Culture of Care, Quality of Care strategy, Fundamentals of Care, Trauma informed practice, Safety Improvement Plans and Quality Priorities. While these reflect appropriate ambition for a Trust the size of EPUT, it has also been a very “busy” improvement landscape.

The Fundamentals of Care provides a unifying framework that supports care that is safe, effective and provides a positive experience. It is applicable to mental health, physical health and community and inpatient settings. It describes the core components required to deliver high-quality care, emphasising the central role of nurses and other professionals in building trusting, therapeutic relationships with service users and families/carers. The framework reinforces the importance of integrating physical, mental and psychosocial care, alongside the influence of organisational context.

Fundamentals of Care



The Fundamentals of Care approach is already embedded across several areas of EPUT. To strengthen alignment and sharpen the focus, it is proposed that the Fundamentals of Care becomes the Trust-wide quality priority, with existing initiatives and programmes of work aligned to support its consistent implementation. Each Care Unit will develop and maintain a local improvement plan, setting out how planned and ongoing improvement activity contributes to the delivery of the Fundamentals of Care domains. This will ensure clear local ownership, reduced duplication, and consistent assurance that Fundamentals of Care are being implemented in practice.

Following the review of the data the following were identified as providing the most significant opportunities to improve care and to inform the development of the Trust's Safety Improvement Plans, which are a key prerequisite for the Patient Safety Response Plan.

- Ensuring policies, guidelines and standard operating procedures are fit for practice
- Engaging with and listening to families and carers
- Ensuring the clinical record contains the information required to keep patients and staff safe
- Effective communication within teams and between services
- Consistent managements of physical health for people using mental health services

To translate the Fundamentals of Care from "domains" into daily practice, three priority areas have been identified focusing on:

1. Reliability of basic care delivery
2. Staff capability to improve what matters
3. Ownership and accountability

Priority Area 1
Reliable Delivery of Fundamentals of Care: Mental Health and Inpatient wards
Domain: Safety and Effectiveness

Quality Objective
To ensure consistent and measurable delivery of Fundamentals of Care (physical health, nutrition, hydration, sleep, personal care, therapeutic observation) across all inpatient teams, reducing avoidable harm associated with unmet basic needs.

Why this priority has been chosen
National learning from patient safety incidents highlights that physical health neglect in mental health settings (e.g. dehydration, constipation, undetected deterioration) remains a recurrent risk.

Audits consistently show variation between wards and teams, demonstrating that reliance on Trust documents such as policies or standard operating procedures alone does not always ensure reliable implementation of fundamental care.

This priority addresses the known implementation gap between policy and day-to-day practice across our services.

What improvement we are aiming to achieve
- Improved reliability in meeting physical and emotional fundamental care needs.
- Reduction in avoidable harm related to poor physical care and unmet basic needs.
- Improved effectiveness of care through earlier identification of deterioration.

Measurable improvement aims
- ≥80% compliance with physical health assessments.
- Reduction in incidents where unmet fundamental care needs are contributory factors.
- Improved audit results showing reduced variation between inpatient wards.

How progress will be monitored
Metrics
- Tendable ward audits
- Incident reporting themes where basics of care are contributory.

Reporting routes

- Ward meetings.
- Fundamentals of Care Steering Group
- Accountability Framework
- Quality of Care meeting

Priority Area 2
Building Frontline QI Capability focussing on improvement cycles to deliver the Fundamentals of Care: trust wide
Domain: Effectiveness and Safety

Quality Objective
To build frontline staff capability to identify, test and sustain improvements in mental health fundamentals of care using structured Quality Improvement methods.

Why this priority has been chosen
National patient safety reviews confirm that staff engagement in improvement is a key determinant of safety in mental and physical health services.
Evidence from QI programmes shows that improvement in complex environments (e.g. seclusion use, physical health, observation quality) requires local testing and learning, not top-down implementation to ensure that improvements deliver the expected positive impact.
This priority reflects evidence that sustainable improvement depends on staff having improvement skills, not just awareness of standards.

What improvement we are aiming to achieve

- Increased staff confidence to lead improvements in fundamentals of care.
- More rapid identification and correction of issues affecting basic care.
- Identification if changes are not improving care.
- Improved sustainability of improvements with less reliance on repeated audits.

Measurable improvement aims:

- 50% of teams with a named Fundamentals of Care QI lead.
- Increase in staff trained in basic QI methods.
- Increase in number of locally owned improvement projects aligned to the Fundamentals of Care.

How progress will be monitored
Metrics

- Numbers of staff trained in QI.
- Number of active QI projects addressing Fundamentals of care.
- Improved outcomes achieved through local projects.

Reporting routes

- Ward/team meetings.
- Fundamentals of Care Steering Group
- Accountability Framework
- Quality of Care meeting

Priority Area 3
Increased involvement, ownership and accountability for the delivery of the Fundamentals of Care domains: trust wide
Domain: Experience and Safety

Quality Objective
To strengthen local ownership and accountability for Fundamentals of Care, ensuring teams routinely review patient experience, safety data and audits, and take action to improve care delivery.

Why this priority has been chosen
National CQC Mental Health reports highlight that excellent services demonstrate local ownership of care quality, with staff able to evidence how they monitor and respond to issues.

- From feedback of frontline staff and those with lived experience they frequently have the solutions to the issues identified they just need the support and permission to improve.
- Evidence shows that patient experience deteriorates where teams lack clarity over accountability for improvement.

This priority embeds the cultural and governance conditions necessary for effective implementation.

What improvement we are aiming to achieve

- Improved patient experience of dignity, compassion and daily care.
- Reduction in repeated complaints related to basic care.
- Stronger safety culture with empowered teams.

Improvement aims:

- Increased proportion of patient feedback reviewed and incorporated into QI activity.
- Reduction in repeat complaint themes relating to fundamentals.
- Improved staff survey scores relating to empowerment and improvement.

How progress will be monitored

Metrics

- Patient experience IWGC themes.
- Complaints and concerns analysis.
- Staff survey indicators related to engagement and improvement culture.
- Evidence of action in Care Unit Quality of Care meetings
- Point prevalence interviews with patients and families.

Reporting routes

- Ward/team meetings.
- Fundamentals of Care Steering Group
- Accountability Framework
- Quality of Care meeting

Agreement of Priority

Our Patient Safety Incident Response Plan: National Requirements

PSIRF supports organisations to respond to incidents and safety issues in a way that ensures we identify and capture learning and improvement rather than basing responses on definitions of harm. Organisations can explore patient safety incidents relevant to their context and the populations they serve rather than exploring only those that meet a certain nationally defined threshold. Beyond nationally set requirements, we as a trust have explored the key patient safety incidents relevant to the organisation and their populations rather than only those that meet a certain threshold.

The trust will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on learning and improvement. The trust approach will align to the documents “Guide to responding proportionately to patient safety incidents” and the “Patient safety Incident response standard’s”.

National		
Patient safety incident type	**Required response**	**Anticipated improvement route**
Incidents meeting the Never Events criteria	PSII or other review due to severity of incident and opportunity for learning	Map recommendations against Care Unit Improvement plan, add

		additional improvement if required.
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII due to the severity of the incident and opportunity for learning	Map recommendations against Care Unit Improvement plan, add additional improvement if required.
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	PSII due to the severity of the incident and opportunity for learning	Map recommendations against Care Unit Improvement plan, add additional improvement if required.
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII Locally led PSII may be required	Map recommendations against Care Unit Improvement plan, add additional improvement if required.
Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR	Map recommendations against Care Unit Improvement plan, add additional improvement if required.

	panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	
Child deaths	Refer for Child Death Overview Panel Review Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	Map recommendations against Care Unit Improvement plan, add additional improvement if required.
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this	Map recommendations against Care Unit Improvement plan, add additional improvement if required.
Safeguarding incidents in which: babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Map recommendations against Care Unit Improvement plan, add additional improvement if required.
Direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy.	Refer the incident to the Healthcare Safety	Map recommendations against Care Unit Improvement plan, add

(excludes accidents, incidental or where suicide is the cause of death).	Investigation Branch (HSIB)[9]	additional improvement if required.

Our Patient Safety Incident Response Plan: Local Focus

Patient safety incident type or issue	Planned response	Anticipated improvement route
Life-threatening accident/injury/self-harm to an inpatient where life-saving treatment is required	Swarm huddle / PSII (if significant patient safety risks and potential for new learning) Due to the severity of the incident and opportunity for learning	Map recommendations against Care Unit Improvement plan, add additional improvement if required.
Suspected/confirmed suicide of a patient with mental health problems alongside autism or ADHD or autism and ADHD.	MDT review / PSII (if significant patient safety risks and potential for new learning) Due to the severity of the incident and opportunity for learning	Map recommendations against Care Unit Improvement plan, add additional improvement if required.
Mental health inpatient attempted suicide of patients on leave (both detained)	Swarm huddle due to the opportunity for learning	Map recommendations against Care Unit Improvement plan, add additional improvement if required.
Suicide/suspected suicide within 72 hours of discharge from a mental health in-patient ward	PSII (if significant patient safety risks and potential for new learning) Due to the severity of the incident and opportunity for learning	Map recommendations against Care Unit Improvement plan, add additional improvement if required.
3 or more providers (internal, external or combination) involved and	MDTR or PSII due to the severity of the incident	Map recommendations against Care Unit Improvement plan, add

incident results in the death	and opportunity for learning	additional improvement if required.
Infection Prevention Control incident i.e. COVID outbreak or Hospital Acquired Infections with potential for severe consequences	AAR or PSII (depending on severity and in agreement with DIPC)	Map recommendations against Care Unit Improvement plan, add additional improvement if required.
Opportunity to investigate any emerging incident theme	MTDR or thematic analysis for the opportunity for learning	Map recommendations against Care Unit Improvement plan, add additional improvement if required.

Learning from Incident Response

EPUT uses a range of methods to ensure learning from patient safety incident investigations and other learning response reviews is shared widely and embedded into practice.

Learning is shared with patients and families wherever appropriate. Individuals affected by patient safety incidents are offered a copy of the approved report and the opportunity to meet with staff to discuss the findings and learning.

Learning is also disseminated across the organisation through:

- Targeted staff communications, including safety alerts and team briefings
- A Five Key Messages and Lessons Identified newsletter, shared via EPUT intranet and discussed at quality and safety meetings
- Representation at key governance and learning forums, enabling emerging themes to be shared and acted upon across care units, two of these meeting are Learning Collaborative Partnership and Learning Oversight Sub Committee.
- The monthly Learning Collaborative Partnership (LCP) meeting brings together Subject Matter Experts from across the Trust to review and reflect on patient safety incidents, share good practice, and identify key lessons that help us deliver safer, more compassionate care. The Head of Lessons team or Deputies, chairs the meeting to discuss learning across the organisation.
- The LCP reports into the Learning Oversight Sub Committee (LOSC) which is responsible for assurance on aggregating learning from incidents, including those from inquests, and that these are discussed and shared. The group

may also recommend further action for other committees, the care unit leadership, specific leads for training, ongoing work streams and teams.
- Quarterly themed learning events and monthly live learning sessions, which are recorded and accessible to staff

Where there is significant potential for shared learning, Safety and Learning Command Calls are used to support rapid communication and coordinated action in response to safety alerts.

Learning is also shared at system level, including through established partnership forums and Integrated Care Board assurance meetings, supporting consistency of learning and improvement across organisations.

These approaches help ensure that learning from patient safety events informs improvements in care delivery, supports staff learning, and contributes to safer services.

Improvement activity

EPUT acknowledges that any form of patient safety learning response will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. To reliably reduce risk safety actions are needed which will be captured within the safety improvement plan. To achieve successful improvement safety action development will be completed in a collaborative way with a flexible approach from care groups and the Patient Safety team.

Building on our experience of our previous our Safety Improvement Plans which have shaped our understanding of common safety challenges, highlighted the importance of stronger teamwork and communication, and reinforced the need for clearer, more reliable processes across services. They have also shown that improvements are most successful when they are led by frontline teams and informed by people with lived experience.

We are now expanding our use of Quality Improvement (QI) helping staff, services users, families and carers understand problems in a structured way, test new ideas quickly, and make changes that are sustained and reflect what matters most to our service users.

Conclusion

This Patient Safety Incident Response Plan (PSIRP) provides a clear and structured approach to how the Trust will respond to patient safety incidents in line with the Patient Safety Incident Response Framework (PSIRF).

It establishes a clear line of sight from patient safety intelligence through to learning, improvement and measurable impact, ensuring that:

- Learning from incidents, complaints and PFDs are reviewed and prioritised
- Responses are proportionate and focused on areas of greatest risk and opportunity for improvement
- Safety actions are aligned to Care Unit and Trust-wide improvement plans, reducing duplication and strengthening system coherence
- Improvement activity is monitored through established governance structures, including LOSC, Quality Committee and Trust Board

The PSIRP supports a shift from isolated actions to coordinated, evidence-based improvement, with a strong emphasis on:

- Embedding learning into practice
- Strengthening the reliability of care delivery
- Improving outcomes for patients and service users

As a living document, the PSIRP will be regularly reviewed to ensure it remains responsive to emerging risks, aligned to organisational priorities, and focused on delivering sustained improvements in safety and quality of care.

8.4 PATIENT SAFETY STRATEGY Q1

Information Item AS

REFERENCES

Only PDFs are attached

Patient Safety Strategy Q1 2026-27 05.08.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 August 2026

Report Title:	**Patient Safety Strategy Q1 2026/27**					
Executive Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Lucy Beach, Director of Safety & Patient Safety Specialist					
Report discussed previously at:	Quality of Care Group and Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Risk Assessment of Report – *mandatory section*			
Summary of risks highlighted in this report	The Trust has a robust patient safety infrastructure and strong commitment to learning. However, the recurring nature of several themes indicates that the challenge is no longer identifying risks but ensuring that learning is consistently translated into sustainable improvement. Therefore, the direction of travel needs not just to be what are our incidents, but what are we doing to improve care and reduce the likelihood of future harm. The priority for the next quarter will be to strengthen organisational grip on action delivery, reduce variation, improve communication and documentation practices, and provide Care Units with the support required to convert learning into demonstrable improvements in patient outcomes, experience and safety.		
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		
	SR5 Statutory Public Inquiry		✓
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		✓
	SR9 Digital and Data		✓
	SR10 Workforce Sustainability		
	SR11 Staff Retention		
	SR12 Organisational Development		✓
	SR13 Quality Governance		✓
Does this report mitigate the Strategic risk(s)?	N/A		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A		
Describe what measures will you use to monitor mitigation of the risk			
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	N/A	
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors with assurance on the effectiveness of the Trust's patient safety system, whilst also identifying where further action, oversight and support are required. It brings together intelligence from patient safety incidents, complaints, Duty of Candour, safety alerts, quality improvement activity and organisational learning to provide a single view of how safe care is being delivered across EPUT and where risks remain.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

Overall, the report provides assurance that there is a strong framework in place for identifying, reviewing and learning from patient safety incidents across the Trust. A total of 7,223 incidents were reported during Q1, with 89% resulting in no or low harm, demonstrating a positive reporting culture and continued oversight through established governance arrangements. Self-harm and pressure ulcers remain the highest-volume incident categories, reflecting the nature of services provided, particularly within community and mental health settings. The Trust continues to strengthen its response through PSIRF implementation, Duty of Candour improvements, patient safety training and quality improvement programmes.

However, the report highlights several recurring themes that present strategic risks to the organisation. The most significant relate to communication and care coordination, documentation quality, variation in practice, escalation and follow-up processes, and wider system pressures. These themes consistently appear across incidents, complaints, learning forums, inquests and safety reviews, suggesting that they are not isolated issues but systemic challenges requiring coordinated Trust-wide action.

Key Risks

1. **Communication and Care Coordination**
    - Breakdowns in communication, handovers, discharge planning and multi-agency working continue to be associated with patient safety incidents and complaints.
    - Risks are most evident at transitions of care where fragmented pathways can lead to delays, omissions and poor patient experience.

2. **Documentation and Record Keeping**
    - Documentation remains the most prominent cross-cutting theme.
    - Incomplete, delayed or inconsistent records affect decision-making, continuity of care, investigations, legal assurance and organisational learning.

3. **Learning Governance and Action Tracking**
    - Significant numbers of overdue reviews, overdue incident closures and open action plans remain across Care Units.
    - Current processes rely heavily on manual monitoring and fragmented systems, creating a risk that learning is delayed and improvements are not embedded in practice.

4. **Variation in Practice**
    - Inconsistencies in risk assessment, prescribing, MDT processes and adherence to expected standards increase unwarranted variation in patient care.

5. **System and Workforce Pressures**
    - Workforce capacity, equipment availability, environmental risks, delays in safety-critical activities and pressures across care pathways continue to affect the ability to deliver consistently safe care.

The report suggests the need for increased organisational focus on strengthening governance arrangements for action tracking and assurance. Whilst frontline teams continue to identify learning opportunities and undertake improvement work, there remains a risk that actions are not consistently monitored through to measurable impact. A clear organisational approach is required to ensure learning from incidents, complaints, inquests, audits, CQC inspections is brought together, prioritised and tracked through a single improvement framework.

Executive and Board support is required to address the underlying conditions that contribute to these recurring themes. These include improving documentation standards, strengthening multidisciplinary communication, reducing unwarranted variation in practice, investing in improvement capability, and ensuring sufficient systems and processes exist to support timely review, action implementation and 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:	**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**	

Acronyms/Terms Used in the Report			
PSIM	Patient Safety Incident Management	RCA	Root Cause Analysis
PSIRF	Patient Safety Incident Response Framework	DMT	Decision Making Tool
AAR	After Action Review	MDTR	Multi-Disciplinary Team Review
PSII	Patient Safety Incident Investigation	PSI/E	Patient Safety Incident/Event
CQC	Care Quality Commission	LOSC	Learning Oversight Sub-Committee
LCP	Learning Collaborative Partnership	PFDs	Preventing Future Deaths
QI	Quality Improvement	SIP	Safety Improvement Plan

Supporting Reports/ Appendices /or further reading
Patient Safety Strategy Q1 2026/27

Executive Lead

Ann Sheridan
Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

QUARTERLY REPORT

For:
Board of Directors
From: Lucy Beach
Director of Safety and Patient Safety Specialist

Contributors:
Lucy Beach: Director of Safety
Roshni Patel: Head of Patient Safety Incident Management
Didier Stephen: Head of Shared Learning
Bethan Simpson: Clinical Lead for Safety and Family Liaison Officer
Steven Yarnold – Deputy Director for QI
Claire Lawrence – Head of Complaints

July 2026

Reporting Period:
Financial Year: 2026/27- Qtr. 1
April 2026 – June 2026

This Collaborative Learning report contains thematic details relevant to the scope of work relating to Patient Safety Incidents, Learning Lessons, Complaints and PALs, Quality Improvements and Duty of Candour in the delivery of the Patient Safety Strategy within EPUT.

INTRODUCTION

Patient safety remains a central pillar of the Trust's Quality of Care Strategy, underpinning all improvement activity and assurance processes. The Q1 2026/27 report outlines EPUT's progress in delivering its Patient Safety Strategy, highlighting strong governance processes for reviewing incidents, Duty of Candour compliance, and safety improvement activity.

A total of 7,223 incidents were reported during the quarter, with 89% resulting in no or low harm, while self-harm and pressure ulcers remained the most frequently reported incident categories. Key themes identified across incidents and learning forums included communication and care coordination, documentation quality, variation in practice, escalation and follow-up, and wider system pressures affecting care delivery. The report also emphasises ongoing improvements through patient and carer involvement, staff training, quality improvement projects, safety learning events, and the development of more effective systems to turn learning into sustained improvements in patient safety and care quality.

PSIM: Insight

Patient Safety Data

SPC Chart Data – 1st June 2024 to 29th June 2026 (data pulled 29/06/26)

Management of Incidents within EPUT

Incidents reported with a degree of harm of Moderate, Severe or Fatal are reviewed at the daily triage (Mon-Fri) by the Patient Safety Leads and representation from the PSIM team. Incidents are also summarised and discussed at the weekly Emerging incident Review Group. That data and discussion is included in the weekly Executive Committee report.

