

Essex Partnership University NHS Foundation Trust

Annual Report & Accounts

2025-26

EPUT

**Essex
Partnership
University
NHS Foundation
Trust**

***Annual Report &
Accounts***

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Foreword from the Acting Chair and Chief Executive

The past year has been another period of significant change, as the anticipated reforms to the NHS started to take effect and we prepared to begin working with a single integrated care board for the whole of Essex from 1 April 2026. We refreshed our five-year strategic plan, held our first dedicated digital conference and welcomed over 1,200 new colleagues into the Trust. The Lampard Inquiry held further public hearings, bringing a focus to the need to continually develop and improve mental health services for everyone who needs them. We also continued to develop services, invested in our estate and facilities and worked closely with people who use our services, their families and loved ones, as well as our local partner organisations.

Paying tribute to Hattie Llewelyn-Davis

It was with much sadness that we learned of the death of our Chair, Hattie Llewelyn-Davies OBE, in late May 2026 after a short illness. Hattie was an inspirational leader with extensive experience of chairing a number of NHS organisations, including Hertfordshire Partnership University NHS Foundation Trust, Buckinghamshire Healthcare NHS Trust and most recently The Princess Alexandra Hospital NHS Trust. Hattie also contributed significantly to social housing organisations as well as many other areas of public life.

Since joining EPUT as Chair in April 2025, Hattie provided unwavering support to our executive team and Board, leading a focus on the Trust's strategic priorities with communities and patients at the centre of every decision. She was a wise, compassionate person and will be much missed across the NHS and beyond.

Developing and improving our services

Throughout the year, we continued to invest in and develop our services and facilities. We secured funding to create two new mental health emergency diversion units adjacent to our mental health inpatient units at Colchester and Harlow. We installed sensory equipment to support patients at our Rawreth Court dementia care home and in our Rainbow Mother and Baby unit in Chelmsford. We strengthened our peer support services in community teams and introduced what we believe is the first example of a family group conferencing service on inpatient mental health wards in England. We also became the first UK location for a major Alzheimer's Disease blood test trial, run by University College London.

The Care Quality Commission continued to inspect and report on our services. Whilst inspectors noted improvements during inspections of our secure wards at Brockfield House, our learning disability service at Byron Court and our adult acute mental health wards, an inspection of our long stay mental health rehabilitation unit in Colchester found a number of more significant issues which we are currently working through. In late March 2026, the CQC carried out a planned Well Led inspection of the Trust, also visiting some front-line services. Initial feedback from this inspection was positive, and we anticipate receiving the final report later in 2026. After an inspection in June 2025, Ofsted rated our Rochford CAMHS Therapeutic Education Department as *Good*, commenting that it is a school "where kindness shapes daily life."

Embedding our Time to Care programme and renewing our focus on community mental health services

A significant achievement of the last year has been the rollout and implementation of our Time to Care programme, which is revolutionising the way we staff and run our adult acute inpatient mental health wards. At the heart of the programme is the assurance that all inpatient stays have an intended therapeutic benefit, agreed with the patient and their loved ones, and are as short as possible. The model is underpinned by a wider range of clinical and support roles on wards, including activity coordinators, nurse educators and family liaison officers. We are already seeing significant benefits, including a reduction in average length of stay, with EPUT currently ranked 9th out of 47 comparable NHS mental health trusts in England for this measure.

We are now undertaking a similar approach to reviewing and transforming our community mental health services to reduce inequalities between different geographical areas, create a consistent service model and improve patient and carer outcomes. We held a series of initial workshops during the year with our teams, partners and stakeholders, including voluntary sector organisations, primary care teams, local authorities and commissioners. The next set of workshops over the coming year will help colleagues, partners, patients, families and carers get involved in co-designing the future model of care, based on the feedback we have received to date.

Strengthening our community physical health services

Our community physical health services have also been a key focus over the last year. In west Essex, a new adult community assessment and treatment unit opened at St Margaret's Hospital in Epping to provide an alternative referral option for patients needing urgent medical care. The unit saw 200 patients in its first seven weeks, with patients staying an average of five days and reducing pressure elsewhere in the system. We also hosted visits to our west Essex services from the NHS Confederation, the NHS Alliance and a local MP in partnership with Princess Alexandra Hospital NHS Foundation Trust. In south east Essex, our community physical health teams introduced new technology to help ensure all patients are seen by the most appropriate nurse with the right specialist skill sets to meet their needs, as well as a new triage system in each locality to streamline calls and referrals and help us to assess patients' needs more quickly. The service also became the first community nursing service in England to fully implement the use of urethral catheter guidewires, which help nurses to guide a catheter into the body, helping to reduce unnecessary hospital admissions from catheter complications in men.