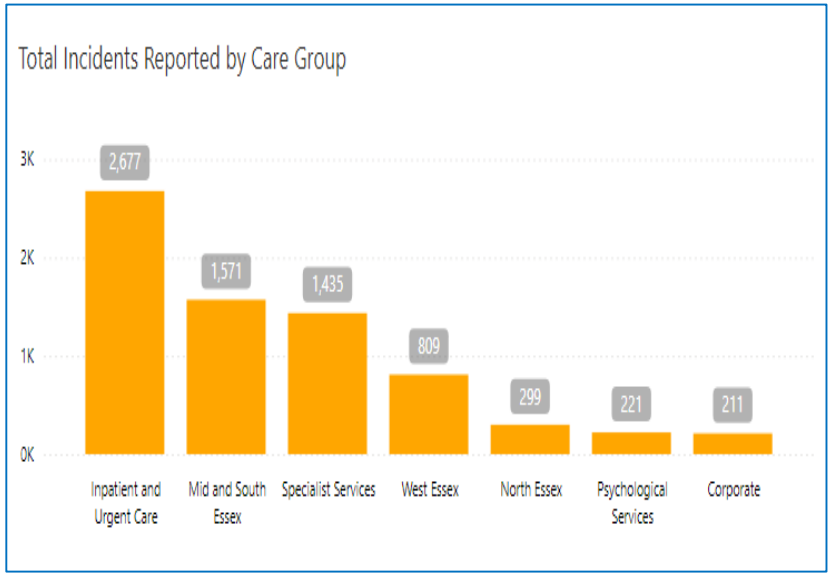
All incidents are also presented on a weekly basis at the Care Unit Clinical Incident Review Groups and patient safety data at the monthly Care Units Accountability Framework and the Care Unit Quality of Care Groups. From that later meeting, cascade through the Care Unit team is expected. This flow of data demonstrates review and control of patient safety data through the organisation.

PSIM: Insight

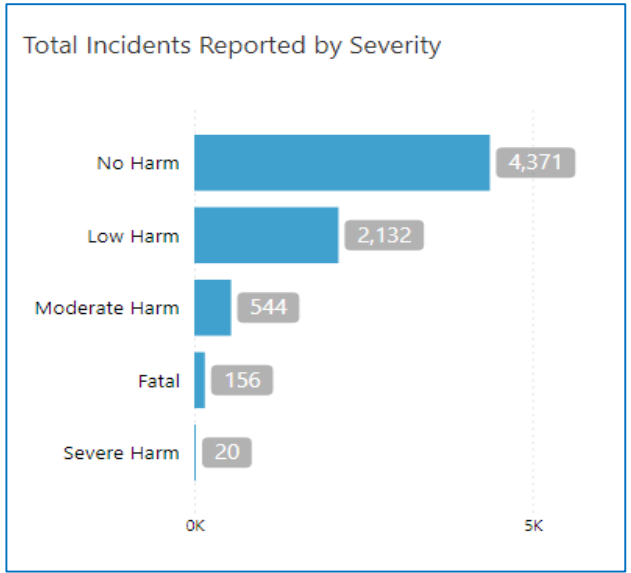
Essex Partnership University NHS Foundation Trust

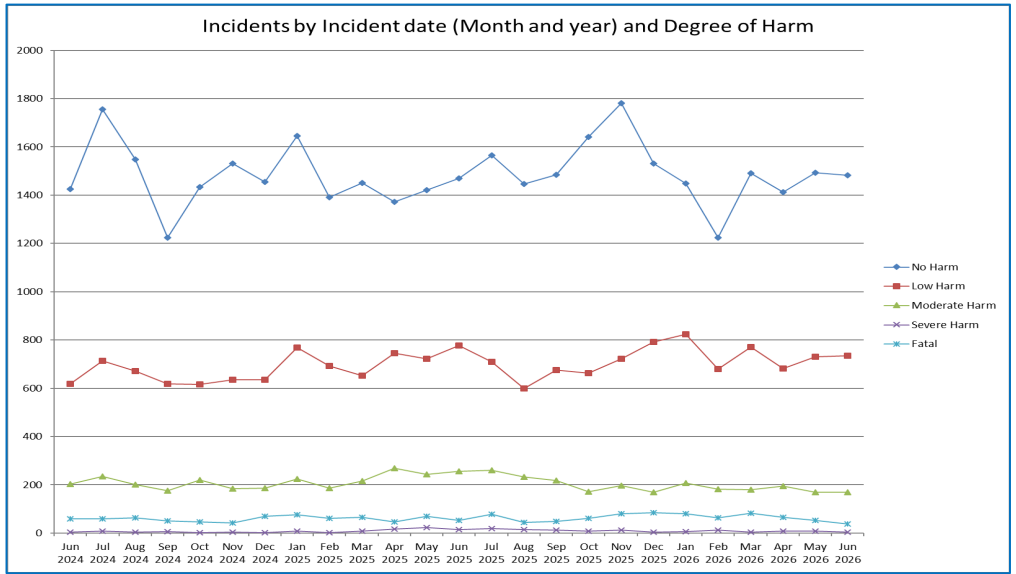
Patient Safety Data

Total Incidents by Care Group – 1st April 2026 to 29th June 2026 (Q1)



By degree of harm (Q1 and over two years)



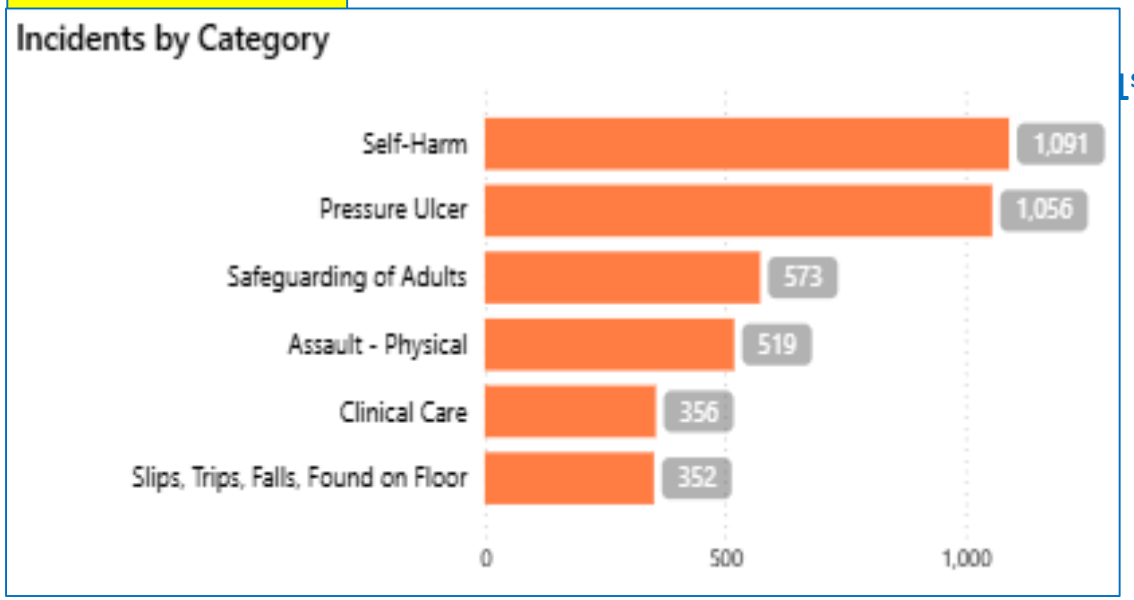


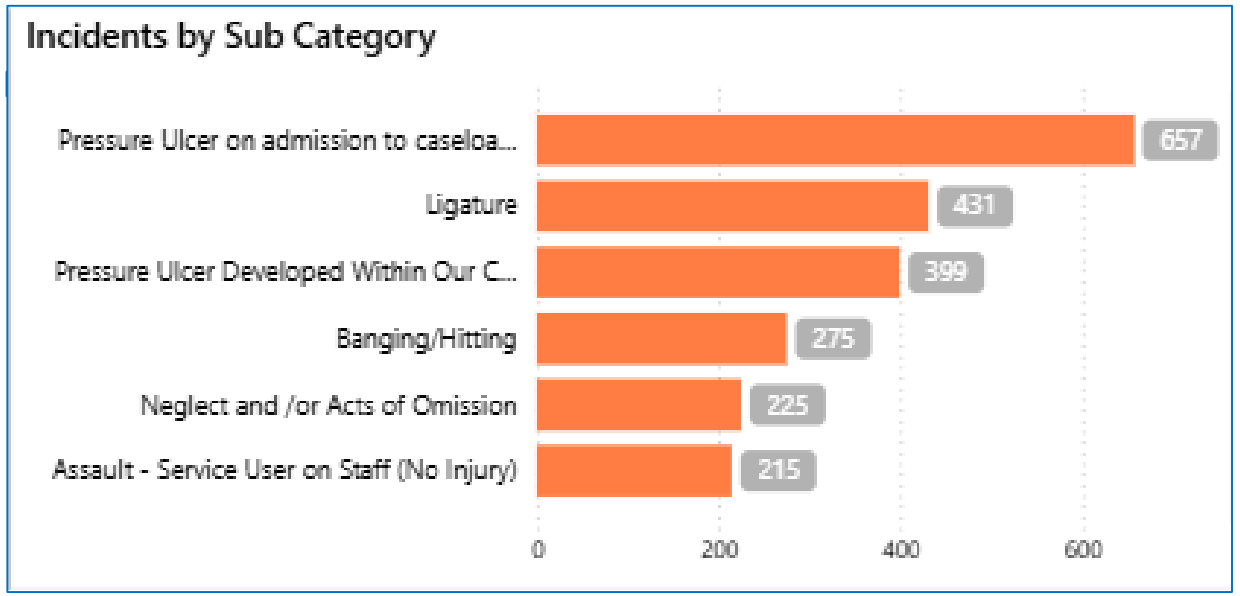
- **7,223** incidents were reported between 01/04/2026 to 29/06/2026 **(Q1).** That is **672 incidents less** than what was reported in **Q3 (7,814).** None of months or incident categories were outside of normal variation levels.
- **89%** of reported incidents were recorded as **no or low harm for Q4, Q3 was 84%.** Incidents of **moderate harm and above were 11% of total in Q4.**
- Our incident reporting system relies on staff to self-report incidents, this is the same in all provider Trusts although we may use different systems. In EPUT we use Datix and hence the terminology often used is number of Datix.
- We encourage staff to report incidents on Datix as this is crucial for us in understanding what is happening within the organisation. Our aim is to have a high reporting level but the harm levels to be no or low harm. Work has recently been undertaken through awareness session to increase knowledge on the NHS Patient Safety Levels of Harm. This will continue into the new reporting period.

(data pulled 29/06/26)

PSIM: Insight

Patient Safety Data





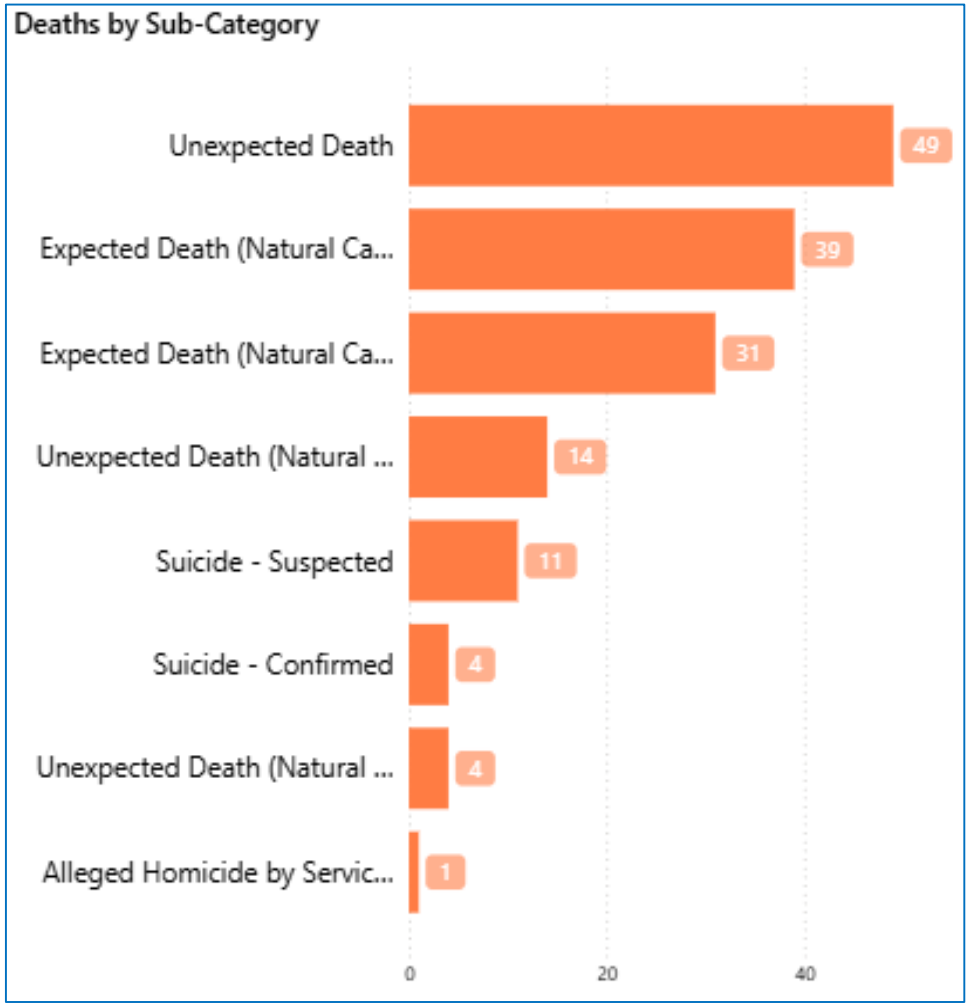
- Self-harm and pressure ulcers remain the highest reported incident categories, reflecting the core role of community health services across the West, Mid and South East Care Units. Of the pressure ulcers reported during this period, 60% developed prior to patients coming under EPUT care.
- Work is ongoing to transition pressure ulcer reviews from Root Cause Analysis (RCA) to the Patient Safety Incident Response Framework (PSIRF), to align review processes across the organisation. In addition, continued work has focused on strengthening Duty of Candour processes to ensure patients and families are appropriately informed and supported when pressure ulcers develop. There have been no concerns regarding the level of scrutiny applied to pressure ulcer reviews.

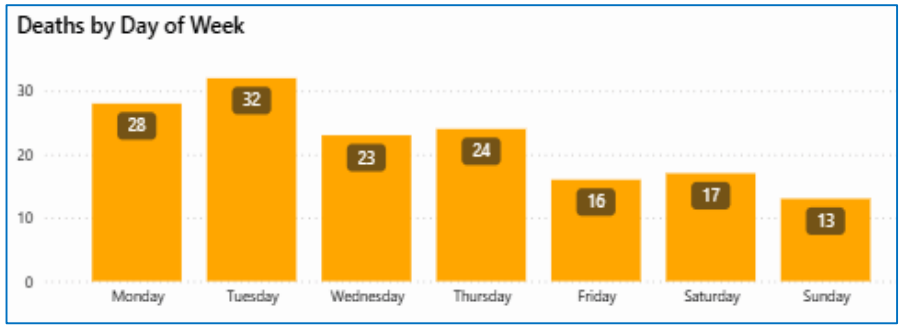
PSIM: Insight

Essex Partnership University NHS Foundation Trust

Patient Safety Data

Total Deaths by Sub-category – 1st April 2026 to 29th June 2026 (Q1 Total 153) - (192 in Q4 25/26)





Deaths Incidents

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2018	51	44	49	45	32	34	42	30	27	37	40	43	474
2019	50	32	51	37	26	36	35	38	20	36	37	46	444
2020	40	26	55	80	22	34	25	35	29	43	41	59	489
2021	95	51	46	26	36	40	38	39	42	39	40	45	537
2022	39	31	40	23	44	48	41	45	33	42	41	62	489
2023	54	59	75	55	80	66	51	52	55	56	83	60	746
2024	74	56	48	45	64	58	58	63	50	42	42	70	670
2025	73	60	65	44	68	51	75	45	49	59	81	84	754
2026	80	62	81	64	52	37							376
Total	**556**	**421**	**510**	**419**	**424**	**404**	**365**	**347**	**305**	**354**	**405**	**469**	**4,979**

46% of all deaths were reported as expected in Q1 (this was 49% in Q4). While all deaths are reviewed through the Learning from Deaths process, not all meet the threshold for reporting as a patient safety incident. Consequently, the incident reporting system captures the occurrence of a death but does not always identify whether it was linked to an incident.

All deaths reported on Datix are subject to an initial Stage 1 review, a SWARM review or a Decision Monitoring Tool (DMT) review. Based on the findings from this initial assessment, a more detailed review may be commissioned, such as an After Action Review (AAR), Multi-Disciplinary Team Review (MDTR), or a Patient Safety Incident Investigation (PSII).

PSIM: Insight

NHS Essex Partnership University NHS Foundation Trust

Patient Safety Data

Total number of internal PSII reports in progress

	Total
PSII	12
Overdue	6 (3 in final governance processes)

Total number of external PSII reports in progress

	Total
PSII	1
Action plans in development or progress	7
Overdue	1

Weekly discussions to progress reviews and ensure progress with completion of reports in a timely way. Monitoring the progress of reviews and ensure the position statement on the incident reporting system is current when data is downloaded. The Care Units and the PSIM team come together on a weekly basis to update progress on reviews and action plans. However, our patient safety system is not intuitive and requires multiple downloads, filtering with the overall theme being that of a system that relies on manual persistence rather than automated assurance. From analysing the data, there are significant delays in the governance process of sign off, this is often after the report has been shared with the family for comments. Focussed work is being undertaken to address this.

Total number of open action plans

MSE	SS	INPUC	WEST	NORTH	PSY	Total
29	19	74	17	33	0	172

This also remains an area where much work is required, and the proposal is we move towards an improvement plan for each Care Unit.

Number of overdue Stage 1 reviews for completion (Q1)

MSE	SS	INPUC	WEST	NORTH	PSY	Total
29	**5**	**4**	**2**	**1**	**0**	**41**

Overdue incidents for closure

	MSE	WEST	NORTH	INPUC	SS	PSY	Corporate
Number	**134**	**115**	**115**	**504**	**99**	**40**	**292**

Significant work has been undertaken by staff in the Care Units and corporate services; however, the numbers are increasing. Work will continue to help break down the corporate incidents.

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PSIM: Insight

Patient Safety Alerts

A new Standard Operating Procedure (SOP) has been developed along side the review of the RM10 Safety Alert Bulletins (including medical device alerts) and the Central Alerting System Policy. This SOP will provide a new way of establishing a robust, consistent and auditable process for the management of safety alerts across the Trust.

The SOP strengthens governance arrangements by introducing a structured framework for the receipt, triage, dissemination, action tracking and closure of both national and internal safety alerts. Central to the process is the creation of a multi-disciplinary Safety Alert Group, which provides coordinated oversight of alerts, ensures timely risk assessment and response, and supports clear accountability for actions.

The SOP also reinforces the use of Datix as the single system of record, improving visibility, consistency and assurance across the organisation. The new process promotes a proactive and learning-focused approach to safety management by introducing clear timescales for review, a differentiated response model based on risk, and enhanced monitoring arrangements. It ensures that safety alerts are not only communicated but also implemented, tested and evidenced through formal assurance mechanisms.

Overall, the SOP provides a more coordinated, transparent and effective system for managing safety alerts, supporting compliance with national requirements and strengthening the Trust's patient safety culture.

Patient Safety Recovery Plan: Care Units

Restoring compliance and oversight while focusing limited capacity on the areas of greatest patient safety risk

Core aim Restore grip on Datix, complaints, PSIRF reviews, learning from deaths and action plans — prioritising high-risk backlogs, statutory/regulatory duties and sustainable improvement themes.

1 **Priority 1: deaths, mod/severe harm, safeguarding, Stat DoC and overdue reviews**

2 **Priority 2: Coroner/PFD actions, formal complaints and historic actions**

3 **Priority 3: low/no harm incidents reviewed for learning**

Datix recovery

Review all overdue incidents through Care Unit Incident Review Group
Focus on Moderate, Severe harm and Death for closure
Streamline duplicates, thematic analysis and focus on learning.
.

Complaints recovery

RAG-rate all outstanding complaints
Group recurring issues such as communication, discharge and risk assessment
Create improvement responses that can be personalized, but standard information such as policies etc. are already collated

Reviews & learning

Check whether each review still needs to occur
Avoid duplication where complaint, safeguarding, coroner or PFD review exists
Focus on learning rather than lengthy narratives

Action plans

Collect all open actions
Identify common themes.
Convert actions into a small number of improvement programmes

Governance route

Weekly EIR review of results, recovery trajectory and high-risk delay escalations; monthly AF and Care Unit QoC review; quarterly Trust-wide reporting to QoC and QC.

Success measures

Reduce overdue Datix by 25% in 4 weeks and 50% in 8 weeks; complaints by 50% in 8 weeks; 80% PSIRF reviews in agreed timescale by 12 weeks; themed improvement plans by end of September.

Complaints

Formal complaints:

Formal Complaints received in Q1: 71 (v. 121 in Q4)

Top 3 themes:

1. ADHD assessment waiting times - 19 (27%)
2. Communication breakdown with patient - 14 (20%)
3. Assessment and treatment - 12 (17%)

Parliamentary & Health Services Ombudsman (PHSO)

- No new Ombudsman investigations opened in Q1
- 1 Ombudsman Final Decision received: **Not Upheld**

Summary:

Mental Health Liaison Team, Basildon MHU
The PHSO found that EPUT clinicians provided appropriate mental health care, carried out thorough assessments, and made suitable treatment and therapy referrals. There was no evidence that symptoms indicated cancer or required a brain scan, and no failings in care were identified.

Complaints relating to patient safety:

- Patient safety complaints remained stable in Q1, with 33 complaints received, unchanged from Q4

Themes from Q1 include:

- Medication safety failures (prescribing, monitoring, continuity of medication, overdose risk management) (9)
- Failure to assess, respond to, or manage acute physical health deterioration/treatment needs (9)
- Neglect and basic care failures (hydration, hygiene, pressure care, observation and physical care) (5)
- Violence, aggression and patient-on-patient harm (2)
- Restrictive practice concerns (seclusion and restraint) (2)

Top 3 locations for complaints re. safety in Quarter 1:

1. St Margaret's Hospital (6)
2. Rochford Hospital (4)
3. Basildon Mental Health Unit (MHU) (2)

PSIM: Involvement

Statutory Duty of Candour:

The duty is triggered when a "notifiable safety incident" occurs, defined as an unintended or unexpected event which causes, or could cause, any of the following:

- Death directly caused by the incident
- Severe harm (e.g., permanent disability or major organ/brain damage)
- Moderate harm (e.g., requiring extra care like unplanned surgery or hospital stay)
- Moderate or above psychological harm

We have undertaken significant work to establish reliable reporting of notifiable incidents and the distribution of the written response to patients or families, please see below.

Mod, Sev, Fatal PSE's - Recorded as a Notifiable Incident? (LFPSE) - Incidents Reported during Current Fin Year - (by Month/Year)

	No	No value	Yes	Total
Apr 2026	241	5	24	270
May 2026	194	11	16	221
Jun 2026	222	13	8	243
Jul 2026	4	11	0	15
No value	0	0	0	0
Total	661	40	48	749

This table shows any incidents recorded as Moderate, Severe or Fatal in Degree of Harm, where the LFPSE Notifiable Safety Incident is ticked Yes/No/No Value. This is our denominator for Duty of Candour. Out of 749 incidents to date, 48 are recorded as Notifiable Safety Incidents. Work remains underway to review the 'No Values' to ensure we have accurate reporting.

Stat DoC (LFPSE) = Y (Reported Current Fin Year) by Was a Statutory Duty of Candour Letter Shared?

	No	No value	Yes	Total
Apr 2026	5	15	4	24
May 2026	3	7	6	16
Jun 2026	2	4	2	8
No value	0	0	0	0
Total	10	26	12	48

This table shows the **compliance** with Regulation 20, which we have defined as a formal letter of apology being shared from the service within 10 working days of an incident being confirmed as Moderate Harm and above.

Note* There is work underway reviewing the No Values, the majority of which are pressure ulcers and which we are awaiting an update from Skin Matters. We currently cannot report on the 10 days timeframe due to limitations within Datix, however through correct management, we will be ensuring that this timeframe will be achieved.

PSIM: Involvement

Duty of Candour and Engagement with those affected by Patient Safety Incidents

NHSE define engaged with those affected as a key element to being open, honest and transparent. Under PSIRF there is an expectation to engage with all of those affected by a Patient Safety Incident/Event (PSI/E).

Quality Improvement Project:

Aim: To improve engagement with those affected by PSI/Es within 6 months.

There is a gap in engagement with those affected by PSI/Es, i.e. the gap between incident and information being shared with those affected, timeliness to sharing early learning and ultimately supportive contact after an incident has occurred. There is a lack of assurance and trust in those affected towards the organisation which leads to an increase in complaints and concerns and ultimately disengagement when we do eventually make contact.

EPUT champions the role of Family Liaison Officers during an investigation, and we continue to develop their skills and expertise.

Membership includes Patient Safety Specialists, Family Liaison Lead, external partners and Lived Experience.

Planned workshop on 15/07/2026.

PSIM: Involvement

Patient Safety Partners update:

Patient Safety Partners (PSPs) are patients, carers, or members of the public who work with NHS organisations.
EPUT initially had several PSPs working within the Trust in a variety of ways but more recently that activity has ceased whilst renumeration issues are resolved. We have now resolved to proceed with PSPs being volunteers and are starting that process.

Workshop – 15 July 2026:

A workshop is scheduled for **15 July 2026**, bringing together people with lived experience, carers, staff and key stakeholders to review and redesign the processes associated with patient safety. This workshop builds upon the work already underway to increase patient and carer involvement across the patient safety journey and supports delivery of the Trust's Patient Safety Strategy, PSIRF requirements and commitment to compassionate engagement.

Key Objectives:

- Review the end-to-end patient safety process through the lens of patients, families and carers
- Identify opportunities for earlier, more meaningful and consistent engagement following patient safety incidents
- Co-design improvements that ensure patient and family voices directly inform learning responses and safety improvement plans

Expected Impact:

By strengthening patient, family and carer involvement, the Trust will move from consultation towards genuine partnership, ensuring that safety improvement is informed by lived experience, enhancing transparency, organisational learning, and confidence in patient safety processes.

IMPROVEMENT: Summary of key discussions - LCP Meeting (April 2026)

NHS Essex Partnership University NHS Foundation Trust

Learning Governance: Learning Collaborative Partnership (LCP) and Learning Oversight Sub-Committee (LOSC) Structure

- Discussion on whether to merge LCP and LOSC to reduce duplication and improve efficiency.
- Distinction reinforced between LCP's operational learning role and LOSC's strategic assurance function.
- Risks identified around blurring assurance responsibilities if structures are combined.
- Proposal explored to retain LCP focus while streamlining assurance through existing quality forums.

Care Quality Commission (CQC) Ipswich Road Learning

- CQC findings highlighted long-standing environmental and governance issues addressed only after inspection.
- Reflection on missed opportunities to resolve concerns through internal processes.
- Need to better integrate CQC learning into Trust forums and governance discussions.
- Plan to strengthen organisational learning through regular compliance reporting.

Five Key Messages and Dissemination

- Agreement that key messages should be more specific and actionable for frontline staff.
- Discussion on whether current audit tools adequately capture learning dissemination.
- Recognition that staff mainly rely on their line managers for information, raising consistency concerns.
- Importance of reinforcing documentation standards, including evidence attached to DATIX incidents.

Carradale Analysis and Targeted Improvement

- Carradale report highlighted recurring themes, particularly around record keeping.
- Emphasis on breaking broad themes into sub-categories to enable targeted interventions.
- Discussion focused on moving away from generic actions toward data-led improvements.
- Board ratification needed before wider dissemination and implementation.

Incident Reporting: Risk vs Issue

- Clarified how the Trust distinguishes potential risks from incidents that have occurred.
- Emphasis on reporting incidents and near misses as the primary route for learning and escalation.
- Importance of precise language to support effective review, assurance, and compliance.
- Approach aligned with NHS England LFPSE principles.

IMPROVEMENT: Summary of key discussion - LCP Meeting (May 2026)

NHS Essex Partnership University NHS Foundation Trust

Attendance, Membership and Governance

- Ongoing concerns about attendance, quoracy, and limited clinical representation at LCP.
- Current Terms of Reference (50% attendance) rarely met, affecting effectiveness and assurance.
- Discussion on escalating concerns and reviewing meeting frequency and structure.
- Proposal to refresh membership, reduce duplication, and clarify purpose through updated Terms of Reference.

LCP Learning Repository and Copilot Use

- Demonstration of a Copilot agent enabling search across LCP documents and learning outputs.
- Agent restricted to Copilot-licensed users with folder access, supporting security and confidentiality.
- Discussion on widening access via agents linked to public intranet resources.
- Emphasis on verification of outputs and awareness of AI limitations and hallucination risks.

Clinical Audit, Incident and Governance Themes

- Review of recent audits highlighted persistent issues with documentation quality and variation in practice.
- Key topics included DNACPR forms, delirium identification, suicide prevention, and equipment availability.
- Incident review data showed ongoing challenges with overdue learning responses and action plans.
- Emphasis on moving beyond actions to demonstrate impact and learning effectiveness.

Incident Management and Safety Learning

- Emerging themes from incident reviews included communication failures, risk assessment gaps, and training needs.
- Discussion on strengthening triage, review timelines, and compliance with learning response processes.
- Importance of feeding incident learning back into Safety Improvement Plans (SIPs) and newsletters.

IMPROVEMENT: Summary of Key discussions - LCP Meeting (May 2026)

NHS Essex Partnership University NHS Foundation Trust

Case Study: Patient Engagement and Harm Reduction

- Case study shared where increased patient engagement led to reduced restraints and self-harm.
- Interventions included named nurses, patient engagement time, and patient-led community meetings.
- Data showed positive trends, alongside discussion on context, staffing, and reporting accuracy.
- Agreement to explore wider learning and assess transferability to other wards.

Environmental and Absconding Safety Risk

- Discussion on incidents involving plastic stools used to climb garden fences.
- Concerns raised about risk assessment, consistency of mitigations, and environmental design.
- Consideration of safety alerts alongside further investigation and site visits.
- Reinforced use of DATIX reporting and swarm huddles to support local learning.

IMPROVEMENT: Summary of key discussions - LCP Meeting (June 2026)

NHS Essex Partnership University NHS Foundation Trust

Communication and Accessibility

- Continued focus on strengthening the quality and consistency of record keeping, with variation in current approaches noted.
- Need for clearer, practical standards and training to support staff with clinical documentation and risk formulation.
- AI-generated messaging being used to support communications, with expectation of editorial review to keep outputs clear and relevant.

Learning Dissemination and Culture

- Greater emphasis on using inquests and Prevention of Future Deaths (PFDs) as a proactive source of learning, rather than retrospective review.
- Recognition that learning is not consistently spreading beyond local teams, with reliance on informal routes.
- Increased focus on evidencing learning through practice, particularly in how patient engagement, risk and decisions are recorded.

Innovation and Improvement

- Exploration of digital solutions (e.g. Power Apps, AI) to support action tracking and organisational oversight.
- Proposed restructure of LCP/LOSC meetings to separate learning from action tracking and improve effectiveness.
- Clear gap in how actions are tracked across complaints, CQC, audits and PFDs, with no single oversight view.

Patient Safety and Case Learning

- Consistent themes from PFDs and inquests: care coordination, documentation, risk management, information sharing, and safe environments.
- Increased focus on demonstrating patient engagement, stability, and clinical reasoning within records.
- Specific risks discussed including unsuitable environments due to bed pressures and the need for clearer escalation.

IMPROVEMENT: Summary of key discussions - LCP Meeting (June 2026)

NHS Essex Partnership University NHS Foundation Trust

Mobile Phone Availability for Community Teams

- Sustained issues with mobile phone availability for community teams, including unmet requests for devices.
- Impact on lone worker safety and clinical delivery, with some staff using personal phones as a workaround.
- Discussion on redistribution of devices.
- Agreed escalation required to telephony and risk teams, recognising this sits outside LCP direct control.

Policy Awareness and Compliance

- SIP improvement work underway in response to PFD themes (e.g. ligature risk, handover, transitions, disengagement).
- Safety alert issued due to delays in ligature inspections linked to estates capacity, with ongoing risk tracking.
- Expectation that risks are escalated through governance routes and monitored at the appropriate level.

Triangulated Themes

THEMES IDENTIFIED ACROSS SUBMISSIONS INTO LCP

NHS Essex Partnership University NHS Foundation Trust

⚠ Key Risk Themes	✓ What We Should Do (Protective Factors)	Trust-Wide Priorities
1. Communication and Care Coordination • Breakdowns in handovers, MDT working, and discharge planning • Fragmented multi-agency pathways increase risk • Failures most visible at **transition points**	Strong **MDT and multi-agency collaboration** Clear **communication and shared decision-making** Consistent d**ocumentation and governance processes**	**1. Strengthen Core Safety Fundamentals** • Standardise documentation, risk recording, and MDT decisions • Improve clarity and audit trails

2. Documentation Quality
• Incomplete or delayed records affect:
  • Clinical decision-making
  • Escalation
  • Continuity of care
• A **dominant cross-cutting safety issue**
		2. Improve Governance Grip
		• Strengthen tracking of:
		  • Actions
		  • Escalations
		  • Reviews
		• Embed accountability and oversight

3. Variation in Practice
• Gap between **expected standards vs real-world delivery**
• Inconsistency in:
  • Risk assessments
  • MDT processes
  • Prescribing and reviews
		3. Reduce Unwarranted Variation
		• Introduce standardised tools, pathways, and checklists

4. Escalation and Follow-Up
• Missed or delayed:
  • Reviews
  • DNA follow-up
  • Incident actions
• Over-reliance on informal processes and unclear ownership
		4. Improve Escalation Reliability
		• Define clear triggers and response expectations
		• Reduce reliance on informal processes

5. System Pressures • Workforce constraints and delays impact care • Increased risk for **complex and vulnerable patients**		**5. Embed Person-Centred Coordination** • Improve patient, carer, and family communication • Focus on transitions and delays in care

PSIRF RELATED TRAINING
QUARTERLY PROGRESS REPORT

Apr to June 2026

Essex Partnership University
NHS Foundation Trust

TRAINING SESSIONS
Human Factors MDP 2 sessions 11 attended
SEIPS 5 sessions (5 staff)
Trust ECOL Induction 6 sessions 145 attendees
MDTR Training 3 sessions 24 attended

EPUT Quarterly Learning Events

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Event Summary

The EPUT Quarterly Learning Event held on 28 April 2026 focused on strengthening Quality Improvement (QI) through alignment with Trust priorities and the Fundamentals of Care Framework. Presentations highlighted the structured QI programme, use of the Life QI system, and increasing application of AI to support thematic analysis and action planning. Emphasis was placed on co-production, culture of care, and person-centred approaches.

Examples of QI in practice included neuroscience-informed psychoeducation, patient-led ward rounds, model ward developments, nature-based wellbeing interventions, and enhanced carer support systems. These projects demonstrated improvements in patient understanding, engagement, experience, and wellbeing.

Key enablers included strong leadership, staff training, and data-driven approaches, while barriers related to workforce pressures and engagement. The session reinforced the importance of scaling effective interventions and ongoing learning dissemination across the Trust.

Patient Safety

QI Projects

Steven Yarnold

Deputy Director of Safety & QI

Date: 01/07/2026

NHS
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NHS Foundation Trust

Frontline teams are identifying the right safety issues. The next step is to build the conditions that allow these ideas to improve care reliably

Purpose of these slides:

- Showcases how frontline teams are responding to the issues that matter most to patients, carers, families and staff.
- Uses Life QI data and registered project to understand how patient safety is being improved in everyday practice.
- Identifies where greater support is needed to ensure improvement efforts result in changes that people can consistently experience and feel.

1. What the Life QI data is telling us

Evidence

There is a strong improvement pipeline. The key issue is movement from idea to tested and sustained change.

87	16	0	335	72	59
active projects	created in past 90 days	completed in past 90 days	verified users	active in past 90 days	projects at score 0.5

- The Life QI portfolio demonstrates strong frontline engagement with improving care, with staff identifying and responding to issues that directly affect safety, dignity and experience.
- While new improvement activity continues to grow, much of it remains at an early stage, and fewer projects are progressing into demonstrable, sustained change.
- This is not a question of frontline motivation; it highlights a gap in the support system around teams. Without consistent coaching, sponsorship and clear pathways to completion, good ideas risk remaining local or short-lived, rather than delivering reliable improvements that patients and staff can experience over time.

2. What frontline teams are trying to improve

Themes

Projects are clustered around issues that affect safety, dignity, trust, access and experience of care.

Medicines and physical health	Time-critical medicines, clozapine monitoring, rapid tranquillisation observations, ECG, pregnancy screening and deterioration recognition.
Communication and coordination	Handover, TTA medicines, multiagency working, leave arrangements and discharge communication.
Risk and safer environments	Ligature risk, self-harm, AWOL, PRN reduction, relational security and use of sensory approaches.
Records and safety visibility	Copy-paste in records, named nurse documentation, Section 17 care plans and visible patient risk information.
Dignity, involvement and access	Hygiene, laundry and belongings, food and culture, carers, patient voice, DNA rates and access to services.

The project list shows a broad understanding of safety: not only preventing harm, but improving dignity, trust, communication and involvement.

3. Two examples of emerging improvement work

Examples

These examples show improvement work moving beyond tasks into systems, relationships and experience.

Model Ward: Safer inpatient care

- Crystal Unit: Ruby and Topaz wards.
- Combines Fundamentals of Care, Culture of Care, Action Learning Sets and clinical microsystems.
- Responds to physical deterioration, variation in care, fragmented complex case management and patient flow.
- Aims to improve experience, continuity, capability and safer flow.

Values-based engagement after harm

- Co-designs a compassionate approach after patient safety incidents.
- Recognises impact on patients, families, staff, peer groups and witnesses.
- Focuses on early contact, honesty, continuity, kindness and meaningful involvement.
- Shifts the lens from process compliance to healing, trust and learning.

Patient safety improvement is about reliable systems and human experience. Both are needed if people are to feel safe, heard and supported.

4. What is limiting progress

Risk

The main risk is not lack of improvement activity. The risk is that good work remains local, unsupported or unfinished.

Current constraint	What this means	Governance response needed
Limited QI coaching capacity	Projects may start but not progress through method, testing and measurement.	Develop local QI coaching roles and a coaching development programme.
Variable sponsorship	Barriers are not consistently removed, and projects may remain dependent on individuals.	Strengthen senior sponsorship for prioritised safety improvement work.
No consistent local QI management system	Care Units may not have a clear route from safety learning to QI action and spread.	Introduce local review rhythms linked to PSIRF and Life QI portfolios.
Variable measurement and evidence	Impact may be difficult to demonstrate even where teams are doing good work.	Improve measurement support and clarity of progress expectations.

We are relying too much on individual effort. The next stage is to design the support system around frontline improvement.

5. Next stage: Building a coordinated QI and patient safety system

Next

The proposed next stage connects safety learning, lived experience, local ownership and improvement capability.

1. Co-design learning event

- Values-based engagement project: learning event to co-design practical change ideas. Workshop designed by Steven Yarnold for Lucy Beech to facilitate.

2. Care Unit safety profile workshops

- Support each Care Unit to understand its own patient safety profile and local improvement priorities.

3. Local QI management systems

- Develop a clear local route for prioritising, tracking, testing, measuring, completing and spreading QI work.

4. QI coaching development

- Identify local influencing roles and develop them as QI coaches to support teams and build capability.

safety learning → local understanding → prioritised QI → coaching support → sustained impact

The next stage is not more projects. It is enabling the system that allows existing improvement work to succeed.

Patient Safety – Quality Improvement

Summary

From learning after harm to reliable, locally owned improvement.

What people tell us experience, harm, trust

What the data shows incidents, themes, Life QI

What teams prioritise local safety profile

What teams test QI projects and PDSA

What changes safer care and spread

Enablers: Compassionate engagement • service user and carer voice • senior sponsorship • coaching • measurement • local review rhythm

Aim: help teams turn patient safety learning into changes that people can feel in the care they receive.

QUESTIONS TAKEN FROM THE GENERAL PUBLIC

9. REGULATION AND COMPLIANCE

9.1 SAFEGUARDING ANNUAL REPORT 2025/26

Information Item AS

REFERENCES

Only PDFs are attached

Safeguarding Annual Report 05.08.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 August 2026

Report Title:	**Safeguarding Annual Report 2025/26**					
Executive Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Tendayi Musundire, Deputy Director of Nursing for Safeguarding & MHA					
Report discussed previously at:	Safeguarding & MHA Sub-committee, Quality of Care Group and Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report – *mandatory section*			
Summary of risks highlighted in this report	None		
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		
	SR5 Statutory Public Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data		
	SR10 Workforce Sustainability		
	SR11 Staff Retention		
	SR12 Organisational Development		
	SR13 Quality Governance		✓
Does this report mitigate the Strategic risk(s)?	Yes		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	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?	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 account of the safeguarding activities undertaken across services and with partners during 2025/26, and priority areas for 2026/27.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

The Safeguarding Annual Report 2025/26 provides assurance on the effectiveness of EPUT's safeguarding arrangements, highlighting continued compliance with statutory safeguarding responsibilities and strong partnership working across Essex, Southend and Thurrock. The report demonstrates significant activity and demand across safeguarding services, including increases in safeguarding concerns, multi-agency enquiries and safeguarding referrals, alongside evidence of improved partnership engagement, strengthened governance and ongoing learning from safeguarding reviews. The report also highlights positive external assurance from safeguarding partners and the independent safeguarding diagnostic commissioned by Essex County Council.