Our people

We welcomed over 1,200 new colleagues into the Trust in 2025, including registered nurses, allied health professionals and estates and facilities staff. We also welcomed in 176 newly qualified nurses and brought in over 200 colleagues who transferred from our staff bank or were previously employed through a staffing agency. Our response rate for the 2025 NHS national staff survey was 52 per cent – our highest ever participation rate.

We worked with local partners to increase support for local people to find jobs in the healthcare sector. We are a partner in the Essex Connect to Work employment programme, part of the government's national programme aimed at people with long-term health conditions, disabilities and other barriers into work, and are also running the four-week Step Forward Programme for people aged 18 to 30 living in Southend and Basildon who are unemployed or on a zero hours contract.

Recognition for our people and services

We are really pleased to report that our services, teams and individual colleagues have again been recognised during the year in national award schemes and by professional bodies.

Our Nova Academy digital education programme – run jointly with Mid and South Essex NHS Foundation Trust – was shortlisted in the 2026 HSJ Digital Awards, whilst our sustainability and net zero programme was announced as the East of England regional champion in the NHS Excellence awards, and our Southend Rough Sleepers Mental Health Team was highly commended in the UK Advancing Healthcare Awards for helping homeless people improve health, tackle social inclusion and find accommodation. The Queen's Institute for Community Nursing provided a grant for an EPUT specialist diabetes nurse for their work in supporting young people living with Type 1 diabetes in south east Essex and three south east Essex community nurses were awarded the prestigious title of Queen's Nurse this year. The award is given to community nurses who demonstrate a consistent commitment to high standards of practice and person-centred care. Also in 2025, our Director of Pharmacy Hilary Scott was appointed a Fellow of the Royal Pharmaceutical Society in recognition of her many years of service in Essex.

Working with our partners and stakeholders

We are fortunate to benefit from the support and engagement of a wide range of partners and stakeholders across the areas we serve. These relationships contribute significantly to our work and help to strengthen services that operate across different systems. We are particularly pleased with the progress we have made in building effective partnerships with lead GPs and general practices, and also within the Mid and South Essex Community Collaborative. During the year, we continued to engage with local stakeholders, councils and Members of Parliament, attending a number of health scrutiny committees and health and wellbeing boards, as well as providing dedicated written updates and responding to over 130 enquiries from MPs and other elected representatives on behalf of local people.

The Lampard Inquiry

The Lampard Inquiry continued to hold public hearings throughout the year, hearing from bereaved families, subject experts and also specific witnesses from core participants including EPUT. We continued to provide a significant amount of information and data to the Inquiry. This work will continue over the coming year as the Inquiry begins to hear evidence from current and former staff who were involved in some of the cases the Inquiry is considering.

The year ahead

As we look to the year ahead, it is clear that change will continue to be a focus. The new single integrated care board for Essex came into being officially on 1 April 2026 and means we now have a single commissioning structure for the majority of our services for the first time in our history. Within EPUT, we will progress the new Nova joint electronic patient record system - which will operate right across EPUT's mental health and community services and acute hospital services at Mid and South Essex NHS Foundation Trust - and with our Community First programme to transform our community mental health services. We will also continue to do all we can to support the Lampard Inquiry as it progresses through its next set of public hearings.

As ever, our final word goes to everyone who works with us and contributes so much to the Trust and our work - our colleagues, volunteers, supporters, patients, families and carers who help us support the 100,000 people who are in our care at any one time.



Loy Lobo
Acting Chair
24 June 2026



Paul Scott
Chief Executive Officer
24 June 2026

Paul Scott will leave his role as EPUT's Chief Executive on 30th June 2026 after nearly six years at the Trust. Paul has driven improvement in every area of EPUT's services, with our shared values and a compelling vision of putting our service users and their families at the heart of everything we do. From 1 July 2026, the Trust will be led by Interim Joint Chief Executives Alex Green (previously Deputy Chief Executive and Executive Chief Operating Officer) and Trevor Smith (previously Deputy Chief Executive and Executive Chief Finance and Resources Officer), who will continue to work together to deliver our plans and ambitions.

Performance Report

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

Performance Overview from Paul Scott, Chief Executive

My reflection on EPUT's performance over 2025/26 focuses on the dedication of our staff and everyone involved in our services who gives so much to support the people and communities who rely on us. We have continued to adapt and develop our services to meet new challenges and changing demands, but most importantly to ensure that we can always provide the best, most appropriate care for people.