The report outlines key achievements during 2025/26, including enhanced safeguarding training and supervision, strengthened multi-agency responses to domestic abuse, MAPPA and MARAC processes, improved safeguarding oversight within operational services, and continued embedding of a Whole Family Approach. It also identifies ongoing challenges associated with increasing safeguarding complexity and demand, whilst setting out clear priorities for 2026/27 focused on further embedding family-centred practice, strengthening safeguarding learning and awareness, improving MCA/DoLS compliance, supporting transitions into adult services, and relaunching the Safeguarding Champions network to drive continuous improvement across the Trust.

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

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

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

Acronyms/Terms Used in the Report			
MARAC	Multi-Agency Risk Assessment Conferences	ICB	Integrated Care Board
MAPPA	Multi-Agency Public Protection Arrangements	SU	Service User
MHA	Mental Health Act	MDT	Multi-Disciplinary Team
LADO	Local Authority Designated Officer	SAR	Safeguarding Adult Review
SAB	Safeguarding Adults Board	DHR	Domestic Homicide Review
CMHT	Community Mental Health Team	LAC	Looked After Children
RHA	Review Health Assessments	MCA	Mental Capacity Act
DoLs	Deprivation of Liberty Safeguards	LPS	Liberty Protection Safeguards
DA	Domestic Abuse	CSPR	Child Safeguarding Practice Review
EHCP	Education, Health Care Plan	HEF	Health Executive Forum
ICS	Integrated Care System	MACE	Missing and Child Exploitation in Essex
SEND	Special Educational Needs	SET	Southend, Essex and Thurrock
SETDAB	Southend, Essex and Thurrock Domestic Abuse Board	STP	Sustainability and Transformation Plan

Supporting Reports/ Appendices /or further reading
Safeguarding Annual Report 2025/26

Executive Lead
Ann Sheridan **Ann Sheridan** **Executive Nurse**

NHS
Essex Partnership University
NHS Foundation Trust

Safeguarding Annual Report

2025-26

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Foreword

by Ann Sheridan, Executive Nurse

I'm pleased to share the 2025/2026 Safeguarding Annual Report for Essex Partnership University NHS Foundation Trust (EPUT). This report is an opportunity to reflect on our safeguarding work over the last year and to look ahead to the priorities we have set ourselves for the coming year. Safeguarding children and adults is at the heart of every service we provide, and we are committed to ensuring that people in our care are always protected from harm. We work closely with our system partners across Essex, Southend and Thurrock, both within the Safeguarding Boards and Partnerships and more widely with partner organisations' services. We recognise the importance of our continued commitment to compliance with safeguarding statutory duties and to ensuring we have the necessary resources and expertise in place.

It has been a very busy year for our safeguarding team and for the Trust as a whole, with a significant number of case reviews and contact from our partner agencies in relation to the people in our care. Although not every safeguarding referral results in a safeguarding case and inquiry, every referral is fully reviewed by both our safeguarding team and the relevant local operational team or teams.

Throughout the year, we strengthened our relationships with colleagues in our three upper tier local authorities – Essex County Council, Southend City Council and Thurrock Council – and with Essex Police, as well as developing relationships with voluntary sector organisations and NHS England. These relationships are critical to enabling the whole Essex-wide health and care system to identify, support and keep safe people who are at risk of harm.

I am particularly pleased with the work we have carried out with Essex County Council following an audit of how we discharge our responsibilities under Section 75 of the Health and Social Care Act. This work provided a high level of assurance of the quality and effectiveness of our work to safeguard vulnerable people across our services and communities. We hosted visits from the Chairs of all three Essex safeguarding boards, providing background information and assurance around on our processes and compliance in relation to safeguarding adults and children. We have also sustained the improvements we achieved in 2024/25, especially around the responsiveness and quality of Section 42 enquiries and our reporting mechanisms.

I also want to recognise instances where we have not always got things right, in particular those issues which our partners and regulators have rightly brought to our attention. Together, we have identified gaps in safeguarding practices and provision, for example at our mental health rehabilitation unit in Colchester, and responded with additional audits, training and support for local teams.

Looking forward into 2026/27 will see a continued focus on partnerships and on supporting and sustaining the work of teams across the Trust to respond to safeguarding enquiries in a timely and effective way. I hope the information included in this report demonstrates our continued commitment to the safeguarding agenda and to supporting our teams in delivering its aims.

Local Authority Safeguarding Boards Feedback

Essex Safeguarding Adults Board

Essex Partnership University Trust (EPUT) continued to be a valued attendee of the Essex Safeguarding Adults Board (ESAB) throughout 2025/26, regularly joining the main Board meetings, providing regular updates on assurance and accountability in relation to the section 75 Agreement with Essex County Council and feedback on patient safety planning and progress. EPUT also regularly attend ESAB Sub-Committee meetings, such as the Safeguarding Adult Review Committee (SAR) and the Southend, Essex and Thurrock Multi-Agency Safeguarding Adult Policy and Procedure Group. Alongside this EPUT's Deputy Director of Nursing for Safeguarding and the Mental Health Act has continued in their role as Chair of ESAB's Prevention and Awareness Sub-Committee whose, delivery plan has focused on co-production, engagement with seldom reached groups, working with Healthwatch Essex, and developing a shared knowledge and understanding of the safeguarding challenges faced by these communities.

In response to a number of Safeguarding Adult Review report recommendations throughout the year, EPUT has demonstrated measurable improvements in safeguarding practice. This includes strengthening multi-agency working through embedded Multi-Disciplinary approaches across community and acute settings, enhancing workforce capability through targeted safeguarding and suicide prevention training, and improving governance through robust supervision, audit and reporting mechanisms. EPUT has also enhanced its approach to managing clinical risk and demand, through the implementation of a system-wide patient flow processes and real-time monitoring tools. Improvements in Mental Capacity Act practice and increased staff confidence in recognising and responding to domestic abuse further evidence the Trust's commitment to embedding learning and improving outcomes for adults at risk.

In addition to the above, and following previous site visits, the ESAB Independent Chair is visiting in June 2026 (originally scheduled for 2025/26) to seek further assurance regarding the implementation of the Community Mental Health Framework (CMHF) within EPUT, in relation to development and transition from the Care Programme Approach (CPA), which was identified as a recommendation in SAR Sandra.

Thurrock Safeguarding Adults Board

The Thurrock Safeguarding Adults Board (TSAB) continues to value greatly the active engagement of colleagues from the ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST (EPUT), who provide valuable updates on the work of the Trust as well as expert contributions in the development and implementation of the safeguarding policy and projects of the TSAB.

The vibrancy and effectiveness of the TSAB was commented on favourably by the latest CQC Local Authority Assessment of Thurrock Council and it was by being able to evidence this positive involvement of EPUT representatives that helped achieve that recognition.

Southend Safeguarding Partnership (SSP)

The Southend Safeguarding Partnership recognises Essex Partnership University NHS Foundation Trust as a committed and engaged partner within local safeguarding arrangements. EPUT consistently contributes to the governance, assurance and learning functions of the Partnership, including active participation in Board activity, subgroup work and statutory safeguarding reviews.

Through timely information sharing, professional challenge and engagement in multi-agency learning, EPUT supports effective oversight of safeguarding practice and helps ensure that risks are identified, responded to proportionately and used to drive service improvement. This engagement strengthens the collective safeguarding system and contributes to improved outcomes and lived experience for children, adults and families in Southend.

Partnership Working

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

Partnership feedback

Alpha Vesta

Since June 2025, we have provided a number of different Domestic Abuse Awareness and Training opportunities for employees at EPUT with an underpinning aim of increasing understanding and awareness and reaching out to either a patient or fellow staff member who could be experiencing it. These sessions were written in line with EPUT 'Safeguarding Adults Policy' and EPUT 'Supporting Staff Experiencing Domestic Abuse Toolkit' written in collaboration with Alpha Vesta.

1. 2hr Basic Awareness Session and Domestic Abuse Supporting Staff Toolkit
2. 2hr Impact of Domestic Abuse on Children and Young People
3. 2hr Domestic Abuse Training for Line Managers

The above consistently over the year, with attendance of over 120 employees across the three sessions and across different departments.

In addition to this, we have run two 2 hour Basic Awareness Sessions for EPUT's Preceptorship Teams with attendance of over 100 students.

We have also delivered one hour practical sessions for employees around domestic abuse in key areas.

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

These three sessions include Survivor interviews of those that had been impacted not just by domestic abuse, but in those three specific areas. These one hour sessions have each been delivered twice across the year with attendance of around 100 across the three sessions.

Essex Adult Police Triage team

The Essex Police Adult Triage Team liaises daily with the EPUT Safeguarding Team, enabling the development of a strong and effective working partnership. We value the consistent provision of prompt and informative responses, which support our joint efforts to safeguard vulnerable adults. We look forward to continuing this collaborative approach.

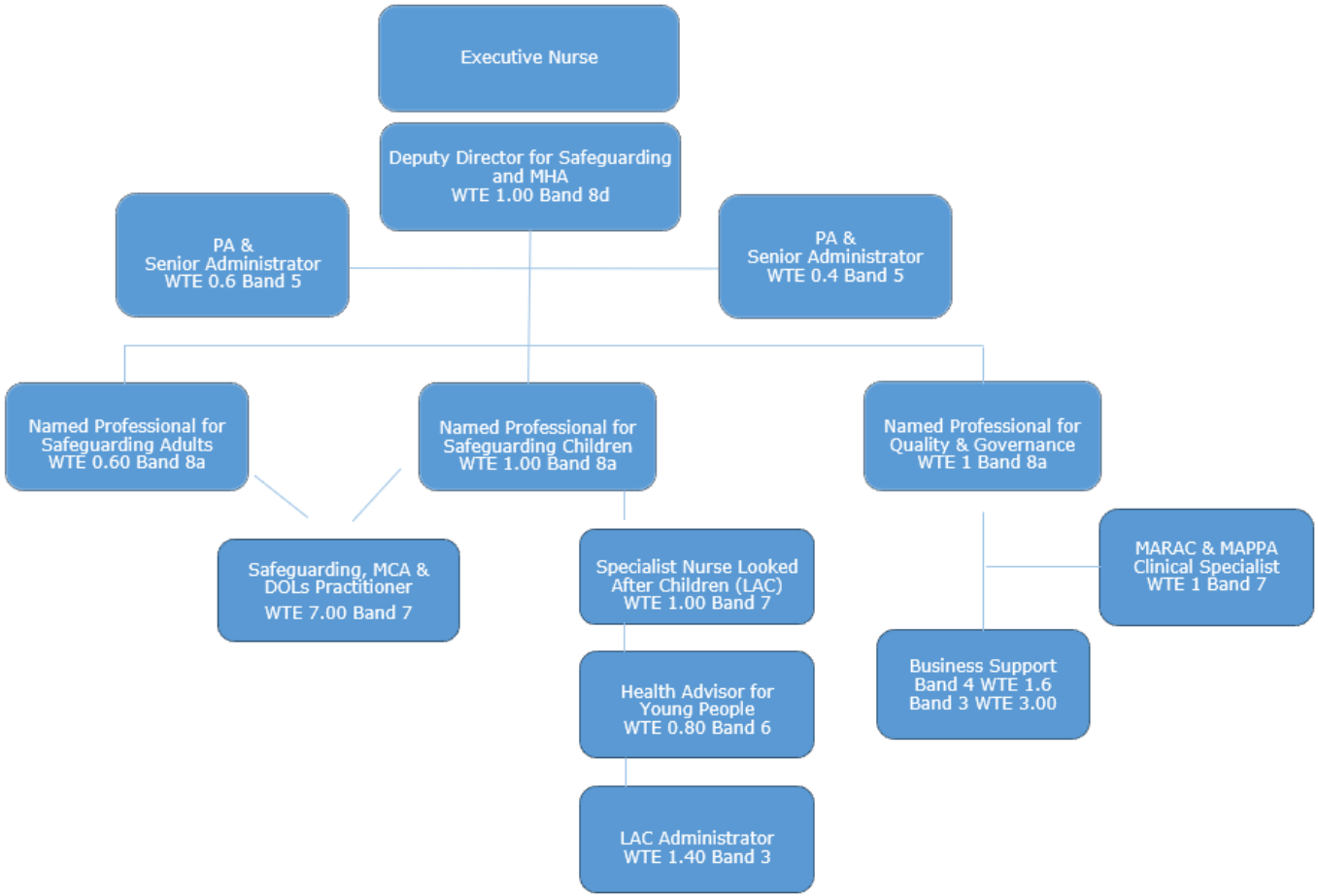
What is the Structure of the Safeguarding team?

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

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

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

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



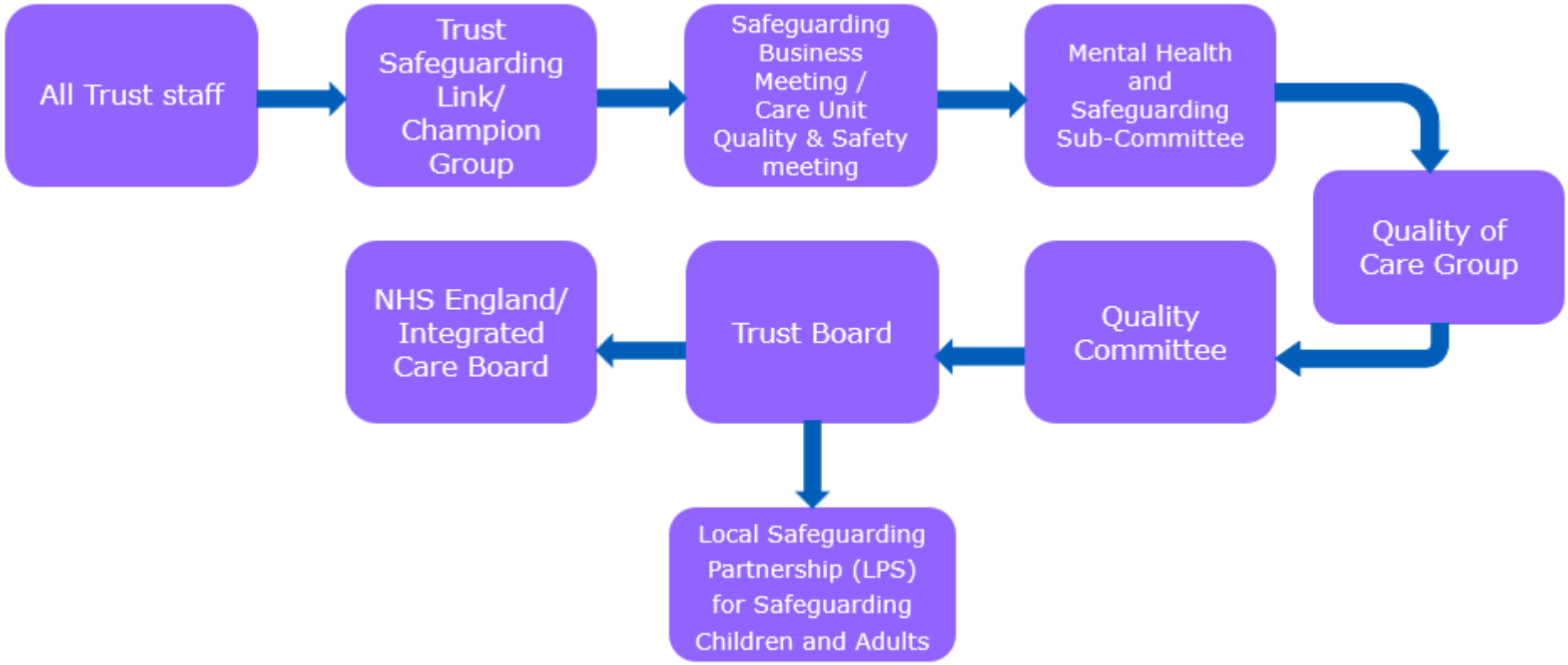
The Integrated adult's and children's Safeguarding team operate a duty system across EPUT between the hours of 9am to 5pm, Monday to Friday.

The Governance Structure for Safeguarding

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

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

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



Overview of Safeguarding Activity – Business Support

Initial involvement queries from partner agencies

Business support received an average of 41 known to service queries per day from both the local authority and police.

Table 1: Number of service queries

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Number of queries	784	904	994	1052	740	868	943	914	883	984	747	997
Average no. per day	36	41	46	35	35	39	41	46	38	45	37	45
Month on month change	-3%	15%	10%	6%	-30%	17%	9%	-3%	-3%	11%	-24%	33%

10, 810 known to services queries received, +51% from previous year.

Table 2: Number of queries known to services

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Police	68	143	195	164	137	127	146	222	256	228	160	191
Social Care	716	761	904	994	603	741	797	692	627	756	597	806

Please see Appendix 1 for Business Support functions.

Key Safeguarding Facts

Safeguarding children

Table 4: Trust safeguarding children referrals raised

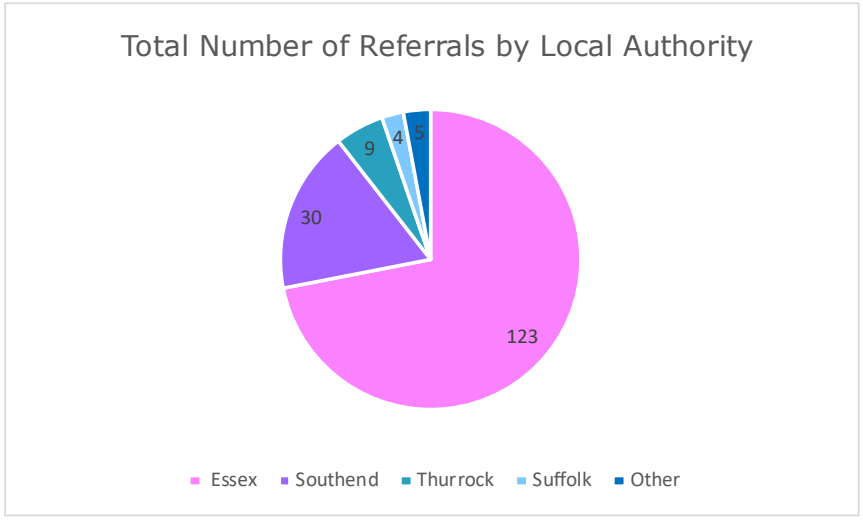
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
No. of children referrals	6	14	7	17	10	20	14	24	7	14	16	22	171

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

EPUT promotes a whole family approach across all services. While the organisation predominantly provides services for adults, it also delivers a range of services that support children, young people, and families.
These services include:

- Tier 4 Adolescent Inpatient Services
- Together with Baby Service
- Perinatal Mental Health Service
- Mother and Baby Inpatient Mental Health Service
- Family Group Conference

In addition, children's service practitioners within EPUT receive mandatory safeguarding supervision.



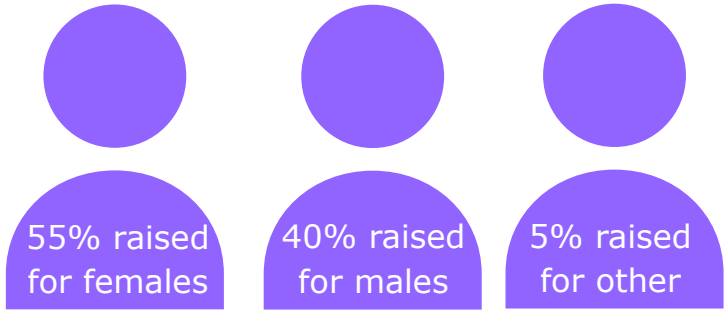
Safeguarding adults

2,876 safeguarding concerns received,

+13% from previous year.

This increase is reflected in the increase of knowns to service queries +51% from previous year.

67% progressed to Section 42 Enquiry



Adult safeguarding referrals

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

Self	27%
Other Professional	22%
Partner	11%
Friend	10%
Stranger	8%
EPUT Staff	6%
Neighbour	6%
Other	4%
Other Family	3%
Other EPUT Service User	3%

Table 6: Source of referral (top 10)

EPUT Mental Health	46%
Other	29%
Police	4%
Ambulance Service	4%
Acute/General Hospital	4%
Family	4%
Local Council	3%
CQC	3%
Residential Care Home	2%
GP Surgery	1%

Table 7: Category of referral

Self-neglect	21%
Physical	15%
Financial	13%
Psychological	12%
Neglect	11%
Domestic Abuse	11%
Organisational	8%
Sexual	6%
Not Determined	1%
Modern Slavery	1%
Discriminatory	1%
Radicalisation	0%

Table 8: Safeguarding referral outcome

Substantiated	40%
Unsubstantiated	25%
Partly Substantiated	11%
Inconclusive/Not Determined	15%
Investigation Ceased at individuals Request	9%

Figure 11: Referrals by area

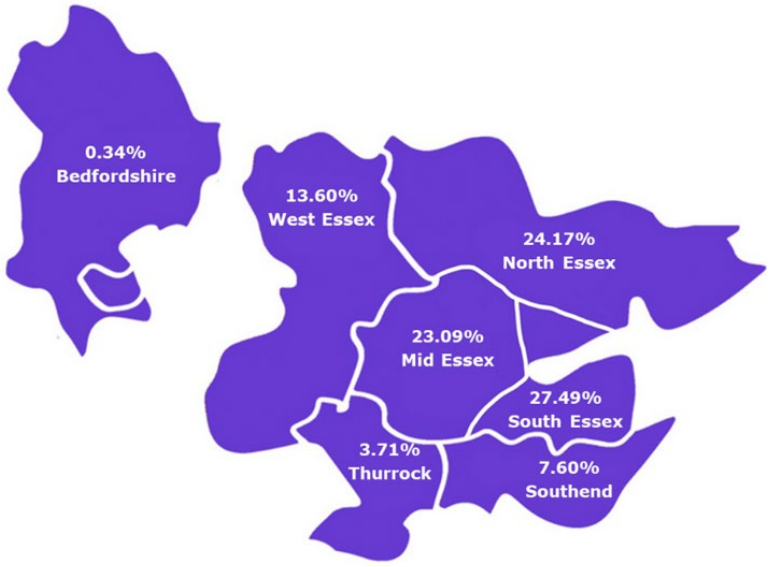


Table 9: Is the vulnerable adult satisfied with the outcome?

Yes	76%
Not applicable/known	17%
No	7%

Table 10: Risk level

Risk reduced	59%
Risk removed	27%
Risk remains	14%

Making Safeguarding Personal

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

Enquiries

Number of enquiries closed: **1272**

Outcome Satisfaction

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

Safeguarding Referral Outcome

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

Desired Outcome

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

Service user feedback

Adult felt listened too when I agreed to close the safeguard. He explained that he is an adult and able to make arrangements for himself.

Adult's daughter said she was grateful for the support

Taken seriously

Adult did not want to be on the same ward as the alleged Perpetrator. Both service users were able to be separated.

46% of service users, family members or advocates provided feedback.
What went well?

Adult is currently being supported by Children Services and has a support worker. Children are waiting for CAMHS intervention.

Agreed to continue the support from myself and accepted help from other services to attempt to end her relationship safely.

Police are aware of the case although no criminal investigation. Adult is keeping herself safe while getting support from local authority to move as long term plan.

Risks were mitigated when patient was unable to share their thoughts on the concern due to catatonic presentation. When this was treated the MDT raised the concerns we saw, shared access to services for support/advice and let the patient make a decision on proceeding with any interventions.

Duty System

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

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

Themes from Duty System

Safeguarding activity remains high with a total of 1,069 calls reported in 2025/26.

EPUT services have been advised of 501 Child in Need enquiries and 213 Child Protection enquiries for children and young people under the care of EPUT service users during the reporting period.

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

Key themes reported through duty

- Disclosures of historical sexual abuse.
- Ongoing domestic abuse reports.
- Increased reports of physical abuse within family settings (adult patients living at home).
- Patient-on-patient aggression, including assaults, altercations, and fights on wards.
- Patients absconding from wards.
- Use of technology to exploit or breach boundaries (e.g. filming staff, posting on social media such as TikTok and Instagram).
- Financially exploitative behaviours between patients (e.g. lending money, transferring large sums, purchasing goods/food for others).
- Financial exploitation concerns.
- Self-neglect among patients.
- Neglect concerns relating to individuals with learning disabilities.
- Increased contact from Eating Disorder services seeking advice.
- High volume of queries/telephone contact from Therapy for You (T4U).
- Additional enquiries from T4U regarding parents struggling to manage very young children's behaviour.

MAPPA

National picture

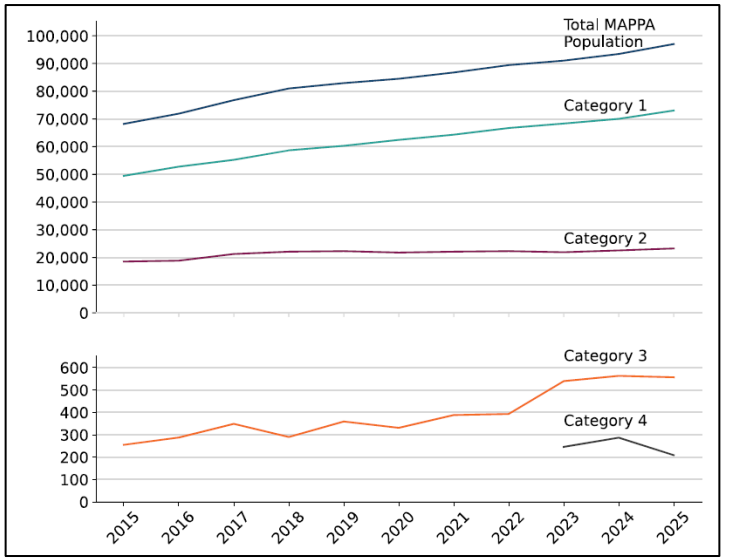
Multi-Agency Public Protection Arrangements is a framework where various agencies, such as the police, probation, and prison services, collaborate to assess and manage the risks posed by certain sexual and violent offenders. MAPPA produce their annual report in October therefore, the below data has been taken from the 2024 – 2025 reports.

Nationally, the MAPPA population continued to grow and was at 97,050 on 31 March 2025 of which 73,047 Category 1; 23,237 Category 2; 703 Category 3; and 209 Category 4. Within this, 995,639 were managed at Level 1; 1,218 managed at Level 2; 193 managed at Level 3.

There was a 4% increase from the previous year, where there were an additional 2,396 MAPPA offenders, accounted for by an increase of 2,995 in Category 1, 703 in Category 2 and offset by decreases of 6 in Category 3, and 78 in Category 4.

Up until year end date March 2025, there has been an increase of 42% in the MAPPA population since 2014, which is demonstrated in Graph 1.

Graph 1: MAPPA population between 2015 and 2025.

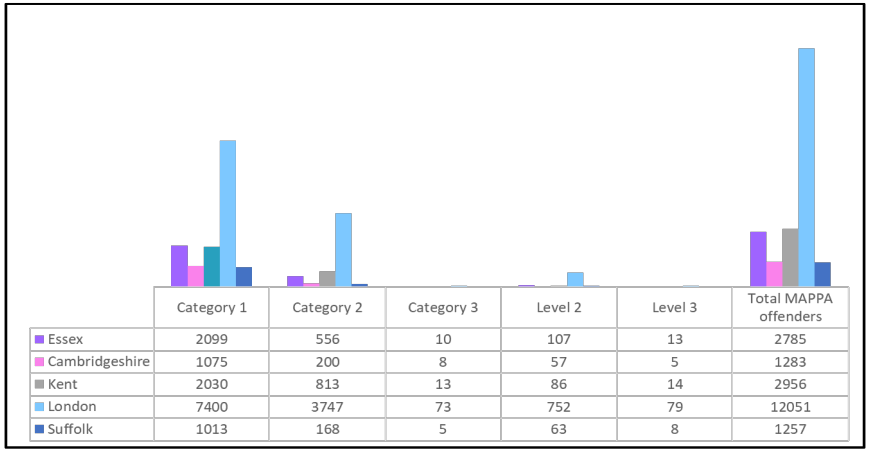


Essex

The Essex MAPPA population continued to grow and was at 2,515 on 31 March 2025 of which 2099 Category 1; 556 Category 2 and 10 Category 3. Within this, 2646 were managed at Level 1; 18 managed at Level 2; 1 managed at Level 3.

There was a 6% increase from the previous year, where there were an additional 150 MAPPA offenders, accounted for by an increase of 119 in Category 1, 35 in Category 2, and a decrease of -4 in Category 3.

Graph 2: How Essex MAPPA compares to nearby counties.

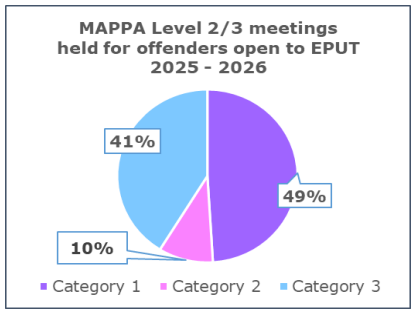


	Category 1	Category 2	Category 3	Level 2	Level 3	Total MAPPA offenders
Essex	2099	556	10	107	13	2785
Cambridgeshire	1075	200	8	57	5	1283
Kent	2030	813	13	86	14	2956
London	7400	3747	73	752	79	12051
Suffolk	1013	168	5	63	8	1257

EPUT themes and challenges - MAPPA

- MAPPA attendance from operational teams has increased from this time last year to 92%.
- There were 29 Level 2 meetings held for MAPPA offenders open to EPUT and 11 Level 3 meetings.
- Figure 1 shows that the category of MAPPA offenders open to EPUT has differed from the previous year, with Category 1 being the greatest at 61% of cases being open.
- Figure 2 demonstrates that Categories of offenders who are open to EPUT are heard at Level 2 more than Level 3.
- Figure 3 shows that there was a 15% increase in requests for information sharing (+249 requests) which shows a significant increase in demand for MAPPA information, indicating the need for multi-agency intelligence and increased risk awareness and information sharing activity.

Figure 1



Graph 3

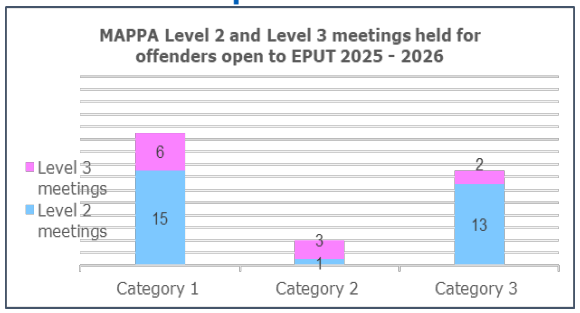
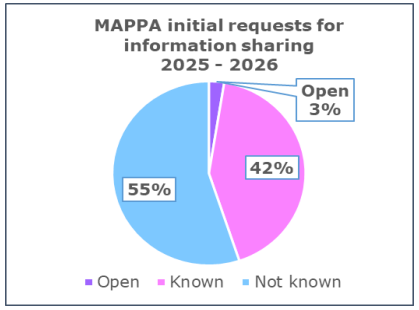


Figure 2



EPUT themes and challenges -MARAC

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

Figure 4

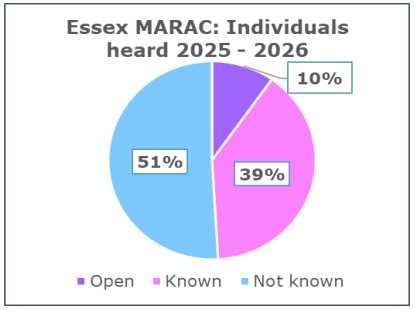


Figure 5

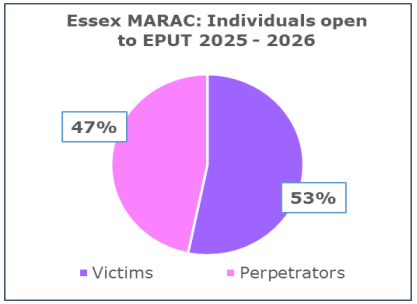
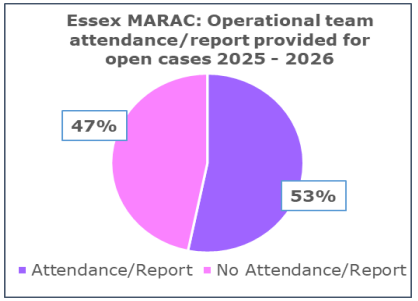


Figure 6



Analysis of the open cases heard at MARAC during 2025 – 2026 showed a consistent safeguarding demand, with high-risk domestic abuse cases continue to require consistent multi-agency response and ongoing resource and attention.

Engagement from operational teams has increased by 13%, to 53%. The clinical specialists for safeguarding MARAC and MAPPA continue to offer support and training to operational teams and are working closely alongside MARAC to develop new ways of communication to aid engagement.

Prevent Channel Panels

Prevent is a Home Office Programme that enables police to protect vulnerable people from being exploited by extremists.

The objectives of Prevent are to:

- Tackle the ideological causes of terrorism
- Intervene early to support people susceptible to radicalisation.
- Enable people who have already engaged in terrorism to disengage and rehabilitate

A representative from EPUT Safeguarding team attends monthly Prevent Channel Panels as a core member for Essex & Southend and Thurrock:

- The Safeguarding Prevent lead responds to queries from the Prevent Police in addition to the routine information requests in preparation for Channel Panels.
- The Safeguarding Prevent lead and administration team will ensure that any known Prevent information is shared with the clinical teams to inform robust risk assessment.
- A Safeguarding Team Duty clinician or Prevent Lead will triage all Prevent referrals raised by EPUT staff and forward these onto the Prevent Police team if appropriate.
- The Safeguarding Prevent lead attends the Essex Prevent Delivery Group. The purpose of the Essex Prevent Delivery Group (PDG) is to bring together the 'specified authorities' under the Prevent Duty to ensure that Prevent is successfully delivered in Essex.

The current terrorist threat is characterised by:

- A significant volume, breadth and complexity of terrorist incidents and cases across various ideologies, including attack planning, extremist travel intent, and online and offline radicalisation.
- Whilst Islamist Terrorism remains the primary threat to the UK, Extreme Right-Wing Terrorism (ERWT) has been on a steadily rising trajectory.
- An elevated threat to Jewish and Israeli individuals and institutions, in the context of the conflict in the Middle East, evident in recent incidents in the UK and overseas.
- The internet has become increasingly prominent in radicalisation pathways and offending over time for convicted extremists in England and Wales.
- Mental health issues, neurodivergence and personality disorder/ difficulties alongside depression and personality disorder/ difficulties have been recorded in a study published by the HM Prison and Probation Service (2022) as the most common types of disorders for those who have primarily been radicalised online.

Supervision

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

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

Table 11: Staff safeguarding supervision

April to March	2022-23	2023-24	2024-25	2025-26
Mandatory 1:1	433	269	304	373
Group (no. of participants)	503	395	613	454
Additional	158	12	8	316
Total	1094	676	925	1143

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

The Safeguarding Team participated in five reflective practice sessions during the year. These sessions provide valuable reflective space and opportunities for peer support, supervision, shared learning, and professional development.

Please see Appendix 2 for more information about supervision.

Feedback

Therapy for You - The Safeguarding team have been providing group supervision for our staff group which has been well received. My supervisee brought a case of domestic violence where the advice was to disclose to the police. This was sensitively handled by the team, follow up support provided for both myself and the supervisee and a summary of this sent to us.

Perinatal - Feedback gathered through general conversations with the team, alongside my own experience, suggests that safeguarding supervision is widely experienced as a valuable, supportive, and containing space. Colleagues have shared that it provides an important opportunity to unpack complex and challenging cases, share ideas, and think collaboratively about risk, formulation, and next steps. It is also seen as helpful in reviewing actions already completed and ensuring that safeguarding considerations remain thorough and well-held.

Children's Safeguarding Practice Reviews (CSPR's)

The key themes for Child Safeguarding Practice Reviews this year include:

Understanding the child's lived experience

Professionals need to keep asking: "What is life like for this child?"

Children's voices and daily experiences can become lost when agencies focus on adults' needs or processes.

Professional curiosity

Avoid accepting explanations at face value.

Be prepared to respectfully challenge parents, carers and even other professionals when information doesn't add up.

Look for patterns rather than viewing incidents in isolation.

Disguised compliance

Families may appear to engage with services without making meaningful changes.

Practitioners should measure outcomes for the child, not simply attendance at appointments or cooperation with professionals.

Information sharing

Small pieces of information held by different agencies often form a much bigger safeguarding picture.

Timely, accurate information sharing remains a key learning point.

Multi-agency challenge

Professionals should feel confident escalating concerns where risks are not being recognised.

Healthy professional challenge is viewed as an essential safeguarding skill.

One emerging area that's particularly relevant is the recognition that high parental distress around child protection intervention or possible removal can significantly increase risk to children.

Reviews nationally and locally are encouraging practitioners to assess not only the child's vulnerability but also the parent's emotional state, access to support, and potential for impulsive or desperate behaviour during periods of acute crisis. Ensuring staff understand the risks when a parent perceives a child may be removed.

See Child Published Reviews on the ESCB website: Child DD, Child JJ, Child CC, Child HH, Child TT, Child LL and Child KK.

Safeguarding Adult Reviews

Safeguarding Adult Reviews (SARs) are undertaken to identify learning and promote improvements in practice, with the aim of preventing future deaths or serious harm. SARs are a statutory requirement of Safeguarding Adults Boards (SABs) in accordance with the Care Act 2014. As of January 2026, 58 cases were reported within the adult safeguarding review workflow to which the Trust was contributing. This includes referrals at scoping stage, and commissioned reviews in progress.

The Trust were involved in the following reviews published in 24/26:

Safeguarding Adult Reviews:

- Sandra
- Harold
- Paula
- Daniel
- Carol (Joint SAR/DHR)

Domestic Homicide Review/ Domestic Abuse Related Death Review

- Chloe
- Laura
- Robert

The Trust works collaboratively with partner agencies to ensure that learning from reviews is identified, understood, and translated into improvements in practice. This includes recognising both the factors that support effective safeguarding and those which may act as barriers, to strengthen practice and better protect adults at risk. Learning from safeguarding reviews is embedded through the Trust's Culture of Learning approach and is reported through established governance arrangements, including the Learning Collaborative Partnership and the Learning and Oversight Sub-Committee, ensuring appropriate oversight and assurance. Key learning is shared across the organisation through a range of established communication channels, including the "Five Key Messages" bulletins, Lessons Identified newsletter, and Safeguarding newsletter. In addition, themes identified from reviews inform the focus of Safeguarding Champions learning events, supporting continuous learning and improvement across the Trust. Identified Newsletter and the Safeguarding Newsletter. Learning also informs topic themes for the Safeguarding Champions Learning Events.

Key Learning Themes That Impacted Practice

Domestic Abuse Identification

EPUT actions include strengthening routine enquiry in Level 3 safeguarding training, delivery of specialist domestic abuse training to teams, planned integration in design and build of the new NOVA electronic patient record to support greater transparency, and the Domestic Abuse Competency and Skills Training Framework. training to teams, planned integration in design and build of the new NOVA electronic patient record to support greater transparency, and the Domestic Abuse Competency and Skills.

Professional Curiosity & Significant Relationships

EPUT has embedded this through training, supervision, NOVA design, EPUT Culture of learning and internal communications such as the safeguarding newsletters.

MCA

Learning has highlighted Mental Capacity Act (MCA) practice as an area for further development. There is a need to improve the quality and consistency of the application of the Act ensuring robust documentation that is legally compliant. The Mental Capacity Act and DoLs Policy and procedural guidance has undergone triennial review and has been ratified.

Improved identification and management of complex risk including suicide, self-harm, and domestic abuse.

A full review has been undertaken of the Level 3 safeguarding training, which is now in delivery, bespoke safeguarding team-based sessions, and STORM suicide prevention training.

Children in Care

The Children in Care (CiC) Service operates in line with Promoting the Health and Well-Being of Children in Care (DfE, 2015). The service is responsible for addressing the health needs of all children and young people in care placed within the two local authorities across the South East locality, regardless of placing authority. This includes overseeing statutory Review Health Assessments (RHAs), supported by robust quality assurance processes to ensure consistency and high standards of care.

The team coordinates and monitors the health needs of all children in care within the South East locality and those placed elsewhere in England, ensuring equitable access to services and parity of care across the cohort. The EPUT CiC Service also provides targeted frontline support for young people aged 16+, particularly those who are not engaged in education, employment or training (NEET), or who do not have a lead health professional in universal services. The number of young people within the NEET and non-universal services cohort has increased over the past year. These young people often present with additional vulnerabilities and complex health needs, requiring enhanced liaison, comprehensive health history reviews, and coordinated support to ensure unmet needs are identified and addressed. Separated migrant children and young people similarly require targeted interventions to support their health and wellbeing.

The service supports EPUT professionals through the delivery of accessible, evidence-based training, enhancing understanding of the specific health and developmental needs of children in care and strengthening the quality of statutory health assessments. The administration team plays a critical role in coordinating Initial Health Assessments (IHAs) and RHAs, ensuring statutory requirements are met and care is delivered in a timely and effective manner. Partnership working remains central to the service. The CiC team contributes to multi-agency operational groups and works closely with Integrated Care Board (ICB) colleagues to support corporate parenting responsibilities, reporting requirements, and improved outcomes for children in foster and residential placements.

A key area of focus is supporting young people as they transition from being a Child in Care to becoming a Care Leaver at age 18. Effective transition planning is essential to ensure continuity of care, maintain ongoing health interventions, and support engagement with adult health services. This is achieved through coordinated working between health professionals, social care teams and partner agencies, with clear communication and timely review of health assessments, care plans and referrals.

Requests for service data have increased during the reporting period. The team has continued to support accurate data collection and reporting, with a particular focus on Initial Health Assessment (IHA) activity to inform the development of the new IHA model commissioned by the ICB.

Local picture

The current CIC caseload held by the service within the South East locality is 774, which is broken down by area as:

Castlepoint & Rochford: 128

Under 18 years of age children

Southend: 287

Under 18 years of age children

Care leavers: 84

18 to 19 years old

Out of Area: 275

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

Safeguarding Training Update

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

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

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

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

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

In February 2026 the Safeguarding Team implemented new Safeguarding packages to reenergise the sessions.

Adults Lvl 3

29 sessions
1095 trained

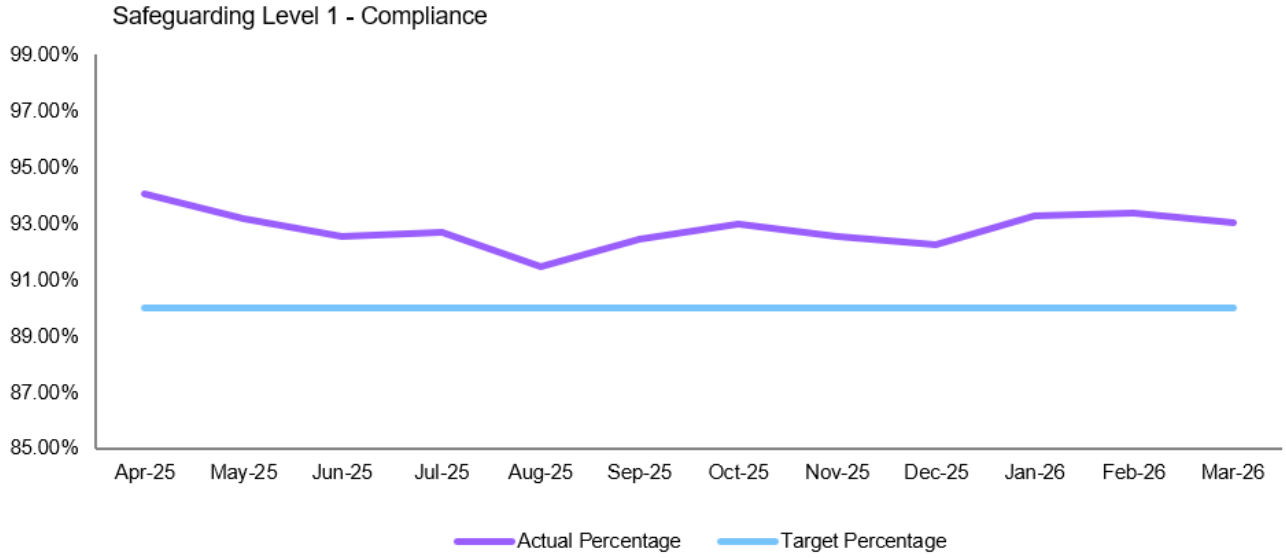
17 sessions held face to face

Children's Lvl 3

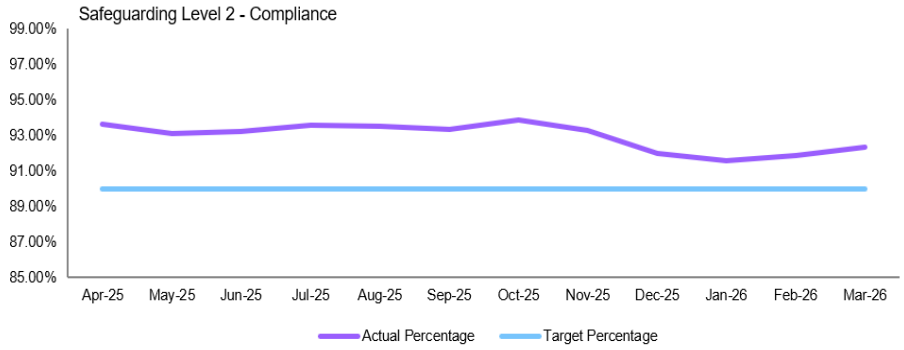
27 sessions
991 trained

18 sessions held face to face

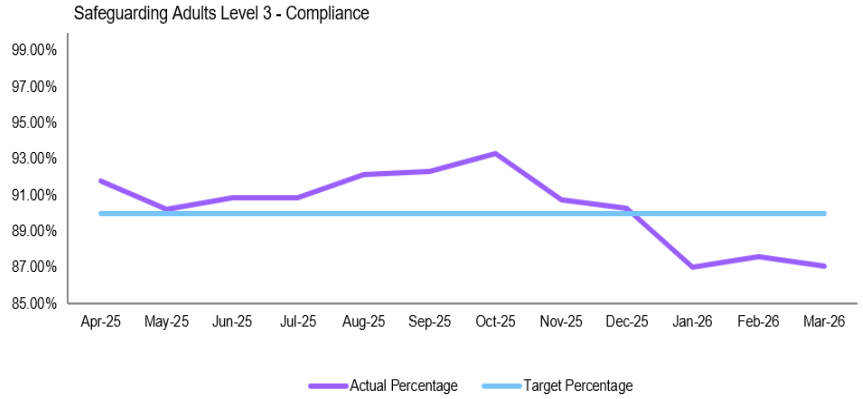
Graph 4: Safeguarding Level



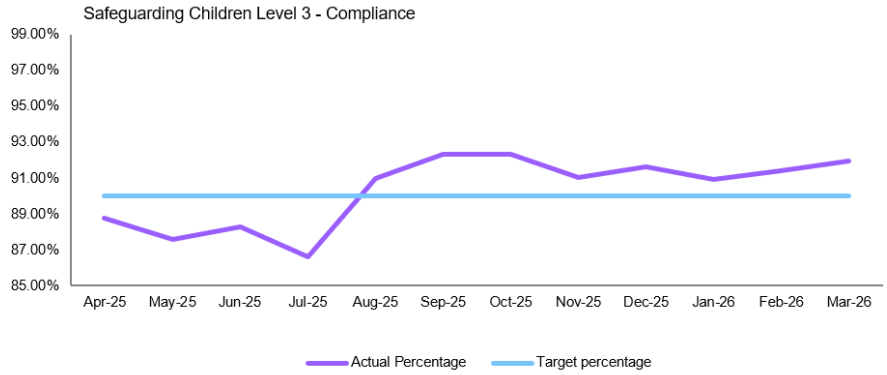
Graph 5: Safeguarding Level 2



Graph 6: Safeguarding Adults Level 3



Graph 7: Safeguarding Children Level 3



In 25-26 Safeguarding offered increased face to face in person training across the localities. Children Level 3 dipped in compliance in July 2025 but regained compliance from August. Adults Level 3 was in compliance until January 2026 and additional courses have been offered to create more spaces. The number of people who do not attend is an ongoing focus.

Training feedback

Importance of recording the voice of the child. Always have professional curiosity.
Greater detail MCA assessments. More confidence to ask difficult questions and call safeguarding for advice if I'm not sure a concern is a safeguarding. The course has opened my eyes and the way I will deal with situations should they occur. It has also given me the knowledge and confidence to be aware of and refer to safeguarding.

While our service (STaRS), does not directly after under 18 year olds, we need to keep children in our minds in the wider context. Our clients normally have substance abuse, domestic violence, history of traumatic childhoods, financial and accommodation issues, this quite clearly will have a safe guarding knock on effect to any children involved in the relationship. Action point is to remind all staff to assess the family situation fully and ascertain if children are at risk.

I will be more curious and ask more questions. I will contact safeguarding team if I'm unsure about anything

Engage with staff in the upcoming roadshows, to ensure staff are aware of the online portal where further safeguarding information can be shared

An understanding of the case reviews and implications for practice. For adult referrals being aware of whether there are children involved

Feedback post-training actions

I will be more curious and ask more questions. I will contact safeguarding team if I'm unsure about anything. I engage with staff in the upcoming roadshows, to ensure staff are aware of the online portal where further safeguarding information can be shared. I have an understanding of the case reviews and implications for practice. For adult referrals being aware of whether there are children involved.

I have ensured that I have had discussions during handovers about patients who may be more vulnerable and using an MDT approach discussed whether a safeguarding needed to be put in place for them. I will ensure I further my learning by utilising the mandatory training portal to imbed the knowledge from the level 3 training day

Communications

Safeguarding Champions

Safeguarding champions act as conduit of information between the Safeguarding team and their clinical area by raising awareness of safeguarding practices and initiatives and supporting the identification of team learning needs. The following Champions events have been held during the reporting period to support this function and are open to safeguarding champions and EPUT practitioners to support best practice in Safeguarding.

April 2025:

- Alpha Vesta Preceptorship Domestic Abuse Awareness- Attended by 100 staff members.

May 2025:

- Safeguarding & Sexual Safety Induction Training for students – ARU and Essex University.

August 2025:

- Self-Neglect and Hoarding- Attended by 54 staff members.
- Voiceability – Advocacy- Attended by 26 staff members.

September 2025:

- Alpha Vesta Domestic Abuse Basic Awareness**-** Attended by 52 staff members
- MARAC & MAPPA DA Training- Attended by 12 staff members
- GCP2 Training- Attended by 15 Perinatal staff members.

October 2025:

- Alpha Vesta Recognising and Responding to Domestic Abuse in the Workplace- Attended by 27 staff members.
- Alpha Vesta Impact of Domestic Abuse on Children and Young People- Attended by 35 staff members
- Alpha Vesta Domestic Abuse Lunchtime Learning 1 - Routine and Sensitive Enquiries attended by 26 staff members.
- Alpha Vesta Domestic Abuse Lunchtime Learning 2 - Attended by 19 staff members.
- Alpha Vesta Understanding Trauma and Suicide Ideation related to Domestic Abuse- Attended by 28 staff members.
- Role of the LADO- Attended by 27 staff members
- Child Death Review Team- Attended by 43 staff members
- Sensory Seeking Training,- Attended by 17 staff members

January 2026:

- Alpha Vesta Domestic Abuse Basic Awareness- Attended by 43 staff members
- Alpha Vesta Domestic Abuse Lunchtime Learning 1 -Attended by 20 staff members
- Alpha Vesta Domestic Abuse Lunchtime Learning 2:- Attended by 32 staff members
- Alpha Vesta Domestic Abuse Lunchtime Learning 3: Attended by 37 staff members

March 2026

- 'What is Transforming Care' and The Dynamic Register - David Landy- Attended by 55 staff members

Safeguarding Newsletter

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

Topics reported over the past year include:

- Mental Health Awareness Month
- The Lost Boys
- Court Orders and Pre- Proceedings
- Southend Youth Council Neurodivergent Recourse pack
- From Harm to Hope
- Misogyny- Lightning Learning Series
- CSPR Child GG Summary
- EPUT Celebrates Pride Month
- Keeping Children safe helping families thrive
- The Families First Partnership Programme
- MCA for LD
- It's never too late- Elder Abuse
- Child Safety Week- Staying Safe this Summer
- Tackling Child Neglect
- Staying Safe this Summer
- Unassisted Births Safeguarding Support
- Keeping Children Safe in Education 2025
- County Lines- See the signs
- Online Grooming
- Suicide Awareness Month
- Care updates for MCA
- Non accidental injuries and bruising
- Child Accident Prevention Trust – Staying safe this Spring
- World Alzheimer's Awareness Month
- DoLs Process Changes

Safeguarding Intranet page

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

Back to Basics sessions:

- How to undertake a safeguarding referral
- How to undertake a safeguarding investigation
- How to conduct and completed a Mental Capacity Assessment
- How to complete a safeguarding children referral
- What does good information sharing with MAPPA MARAC look like

Safeguarding homepage: 10k+ views

Sexual Safety homepage: 3,704 views

Safeguarding Team Roadshow

In November 2025, the EPUT Safeguarding team went out and about across the Trust to celebrate National Safeguarding week. The team visited various sites across Essex, Southend and Thurrock to spread awareness of who we are and what we do.

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

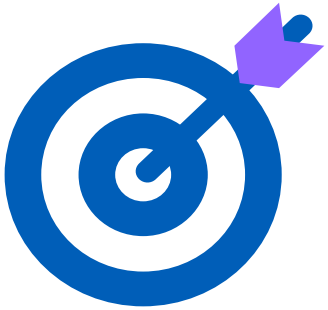
Challenges and innovations

Challenges

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

Innovations and achievements

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



Looking Back 2025/26 Priorities

Objectives 2024/25	What we have achieved	
Whole family Approach	Continued to contribute to the design and development of the safeguarding functionality within the NOVA Electronic Patient Record (EPR) system. This included supporting the development of features that enable robust documentation of significant relationships, strengthening practitioners' ability to identify and assess risk to individuals within their family and community networks. As an active member of the Southend, Essex and Thurrock (SET) Whole Family Approach Working Group, contributed to the development of system-wide resources designed to support practitioners in adopting a whole-family approach to assessment and intervention.	✓
Children's safeguarding	Learning from local and national reviews has been shared via supervision, reflective practice sessions, safeguarding newsletter and ECOL. Following the successful delivery of Graded Care Profile 2 Tool training to children's practitioners this has now been rolled out to adult practitioners within EPUT commencing with all practitioners in the Perinatal Mental Health Service. Two Safeguarding Team members trained to deliver the Brook Traffic Light Tool, increasing organisational capacity to identify and respond to harmful sexual behaviour in children. Review and submission of the S.11 audit of EPUT's statutory responsibilities regarding the safeguarding of children and the promotion of their welfare within the community. Strengthened partnership working with Essex Children's Social Care SPOA and Southend C-SPOC to improve communication, information sharing and safeguarding responses. Contributed do Multi-Agency Case Audits (MACAs) and Multi-Agency Thematic Audits (MATA) on behalf of the Essex Safeguarding Children Board.	✓
Learning	Progressed delivery of Level 3 Safeguarding Adults and Children training to a predominantly face-to-face model, enhancing engagement and learning outcomes. Delivered 13 Spotlight on Safeguarding sessions covering key topics including advocacy, domestic abuse, hoarding, Child Death Review, MAPPA, MARAC, Mental Capacity Act and young carers. Produced and distributed eight safeguarding newsletters across the Trust and partner agencies to promote learning and awareness. Shared learning from safeguarding reviews through ECOL to support continuous improvement in practice. Safeguarding practitioners, alongside senior operational leaders, completed Level 4 safeguarding training on report writing, strengthening	✓

	the quality of safeguarding reports and contributions to formal processes. Aligned EPUT's Section 42 enquiry audit process with Essex County Council, creating opportunities for joint audit activity, shared learning and improved safeguarding practice.	
MCA and DoLS	Commenced the triennial review of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) Policy and Procedural Guidance, ensuring continued compliance with legislative and best practice requirements. Reviewed and developed updated patient information leaflets and correspondence for relatives and carers to improve communication and understanding of MCA and DoLS processes. Developed and implemented a DoLS process flowchart, communicated across operational teams, including guidance on Datix reporting for patients awaiting DoLS assessments. Delivered skills-based training to clinical teams on the Mental Capacity Act and DoLS, enhancing practitioner knowledge, confidence and compliance in practice.	

Forward Plan Review 2026/27

Objectives 2026/27	Success Criteria
Whole Family Approach	• Evaluate and measure the impact of Whole Family Approach training to assess practitioners' confidence, knowledge and application in practice, using findings to inform future learning and development programmes. • Continue to support the development and optimisation of safeguarding functionality within the NOVA Electronic Patient Record, ensuring effective documentation of significant relationships, support systems and the development of genograms to inform risk assessment and care delivery. • Once the NOVA system goes live promote the effective use of NOVA's family and relationship mapping functions through training, guidance and audit activity to improve the quality of safeguarding assessments and recording. • Embed Whole Family Approach principles within safeguarding duty functions, ensuring family context, caring responsibilities and wider support systems are routinely considered in safeguarding decision-making and interventions. • Develop mechanisms to audit and evaluate the application of the Whole Family Approach within safeguarding practice, identifying opportunities for improvement and sharing examples of good practice across services. • Continue collaboration with system partners through the SET Whole Family Approach workstream to support consistent implementation of family-centred practice across health and partner agencies.

Learning and Awareness Safeguarding Agenda	• Strengthen safeguarding knowledge and preparedness of learners by reviewing and enhancing the safeguarding training offer provided to Higher Education Institutions, ensuring students are equipped with a solid foundation in safeguarding adults and children prior to undertaking placements within EPUT. • Promote organisational learning on neglect through the planning and delivery of an EPUT Safeguarding Conference, bringing together practitioners and partner agencies to share learning, evidence-based practice and emerging developments. • Enhance multi-agency learning and collaboration through the delivery of a minimum four' Spotlight on Safeguarding events' in partnership with external agencies, focusing on emerging safeguarding themes and lessons identified from local and national reviews. • Maintain effective communication and dissemination of safeguarding learning through the publication of a minimum of six safeguarding newsletters. • Evaluate the impact of safeguarding learning initiatives and the dissemination of learning from reviews . In partnership with the Compliance Team, undertake two audits during the year to assess the embedding of learning, identify improvements in practitioner knowledge and confidence, and demonstrate positive outcomes for adults, children and families.
MCA/DoLS and interface with MHA	• Following the Supreme Court judgment (AG for Northern Ireland [2026] UKSC 16) in June 2026, which effectively overturned the Cheshire West judgement, in that the 'acid test' is no longer law, the MCA and DoLS policy and guidance will need to be amended to reflect the current legal position and provide guidance for practitioners to ensure robust record keeping of wishes and feelings and decision-making rationale. • Safeguarding MCA Leads are involved at regional and local level to support implementation of change in line with emerging guidance and practice tools with LA partners across the system. • Recent legislative change and practice implications to be communicated to operational leaders via the communications team and to practitioners through Safeguarding Training Framework, Newsletter and Spotlight on Safeguarding.
Transition to Adult Services	• Undertake a review of the transition's pathway from a safeguarding perspective, identifying high-risk areas and prioritise targeted engagement and support. • Develop links and identify provision and transition nurse functions within inpatient services to promote effective safeguarding oversight and support the safe and seamless transition of young people into adult services. • Safeguarding representation at transition forums for high risk and complex cases to provide specialist support to operational services.
Safeguarding Champions	• Relaunch the Safeguarding Champions Network with a refreshed role profile and clearly defined responsibilities, strengthening safeguarding leadership across the Trust. • Safeguarding Champions will support the promotion of safeguarding priorities, dissemination of learning from reviews and audits, sharing of best practice, and act as a key link between operational teams and the Safeguarding Team to support continuous improvement in safeguarding practice.

Closing Remarks

As we move into 2026/27, this annual report provides an opportunity to reflect on the significant progress made across EPUT's safeguarding agenda and to recognise the dedication of staff, services and partners in protecting children, young people and adults at risk.

Despite a challenging year characterised by increased demand, complex safeguarding enquiries, safeguarding review activity and workforce pressures, including periods of long-term staff absence, the Safeguarding Team has demonstrated resilience, professionalism and an unwavering commitment to delivering an effective service. Their efforts have ensured continued compliance with statutory duties and supported the Trust in meeting its safeguarding priorities.

An important milestone during the year was the independent safeguarding diagnostic commissioned by Essex County Council. The review concluded that *"This diagnostic highlights the high standards of safeguarding practice held within EPUT, particularly within the dedicated safeguarding team,"* and provided assurance that EPUT is fulfilling its responsibilities under the Section 75 Agreement.

The year has also seen several notable achievements. These include continued reductions in outstanding Section 42 enquiries, strengthened partnership working with Essex County Council and other safeguarding partners, and enhanced collaboration with specialist domestic abuse services, including Alpha Vesta. The Safeguarding Team has refreshed Level 3 Safeguarding Adults and Children training to provide a more interactive learning experience, with a renewed focus on face-to-face delivery and consistently positive feedback from participants. Increased visibility within operational services has further strengthened safeguarding awareness and engagement across the Trust.

Learning and continuous improvement remain central to our approach. Insights from audits, reviews and multi-agency learning processes have informed practice development, training and service improvements, helping to ensure that safeguarding remains embedded across all areas of the organisation.
Looking ahead, we will build on these achievements by continuing to strengthen the Whole Family Approach, enhance safeguarding knowledge and practice, improve Mental Capacity Act and Deprivation of Liberty Safeguards compliance, support safe transitions between services, and further develop the role of Safeguarding Champions. Through continued partnership working, professional curiosity and a shared commitment to safeguarding, EPUT is well placed to continue improving outcomes for those we serve and to provide assurance that safeguarding remains at the heart of everything we do.

Tendayi Musundire
Deputy Director of Nursing (Responsible for Safeguarding)

Appendix 1

Business support

The Business Support team within the Safeguarding team provide secretarial and administrative support to the safeguarding service. They manage the 'Duty Line' which is a single point of access number and email which feeds into the team. Business support receive a high workflow of enquires as to whether the adult/child is open to our secondary Mental Health Service from:

- Social workers
- Police
- Social care teams
- LA business support teams

Following triage from the duty clinician, business support administer the safeguarding enquiry or case management process, where further action or progression are required to be communicated. Business support manage the booking function that supports provision of mandatory, informal and group safeguarding supervision for practitioners within EPUT.

The administrators also support the child death review process by notifying safeguarding clinicians of the receipt of a child death notification within Essex and the organisation, so that they can identify the relevant practitioners that have been involved in the child's care.

Business support receive, disseminate and manage the Safeguarding Children's inbox. This includes information received or requested from:

- Domestic abuse notifications
- Child Protection Minutes and Invitations
- Children's Social Care
- National Crime Agency
- Essex Police
- Prevent Enquiries
- LADO
- Safeguarding Adult Reviews (SAR)
- Domestic Homicide Reviews (DHR)
- MARAC

The team produce a monthly Safeguarding Newsletter, covering clinical topics identified by the Safeguarding team and administrate the Safeguarding Champion's events.

Appendix 2

Supervision

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

Supervision enables both the supervisor and the supervisee to reflect, scrutinise and evaluate cases where safeguarding concerns have occurred. The process of safeguarding supervision is both educational and supportive, whilst facilitating the supervisee to explore their feelings about the work and the family. Staff will be encouraged to use professional curiosity when discussing their cases and will bring cases for escalation. As a 'Whole Family' organisation, we offer formal supervision to both adult and children's services. The frequency of supervision is mapped to the roles that staff undertake within the organisation. Supervision covers safeguarding concerns in regard to both children and adult safeguarding.

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

The Safeguarding team also offer joint supervision where practitioners across services are working with the same family. This is actively encouraged in the Trust to support the building of knowledge and skills in practice and the organisation's active ethos of 'Whole Family', both adult and children concerns can be considered and a plan agreed and documented.

Benefits of supervision

The benefits of supervision are well documented, and the model adopted by the Safeguarding team covers the four areas below:

- Management (ensuring competent and accountable performance/practice)
- Engagement/mediation (engaging the individual with the organisation)
- Development (continuing professional development)
- Support (supportive/restorative function).

Appendix 3

Glossary of terms

CIC	Children in Care
DA	Domestic Abuse
DARDR	Domestic Abused Related Death Review
DoLS	Deprivation of Liberty Safeguards
ECOL	EPUT Culture of Learning
EHCP	Education Health Care Plan
HEF	Health Executive Forum
ICB	Integrated Care Board
ICS	Integrated Care System
LAC	Looked after Child
LADO	Local Authority Designated Officer
Mace Group	Missing Child Exploitation in Essex Group
MAPPA	Multiagency Public Protection Arrangements
MARAC	Multiagency Risk Assessment Conference
MCA	Mental Capacity Act
MHDAP	Mental Health Domestic Abuse Practitioner
MSE	Mid and South Essex
RHA	Review Health Assessment
SAB	Safeguarding Adults Board
SAR	Safeguarding Adults Review
SEND	Special Education Needs
SET	Southend, Essex and Thurrock
SETDAB	Southend, Essex and Thurrock Domestic Abuse Board
SPOC	Single Point of Contact

9.2 QUARTERLY REPORT ON SAFE WORKING OF RESIDENT DOCTORS

Information Item KS

REFERENCES

Only PDFs are attached

Quarterly Report on Safe Working Hours for Resident Doctors 05.08.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 August 2026

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

Risk Assessment of Report		
Summary of risks highlighted in this report	Assurance provided that doctors in training and safety rostered and that they working hours are compliant with the terms and conditions of their contract.	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Statutory Public Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital and Data	
	SR10 Workforce Sustainability	✓
	SR11 Staff Retention	
	SR12 Organisational Development	
	SR13 Quality Governance	
Does this report mitigate the Strategic risk(s)?		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk	Trainees escalate any issues to their Clinical Supervisor and Clinical Tutor. If unresolved they escalate at the Resident Doctors Forum. Any unresolved issues is further escalated to the Executive Chief Medical Officer. Medical Workforce ensures that the Resident doctors working hours are in line with the terms and conditions of the Resident Doctors Contract 2016.	
Are you requesting approval of financial / other resources within the paper?	No	

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

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

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents and the new format of the report.

Summary of Key Issues

1. The National recruitment of trainees is an ongoing issue, however the intake of trainees for the Trust has improved, leaving less gaps on the rota. In this quarter there are three gaps in the rota.

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

3. 11 Exception reports were raised in this quarter:

   a) The Trust was fined a total of £376.39 for 3 exception reports raised on 8 May, 23 June and 17 April, as it was a breach of contractual working hours.
   b) 10 trainees received payment for the extra hours they worked.
   c) 1 trainee received time off in lieu.

4. The bi-monthly Resident Doctors Forum (RDF) is well attended by Doctors representatives from all sites of the Trust. All matters discussed in this meeting are resolved in a timely manner and escalated to Clinical Tutors/DME/Senior Managers where necessary.

5. The Board is asked to note that the number of exception reports in this quarter has reduced compared to previous quarter where 19 exception reports were raised.

6. Consultation with higher trainees is in progress on the opening of Urgent Care Department at Colchester and Harlow, as a change in their work pattern is anticipated. Discussions were held in JLNC regarding this and it will be discussed further at the Resident Doctors Forum on 30 July 2026.

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

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

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

Governance implications		
Impact on patient safety/quality		
Impact on equality and diversity		
Equality Impact Assessment (EIA) Completed	**~~YES~~/NO**	

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

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

Lead

Dr Kallur Suresh
Executive Chief Medical Officer

QUARTERLY REPORT ON SAFE WORKING OF RESIDENT DOCTORS

1 PURPOSE OF REPORT

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

2 EXECUTIVE SUMMARY

This is the thirty sixth quarterly report submitted to the Board on Safe Working of Resident Doctors for the period 1 April 2026 to 30 June 2026. The Trust has established robust processes to monitor safe working of resident doctors and report any exceptions to their terms and conditions.

Work Schedule Report

Work schedules were sent out to all trainees who commenced their placements on 1 April 2026.

Doctors in Training Data (Average across reporting period)

Total number of posts EPUT Training Scheme inclusive of FY/GP/ACF& Military	**166**
Total number of psychiatry training posts inclusive of ACF and Military Trainee	**111**
Total number of doctors in psychiatry training on 2016 Terms and Conditions inc of trainees on maternity leave	**102**
Total number of foundation posts	**39**
Total number of GP posts	**16**
Total number of vacancies across all grades	**14**
Total vacancies covered LAS/Agency	**11**
Total gaps	**3**

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

Exception Reports:

Number of exception reports submitted over the last quarter: 11

Categories of exception reports submitted

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Additional hours an unscheduled early start					0

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Additional hours an unscheduled late finish	9	1	3 (of the 9 Exception reports where doctors requested payment, fine was levied for 3 reports due to breaching contractual hours)		10
Breaches of non-resident on-call patterns					0
The inability to take contractual breaks					0
Inadequacy of clinical support				Trainee unable to complete portfolio for ARCP due to clinical commitments and lacking time for admin support.	1
Inadequacy of rostered skills mix					0
Raising concerns of a suspected non-compliant rota pattern					0
Detriment or threat of detriment related to exception reporting					0
Information breach					0

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Access and completion resolved in time					0
Access and completion breaches					0
Access and completion test					0
Other: optional free text box					0
Total					11

Experiences of actual or threatened detriment

One of the guiding principles of the exception reporting reforms is to prevent doctors experiencing, either threatened or actual, detriment as a result of exception reporting or indicating intent to exception report. Detriment in an employment context is when an employer, or colleagues, treats an individual unfairly or subjects them to a disadvantage for the sole or main reason that they asserted an employment right. This is usually captured through a survey of resident doctors and the Trust plans to carry out a survey going forward.

Withdrawals

A doctor can choose to withdraw an exception report that they have submitted at any point in the process following submission. All exception reporting data, including those which have been withdrawn, will be retained for the GoSWH to allow them to perform their role in checking for potential safety implications.

Number of exception reports withdrawn over the last quarter	0

Access to individual doctors' exception reporting data

A doctor can choose to withdraw an exception report that they have submitted at any point in the process following submission. All exception reporting data, including those which have been withdrawn, will be retained for the GoSWH to allow them to perform their role in checking for potential safety implications.

Number of exception reports disclosures over the last quarter	0

Work schedule reviews related to exception reporting pattern/instances

The purpose of work schedule reviews is to ensure that a work schedule for a doctor remains fit for purpose. A work schedule review can be triggered by one or more exception reports, or by a request from either the doctor or the employer.

Number work schedules reviews related to exception reporting patterns or instances	0

Rota gaps on all shifts

Total number of rota gaps on all shifts over the last quarter	3

Agency

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

Locum bookings (internal bank) by reason*					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy/Maternity/ sick	148	148	0	1893	1893
Total	148	148	0	1893	1893
Total Cost	**£106.820**				

Resident Doctor Industrial Action

Resident doctors took part in industrial action held from 7 April 2026 until 13 April 2026. The Trust ensured that patient safety was not compromised, and a shadow rota was set up to cover both day and night shift across all five areas of the Trust.

In total 539.5 hours were covered by internal locums and 5 consultants stepped down to cover Resident Doctors over the strike period, so a total of £63,587.50 was spent on the shadow rota.

Actions taken to resolve issues:

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

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

Fines:

A total of £376.39 was levied to the Trust for 3 Exception reports (raised on 8 May, 23 June and 17 April) where trainees breached their contractual working hours.

Issues Arising:

1. Trainees have faced some delay in accessing the fine money due to finance and governance arrangements. The finance delays related to budgets and governing processes have now been resolved. The governance delays related to how the money can be spent. Any such spend is to approved by the non-pay panel and must be to “benefit the education, training and working environment of trainees”. It takes time to provide the rationale to the non-pay panel and this is being discussed with Resident Doctors to achieve a resolution.

2. Higher trainees in the North anticipate a change in their work pattern due to the proposed plan on opening of Urgent Care units at Colchester and Harlow. Discussions are held at JLNC and RDF in conjunction with HR and matters are addressed.

3 ACTION REQUIRED

The Board of Directors is asked to:

1 Note the contents and the new format of the report.

Report prepared by

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

9.3 RESPONSIBLE OFFICERS & REVALIDATION ANNUAL REPORT AND STATEMENT OF COMPLIANCE

Decision Item KS

REFERENCES

Only PDFs are attached

Revalidation Report 05.08.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 August 2026

Report Title:	**A Framework of Quality Assurance and Improvement for Responsible Officers and Revalidation – Annual Board Report**					
Executive/ Non-Executive Lead:	Dr Kallur Suresh, Executive Medical Director					
Report Author(s):	Dr.Gladvine Mundempilly – Director for Medical Appraisal and revalidation					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report – *mandatory section*			
Summary of risks highlighted in this report	None identified		
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		
	SR5 Statutory Public Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data		
	SR10 Workforce Sustainability		
	SR11 Staff Retention		
	SR12 Organisational Development		
	SR13 Quality Governance		
Does this report mitigate the Strategic risk(s)?	N/A		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors information on the implementation of revalidation within the Trust for 2025/26 appraisal year to provide an annual statement of compliance provided to the higher level Responsible Officer at NHS England.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report and approve the compliance statement.
2 The Designated Body (EPUT) through its Chair or Chief Executive to submit the compliance statement to the Higher Responsible Officer at NHS England.
3 Request any further information or action.

Summary of Key Issues

The Board of Directors of Essex Partnership University NHS Foundation Trust as a designated body has a responsibility to ensure that it is compliant with the Medical Professional (Responsible Officers) Regulation 2010 (as amended in 2013) Act.

The report is expected to follow the format specified by NHS England and includes comprehensive details on quality assurance, clinical governance, the Trust's performance on revalidation, action plans to enhance the revalidation process, audits on concerns regarding doctors' practice, and audits on appraisal inputs and outputs.

As of 31st March 2026, there were 218 doctors with a prescribed connection to EPUT. Of these, 203 (93%) completed their annual appraisal, within the timeframe during the period from 1 April 2025 to 31 March 2026. Of the remaining 15 appraisals, 14 were delayed with approval and 1 was unapproved.

Of the 14 approved delays; 9 doctors were new starters not due for appraisal within the 2025-26 year, 3 delays were due to sickness, and 2 doctors had other valid reasons for the delay.

Of the 15 appraisals, 9 doctors have since completed their appraisals and a further 2 have had the appraisal meeting and are awaiting signoff. Of the remaining 4 appraisals, 2 are still currently on long-term sickness, 1 new starter appraisal is due shortly and 1 unapproved delayed appraisal is outstanding but there is a plan in place for completion.

Excluding the new starters not due for appraisal, the annual appraisal rate for EPUT stands at 97%.

There are a couple of questions on the form where the Trust has answered "no" with action being taken to address these areas. Steps are being taken to increase the recruitment and retention of the medical appraisers to ensure that appraisal processes are carried out at the expected standards.

The Board will need to continue its support for annual appraisal and revalidation process in order to maintain and improve upon current processes, and to ensure compliance with the Responsible Officer Regulations Act.

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

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓
Data quality issues	N/A
Involvement of Service Users/Healthwatch	N/A

Communication and consultation with stakeholders required	N/A
Service impact/health improvement gains	✓
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**	No new financial implications
Governance implications	✓
Impact on patient safety/quality	✓
Impact on equality and diversity	N/A
Equality Impact Assessment (EIA) Completed	**NO**

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Annex A: Illustrative Designated Body Annual Report and Statement of Compliance

Lead

Dr Kallur Suresh
Executive Medical Director and Responsible Officer

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board of:
Essex Partnership University NHS Foundation Trust

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Y
Action from last year:	Change of Responsible Officer within the year
Comments:	EPUT has had a change of Responsible Officer within the 2025 – 2026 year. It was initially Dr Milind Karale who held the

	position since 2012. It then changed to Dr Kallur Suresh who was appointed as Responsible Officer in December 2025 and undertook the Responsible Officer training in February 2026.
Action for next year:	None

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Y
Action from last year:	The Board to continue its support for annual appraisal and revalidation processes.
Comments:	The Designated Body currently provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role. The Board will need to continue its support for annual appraisal and revalidation process in order to maintain and improve upon current processes, and to ensure compliance with the Responsible Officer Regulations Act.
Action for next year:	The Board to continue its support for annual appraisal and revalidation processes.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Y
Action from last year:	Continue to carry out process and amend the prescribed connection list as appropriate.
Comments:	There is an established process to ensure the accuracy of the list of doctors with prescribed connections to the Trust. In addition to the information gathered prior to and at the time of a job offer to a doctor, the Workforce Department provides a monthly report of new starters and leavers to the Appraisal and Revalidation Manager. Triangulation of this information is carried out with Human Resources – Medical Staffing Department and the clinician concerned. This is cross-checked with our Prescribed Connection list with the GMC and is amended as appropriate.

Action for next year:	Continue to carry out process and amend the prescribed connection list as appropriate.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Y
Action from last year:	Continue to monitor and review the policies in place to support medical revalidation.
Comments:	All new national guidance and amendments to existing documentation is read, shared appropriately and implemented where possible. EPUT's Medical Appraisal and Development policy was reviewed, updated and ratified in January 2025.
Action for next year	Continue to monitor and review the policies in place to ensure that these support medical revalidation.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Y
Action from last year:	Organise a peer review of our appraisal and revalidation processes.
Comments:	We undertook a Designated Body Peer Review exercise with Cambridgeshire and Peterborough NHS Foundation Trust in July 2024. We looked at and discussed each other's Appraisal and Revalidation processes and procedures as a way to inform best practice and further improve. The feedback from this was positive. We also had an independent quality assurance process of our appraisal policies and procedures which was completed by an external provider and concluded in February 2023. The external provider completed a comprehensive report on our appraisal and revalidation policies and processes and the findings were presented to Board at the time. An action plan on the feedback was drawn up accordingly. We continue to carry out internal quality assurance processes and annual audits. The processes have been regularly reviewed by the RO and the Director of Medical Appraisals and Revalidation along with Human Resources. The

	information relating to appraisal and revalidation is shared with the CQC as part of their inspections of the organisation as and when required.
Action for next year:	To continue to carry out the action plan resulting from the feedback that we received from the independent quality assurance process and to continue the internal quality assurance processes and annual audits.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Y
Action from last year:	Continue to ensure that all doctors are supported in their induction, continuing professional development, appraisal, revalidation and governance.
Comments:	All doctors are supported in their induction, continuing professional development, appraisal, revalidation and governance. The Medical Education department has regular internal CPD activities and all the doctors are encouraged to attend. The doctors are also assisted with their external CPD requirements both in terms of study leave and financial support. The Revalidation Office provides regular support for the doctors on appraisal and revalidation, including timely reminders of appraisals, appraisal training and support in developing appraisal portfolios. Where the doctor does not have a prescribed connection to the Organisation, such as agency locums, they are provided with the necessary supporting information to pass on to their Designated Body and include at their appraisal.
Action for next year	Continue to ensure that all doctors are supported in their induction, continuing professional development, appraisal, revalidation and governance.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Y
Action from last year:	Continue to ensure all doctors on our prescribed connection list have a whole practice annual appraisal.
Comments:	All doctors with a prescribed connection to EPUT are required to have a whole practice annual appraisal, which includes any necessary information on complaints and/or significant events that they have been named in for each appraisal year so that lessons learnt and reflections can be drawn upon. The Trust has a process in place to assist the doctor to collate this information held internally. The doctor is required to declare all their medical work, both with EPUT and any external, within the appraisal document. Where the appraiser is not the line manager of the doctor, the latter provides a medical managers report covering specific issues if any, to be discussed during the appraisal. Where EPUT is not the doctor's sole employer within their appraisal year, the doctor is required to provide a fitness to practice statement from all places where they were employed in a medical capacity. The Trust has changed to a new appraisal software provider within the year which is line with the Appraisal 2022 model.
Action for next year:	Continue to ensure all doctors on our prescribed connection list have a whole practice annual appraisal.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Y
Action from last year:	Continue to put in place action plans for those who do not have an annual whole practice appraisal and complete the annual audit on missed or incomplete appraisals.
Comments:	Where a doctor does not have a whole practice annual appraisal, the reasons are explored and a plan put in place for its completion. These are further analysed to improve the process and ensure that the doctor is supported to complete these in a timely manner. The Responsible Officer and the Director of Medical Appraisal and Revalidation review the report on delayed appraisals on a monthly basis.
Action for next year:	Continue to put in place action plans for those who do not have an annual whole practice appraisal and complete an audit on missed or incomplete appraisals.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Y
Action from last year:	Continue to review national policy and update the Medical Appraisal policy and procedure accordingly.
Comments:	EPUT has a Medical Appraisal policy in place, which is in line with national policy. This was updated and ratified in January 2025.
Action for next year:	Continue to review national policy and update the Medical Appraisal policy and procedure when it is up for renewal.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	N
Action from last year:	Look at options to encourage recruitment and retention of medical appraisers and organise new and appraiser refresher training.
Comments:	The recruitment and retention of the appraisers has been challenging under the current work pressures of the doctors. As of 31st March 2026 we have 218 doctors on our prescribed connection list and 32 medical appraisers for the Trust who are not currently remunerated for the role. This equates to our medical appraisers completing a minimum of 6-7 appraisals per year which is above the minimum of 4 we would usually expect. To meet the demand of the organisation we need at least 43 trained medical appraisers at a time with the expectation of completing 5 appraisals per appraiser each year. Until now we have relied on volunteering and goodwill to carry out the appraiser role by incorporating them into their job plans. With increasing demands on the clinical work situation, it has become unsustainable and most appraisers are either relinquishing or reluctant to take on the role. This has put pressure on the remaining appraisers causing them to do more than what was previously agreed leading to a vicious cycle. We have invited expressions of interest to this role and uptake has been very minimal and does not meet current or future requirements. We therefore need to look at ways to recruit and retain our appraisers. We did not hold any new or refresher appraiser training within the year as it was not needed. All current appraisers have previously had the required training and we were unable to recruit any further appraisers in the year.
Action for next year:	We will look at options to encourage recruitment and retention of medical appraisers and will look at further training opportunities for 2026-27 year.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Y
Action from last year:	Continue to support the appraisers in their role and ensure that they undergo training when required. Provide them with the necessary information in relation to their appraiser role to include in their appraisal.
Comments:	There is on-going support for the medical appraisers by way of regular updates. The Appraisal and Revalidation Team is available to address their queries as and when they arise. Training is also made available to the appraisers periodically. Each appraisee is expected to complete an anonymised feedback of their experience, which is summated annually and provided to individual appraisers for their reflection. The individual appraisers include their appraiser role within their own annual appraisal for discussion and reflection. We hold appraiser network meetings every 4 months where the appraisers can raise any issues or queries, participate in peer review and calibration of professional judgements. Uptake for these meetings has been good and we will continue this for 2026-27.
Action for next year:	Continue to support the appraisers in their role and ensure that they undergo training when required. Provide them with the necessary information in relation to their appraiser role to include in their appraisal. Continue the appraiser network meetings.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Y
Action from last year:	Continue to complete annual audits and submit to the Board.
Comments:	Annual audits of our appraisal system are completed and shared with the Executive Team and discussed at the

	Quality Committee. This is submitted with the Board Report. Please see attached Appendix A and Appendix B for 2025/26 findings. As per section 1A(v), we have also had an independent quality assurance process of our appraisal policies and procedures completed by an external provider in 2023 and the findings were submitted to Board.
Action for next year:	Continue to complete annual audits and submit to Board.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Y
Action from last year:	To ensure that timely recommendations are made to the GMC and that the doctors are ready for revalidation in good time to mitigate against any delays
Comments:	The GMC Connect is reviewed regularly and recommendations are made in a timely manner.
Action for next year:	To ensure that timely recommendations are made to the GMC and that the doctors are ready for revalidation in good time to mitigate against any delays.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Y
Action from last year:	Continue to ensure that revalidation recommendations are communicated promptly.
Comments:	Revalidation recommendations are communicated to the doctor at the point of the recommendation being made, if not sooner. Where the recommendation of deferral or non-

	engagement is made, the reasons are discussed with the doctor in advance and a plan is put in place to ensure a subsequent positive recommendation.
Action for next year:	Continue to ensure that revalidation recommendations are comunicated promptly.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Y
Action from last year:	Continue to create an environment which delivers effective clinical governance for doctors.
Comments:	The organisation has effective clinical governance processes for doctors in place which includes regular Trust wide learning sessions and audit presentations. In addition, reports are published regularly on the Trust intranet by the Lessons Learned Team. The doctors are also encouraged to contribute to the clinical governance process by undertaking investigations and reviewing the incidents.
Action for next year:	Continue to provide an environment which delivers effective clinical governance for doctors.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Y

Action from last year:	Continue to monitor the conduct and performance of all doctors working in our organisation.
Comments:	Monitoring the performance of all doctors working within the Trust is carried out regularly in a variety of ways. Some examples include monitoring adherence to Trust policies and procedures, recording data on complaints, significant events and service provision, compliance with mandatory training and revalidation requirements and feedback from trainees. In addition the Clinical Directors have a monthly meeting with the doctors under their line management to discuss any concerns relating to working practices or performance.
Action for next year:	Continue to monitor the conduct and performance of all doctors working in our organisation.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Y
Action from last year:	Continue to provide all relevant information to include at their appraisal.
Comments:	Corporate data such as information on complaints, significant events, audits and attendance at internal weekly teaching sessions are provided to the doctor to include in their annual appraisal. In the appraisal, the doctors include their updated job plan, mandatory training record, probity declaration and issues relating to any suspensions/investigations that they are subjected to. This is triangulated with Trust and GMC Connect data.
Action for next year:	Continue to provide all relevant information to include at their appraisal.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Y
Action from last year:	Continue with established process and update the policy and procedure as and when required.
Comments:	EPUT has a process in place for responding to concerns and has a Maintaining High Professional Standards – Conduct and Capability policy for Medical and Dental staff, which is in line with national guidance and was last updated in 2024. The Trust has an adequate number of trained Case Managers and Case Investigators.
Action for next year:	Continue with established process and update the policy and procedure as and when required. Review further MHPS training courses

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Y
Action from last year:	Continue to complete annual audit and submit to Board.
Comments:	Annual audit of responding to concerns about a doctor in our organisation is completed and submitted to Board with the Board Report. Please see Appendix C
Action for next year:	Continue to complete annual audit and submit to Board.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Y
Action from last year:	Continue to transfer information and concerns in a timely manner between Responsible Officers when necessary.
Comments:	Medical Practice Information Transfer forms are used to transfer information and concerns between Responsible Officers where necessary. This is a nationally approved form. The doctors are required to declare to the organisation, all the places where they are employed in a medical capacity and to provide a fitness to practice statement from them to include in their annual appraisal.
Action for next year:	Continue to transfer information and concerns in a timely manner between Responsible Officers when necessary.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Y
Action from last year:	Continue to ensure the appropriate policies and procedures in place are followed and updated to ensure that those involved in investigations are adequately trained.
Comments:	The organisation has a Maintaining High Professional Standards policy and procedure which has been ratified and which is in line with national guidance. Those involved in investigations are appropriately trained for the role. There is

	also an appeal and remediation policy and procedure, which are followed when required.
Action for next year:	Continue to ensure the appropriate policies and procedures in place are followed and updated and to ensure that those involved in investigations are adequately trained.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Y
Action from last year:	Continue to ensure that systems are in place to capture development requirements and opportunities in relation to governance from the wider system.
Comments:	The organisation has systems in place to capture development requirements in relation to governance from the wider system. The Trust's Clinical Director for Clinical Governance takes the lead on learning lessons within the organisation. This is in the form of regular Trust wide learning sessions and audit presentations. In addition, reports are published regularly on the Trust intranet by the Lessons Learned Team and relevant reminders are sent to the doctors by the Medical Director. Our policies and procedures are updated as and when necessary in light of information from the wider system.
Action for next year:	Continue to ensure that systems are in place to capture development requirements and opportunities in relation to governance from the wider system.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	To review the systems in place for assessing professional standards for clinical staff other than medical and nursing.

Comments:	Systems are in place to review professional standard arrangements for medical staff. This is done through appraisals and there are systems in place to provide doctors with copies of their complaints, patient safety incidents and report from the line manager. The Trust has a system for appraising all staff.
Action for next year:	Ongoing monitoring

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Y
Action from last year:	Continue with new starter processes
Comments:	EPUT has systems in place to ensure that we are compliant with the Responsible Officer Regulations Act with regards to recruitment and employment checks. Medical Workforce carries out the necessary pre-employment checks prior to any doctor joining the Trust. Once the doctor is in the post the Appraisal and Revalidation Team carries out further assurance checks, which include the name of the last Responsible Officer, revalidation due date, copies of previous appraisals, appraisal due date and the MPIT Form. The Medical Workforce department follows an agreed process for recruiting agency locums ensuring that they meet the expected standards for their role.
Action for next year:	Continue with new starter processes

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Y
Action from last year:	Continue with the systems in place to ensure that professional standards activities support an appropriate organisational culture.
Comments:	As mentioned previously, we have regular Trust wide learning sessions and audit presentations. In addition, reports are published regularly on the Trust intranet by the Lessons Learned Team and relevant reminders are sent to the doctors by the Medical Director. This has created a learning culture within EPUT whereby excellence in clinical care can flourish and be continually enhanced.
Action for next year:	Continue with the systems in place to ensure that professional standards activities support an appropriate organisational culture.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Y
Action from last year:	Develop and continue to enhance our People and Culture Strategy
Comments:	Our people strategy sets out how we will develop, support, and grow our workforce to deliver EPUT's strategic aims, with a clear emphasis on clinical quality, safety, and patient-centred care. It recognises that our people are our greatest asset and that investing in them is essential to achieving sustainable, high-quality services for the communities we serve. This strategy is designed to respond to both national

	drivers-including the NHS People Plan, the NHS Long Term Workforce Plan, and the People Promise-and to the priorities of the Greater Essex Integrated Care System (ICS). It also reflects the lessons learned from recent challenges such as the pandemic, workforce shortages, and the increasing demand for more flexible, inclusive, and digitally enabled ways of working. To truly empower our workforce, this strategy must be a living, shared commitment. Our People & Culture team has been structured to provide the right expertise to guide this journey, but real change will be driven through genuine collaboration with our care units and corporate teams across EPUT. A strategy is only as meaningful as the actions behind it. To ensure we build an environment that attracts brilliant people and retains the invaluable experience already within our teams, this document is supported by a practical Implementation Plan (included as an appendix). Rather than rushing for short-term fixes, this plan outlines a sensible, prioritised approach, which breaks down our journey into achievable phases over 1 year, 2-3 years, and 4-5 years. We owe it to our colleagues to follow through on these promises. To ensure we stay on track and remain responsive to our teams' needs, we have established clear and supportive checkpoints: The Executive Committee will review our progress yearly, ensuring that our actions consistently support our ambitions for our people. The People Committee will lead an annual reflection on the strategy, supported by quarterly check-ins on our implementation plan. This is not just about reporting data but an opportunity to listen, adapt and ensure our governance drives meaningful improvements. Ultimately, by holding ourselves accountable and leading with compassion, we create the strongest possible foundation for our staff to thrive. When we support and value our people, we directly improve the care, services, and outcomes we deliver to our patients.
Action for next year:	Support the implementation plan as described above

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Y
Action from last year:	Continue to enhance these processes within the Organisation at all levels.
Comments:	Behaviour framework in place -Where people do not behave in line with our values and behaviours we will challenge this and will ensure that where performance and behaviour are not consistent with our vision for a high performing organisation, this is addressed. Leaders are role models for personal and professional development. They equally encourage all of those in their teams to develop the values, skills and knowledge to be their best for patients and their families. Reflective learning is part of the appraisal and 1-1 process so that shared learning and action becomes 'how we do things around here'. Feedback is regularly provided and time for critical reflection promotes individual and organisational learning. Leaders consistently demonstrate compassion with their staff and take a genuine interest in their lives and well-being. They actively role model what high standards of care look and feel like, both in clinical or non-clinical roles. Leaders care for themselves and others so they are psychologically able to manage the challenges of leadership - they create a just culture of fairness, openness and learning.
Action for next year:	Continue to enhance these processes within the Organisation at all levels.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Y
Action from last year:	Continue to ensure that mechanisms exist that support the feedback process and that our doctors know how and when to utilise them.
Comments:	We have mechanisms that support feedback about the organisation' professional standards processes. Feedback can be provided in a number of ways in both a formal and informal manner. Such processes include freedom to speak up, complaints and grievance procedures.
Action for next year:	Continue to ensure that mechanisms exist that support the feedback process and that our doctors know how and when to utilise them.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	N
Action from last year:	Formally record and review any parity issues due to protected characteristics or country of primary qualification
Comments:	The organisation has not collected the data in terms of their country of primary care qualification or protected characteristics while addressing concerns about doctors' practice. The line managers are often aware of protected characteristics and take these into account. This is however not formally recorded. However, protected characteristics are recorded on ESR. Country of primary qualification is to be included and is currently being discussed with ESR regarding recording capability. All documents pertinent to individuals' qualifications are on personnel files.
Action for next year:	Formally record and review any parity issues due to protected characteristics or country of primary qualification

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Y
Action from last year:	Continue to calibrate and network with others and engage with peer review programmes when requested.
Comments:	The Appraisal and Revalidation Team attend the NHS England networking events and read any updates when available. The Responsible Officer also meets with the GMC ELA on a routine basis. As mentioned previously, we have had an independent review of our appraisal and revalidation processes in 2023 and a peer review with CPFT in July 2024.
Action for next year:	Continue to calibrate and network with others and engage with peer review programmes when requested.

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	218
Total number of appraisals completed	203
Total number of appraisals approved missed	14
Total number of unapproved missed	1
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	6
Total number of late recommendations	0
Total number of positive recommendations	3
Total number of deferrals made	3
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	Approx 25
Total number of trained case managers	Approx 25
Total number of concerns received by the Responsible Officer[2]	3
Total number of concerns processes completed	1
Longest duration of concerns process of those open on 31 March (working days)	18 weeks
Median duration of concerns processes closed (working days)[3]	20 weeks
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	1

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	35*
Total number of new employment checks completed before commencement of employment	35*
Total number claims made to employment tribunals by doctors	1
Total number of these claims that were not upheld[4]	TBC

***** There were a total of 48 doctors starting in new roles across the organisation but of these 13 were already employed by the Trust and just moved to a new role. Technically some checks are carried out such as GMC specialist registration, AC/Section 12 and new references for those moving to consultant roles.

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Our action plan for the 2025-26 appraisal year consisted of: • Look at ways to recruit and retain our medical appraisers • New and refresher appraiser training • Continue to develop the appraiser network • Procurement process of an appraisal system We have made good progress with this action plan over the course of the year. The procurement process of an appraisal system has been completed and the contract with the new provider started in January 2026. Recruiting and retaining our medical appraisals remains an issue and we will need to continue to address this over the course of 2026-27. New and refresher appraiser training was not needed this year as there was not enough interest in the role to warrant it but will take this forward for 2026-27.

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

The appraiser network is fully back up and running and uptake has been good. We will continue the network meetings going forward with the current format.
Actions still outstanding
Looking at ways to recruit and retain our medical appraisers and arrange any new or refresher appraiser training as required.
Current issues
The main current issue is to recruit and retain our medical appraisers. As of 31st March 2026 we have 218 doctors on our prescribed connection list and 32 medical appraisers for the Trust who are not currently remunerated for the role. This equates to our medical appraisers completing a minimum of 6-7 appraisals per year which is above the minimum of 4 we would usually expect. To meet the demand of the organisation we need at least 43 trained medical appraisers at a time with the expectation of completing 5 appraisals per appraiser each year. Until now we have relied on volunteering and goodwill to carry out the appraiser role by incorporating them into their job plans. With increasing demands on the clinical work situation, it has become unsustainable and most appraisers are either relinquishing or reluctant to take on the role. This has put pressure on the remaining appraisers causing them to do more than what was previously agreed leading to a vicious cycle. We have invited expressions of interest to this role and uptake has been very minimal and does not meet current or future requirements. We therefore need to look at ways to recruit and retain our appraisers.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
• Look at ways to recruit and retain our medical appraisers • New and refresher appraiser training as required • Successfully implement the new appraisal system ensuring that all required information is transferred and provide training for users of the system
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
As of 31st March 2026, there were 218 doctors with a prescribed connection to EPUT. Of these, 203 (93%) completed their annual appraisal, within the timeframe during the period from 1 April 2025 to 31 March 2026. Of the remaining 15 appraisals, 14 were delayed with approval and 1 was unapproved.

Of the 14 approved delays; 9 doctors were new starters not due for appraisal within the 2025-26 year, 3 delays were due to sickness, and 2 doctors had other valid reasons for the delay.

Of the 15 appraisals, 9 doctors have since completed their appraisals and a further 2 have had the appraisal meeting and are awaiting signoff. Of the remaining 4 appraisals, 2 are still currently on long-term sickness, 1 new starter appraisal is due shortly and 1 unapproved delayed appraisal is outstanding but there is a plan in place for completion.

Excluding the new starters not due for appraisal, the annual appraisal rate for EPUT stands at 97%.

There are a couple of questions on the form where the Trust has answered “no” with action being taken to address these areas. Steps are being taken to increase the recruitment and retention of the medical appraisers to ensure that appraisal processes are carried out at the expected standards.

The Board will need to continue its support for annual appraisal and revalidation process in order to maintain and improve upon current processes, and to ensure compliance with the Responsible Officer Regulations Act.

Section 4 – Statement of Compliance

The Board have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Essex Partnership University NHS Foundation Trust

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	Nicola Foley
Email address:	Nicola.foley2@nhs.net

Annual Report Template Appendix A – Audit of all missed or incomplete appraisals

	Totals
Number of doctors on GMC Connect as of 31 March 2026	218
Number of Completed appraisals for 2025-26	203
Number of doctors who were not due for an appraisal by 31 March 2026 (new starters after April 2025)	9
Number of doctors who were LTS/Maternity Leave for the majority of the appraisal year	3
Number of Approved Incomplete/Missed Appraisals for 2025-26	14
Number of Unapproved Incomplete/Missed Appraisals for 2025-26	1

Annual Report Template Appendix B – Quality assurance of appraisal inputs and outputs

Total number of appraisals completed		203
	Number of appraisal portfolios sampled	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs - Is there sufficient supporting information from all the doctor's roles and places of work? (To include CPD, QIA & evidence from external roles)	41	41
Review of complaints: Have all complaints been included?	41	41[1]
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	41	41[1]
Has a patient and colleague feedback exercise been sufficiently completed by year 3 of the revalidation cycle?	41	30
Appraisal Outputs		
Appraisal Summary	41	41
Appraiser Statements	41	41
Personal Development Plan (PDP)	41	37

[1] Based on evidence submitted within appraisal portfolio.

Annual Report Template Appendix C – Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level[5]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months (Apr 2025 – Mar 2026) Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	0	2	5	7
Capability concerns (as the primary category) in the last 12 months	0	0	5	5
Conduct concerns (as the primary category) in the last 12 months	0	2	0	2
Health concerns (as the primary category) in the last 12 months	0	0	0	0
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2026 who have undergone formal remediation between 1 April 2025 and 31 March 2026. Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice A doctor should be included here if they were undergoing remediation at any point during the year				0
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				0
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				0
General practitioner (for NHS England only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0

[5] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)	0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies	0
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	0
TOTALS	0
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April 2025 and 31 March 2026: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	1
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	 0 0 1 0 0
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	1
GMC Actions: Number of doctors who:	
Were referred by the designated body to the GMC between 1 April and 31 March	1
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	0

Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	
Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment	3
Number of NCAS assessments performed	0

10. OTHER

10.1 USE OF CORPORATE SEAL

Information Item AG/TS

REFERENCES

Only PDFs are attached

Use of Corporate Seal 05.08.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 August 2026

Report Title:	**Use of Corporate Seal**					
Executive/ Non-Executive Lead:	Trevor Smith, Interim Joint Chief Executive Officer					
Report Author(s):	Angela Laverick, Executive Assistant					
Report discussed previously at:						
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

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

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

Summary of Key Issues
The EPUT Corporate Seal has been used on the following occasions: - 15.07.26 Agreement relating to sale and purchase of Bradd Close, South Ockendon, RM15 6SA - 15.07.26 Agreement relating to sale and purchase of 15 Regent Road, Epping, CM16 5DL - 15.07.26 Lease Renewal Oakley Court, Angel Close, Luton, LU4 9WT

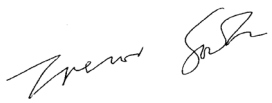
Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading

Lead
 **Trevor Smith** **Interim Joint Chief Executive Officer**

10.2 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING.

Information Item LL

Verbal

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

Decision Item ALL

Verbal

10.4 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

Information Item ALL

Verbal

11. ANY OTHER BUSINESS

Information Item ALL

11.1 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

12. QUESTION THE DIRECTORS SESSION

13. DATE AND TIME OF NEXT MEETING

LL

7 October 2026 at 10:00, The Lodge Training room 1