About EPUT

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

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

The Trusts turnover, including finance income, has risen by £79.2m from £611.8m to £691.0m'. The main increases related to increases and expansion in service provision, pay and non-pay inflationary uplifts and securing additional funding streams.

Our Services

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

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

Mental health services: We provide a wide range of treatment and support to adults and older people and children and adolescents experiencing mental health illness within primary care, community and in secure and specialised inpatient care settings.

We deliver a range of tertiary services, including forensic services and specialist health outreach services to marginalised communities.

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

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

In 2025/26, we:

- Received **492,946** referrals into our services
- Delivered **1,691,419** face to face contacts
- Carried out **44,534** digital face to face contacts
- Held **443,992** telephone contacts
- Cared for **150,435** patients / service users, of whom **4,277** were inpatients.

Our Partnerships

EPUT was part of four Integrated Care Systems (ICSs) during 2025/26:

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

The Trust has been working to prepare for the Integrated Care Boards (Establishment and Abolition) Order 2026 which comes into force on the 1 April 2026 to ensure partnership working continues under the new arrangements of Essex ICB.

At a more local level, we are actively involved in place-based partnerships and neighbourhood health developments in:

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

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

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

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

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

- Mid and South Essex – the Community Collaborative brings together providers delivering community health services hosted by EPUT as principal provider. Further details of this collaborative are included in the Performance Analysis section of this report.
- North East Essex – the Community Collaborative brings together providers delivering community health services (and is hosted by East Suffolk and North Essex NHS Foundation Trust).
- East of England – the Regional Specialist Mental Health Collaborative brings together mental health providers across the region. It focuses on specialist services, such as children and young people's inpatient services, and secure services, which are led by EPUT for the East of England provider collaborative.
- Hertfordshire and West Essex – EPUT is a significant partner to the West Essex Health and Care Partnership (WEHCP). The partners alongside EPUT include Princess Alexandra Hospital (PAH), Harlow, 6 Primary Care Network (PCN) Clinical Directors, Essex County Council social care and public health, District Councils, Health watch, Voluntary sector and the ICB. The partnership is hosted by PAH and is a sub-committee of the PAH Board. WEHCP has a shared commitment to the delivery of the "Care closer to home" model of care. The partnership developed a 5-year integrated delivery plan in 2025-26 and EPUT support with the following:
 - Prevention: Focusing on increasing detection of hypertension and increasing winter vaccinations for the at-risk group and staff.
 - Proactive Care and Frailty: Reducing the rate of emergency falls for people over 65, reducing the rate of non-emergency admissions for people with frailty and reducing the percentage of deaths in hospital with three or more unplanned admissions in the last 90 days.
 - Community Urgent Care: Increasing the use of community urgent care services to support an improvement in the acute urgent care performance.

In addition, EPUT is a key partner with Stellar Healthcare in provision of the integrated urgent treatment centre at Princess Alexandra Hospital.

- Southend, Essex and Thurrock All Age Mental Health Strategy 2023-8 – EPUT partners with three local authorities, three Integrated Care Partnerships, North East London NHS Foundation Trust (NELFT), Essex Police and people with lived experience on a programme of work to improve:
 - Prevention and early intervention
 - Acute and crisis services
 - Supporting recovery.
- Drug and Alcohol Services – EPUT partners with Essex County Council and third sector providers for the provision of drug and alcohol services. This incorporates street homelessness and individuals who have been barred from their GP's and can only access services via the SAS team.

We provide education and training for students from Anglia Ruskin University and the University of Essex, as well as training placements for junior doctors. We are continuing to build our academic partnerships to support innovation and research that will benefit our services. Our strategic partnership with Anglia Ruskin University has commissioned a joint research scoping project to investigate the provision, accessibility and navigability of self-harm and suicide prevention services in coastal communities of North East Essex, which commenced in March 2025. We have joint clinical academic partnerships with University College London and University of Cambridge. We are also in the process of working in partnership with Anglia Ruskin University on a joint clinical academic post which will commence in 2026/27.

EPUT's success is judged against our contribution to the objectives of the integrated care systems in which we operate, in addition to our existing duties to deliver safe, effective care and effective use of resources. *EPUT has collaborated with partners across the three main Integrated Care Systems on the delivery of Joint Forward Plans for 2024-29 and Integrated Care Strategies, overseen by local Health and Wellbeing Boards.*

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

EPUT executives and other senior leaders are active partners within our local integrated care systems, with several executive colleagues being members on local integrated care boards and partnership boards. Our business model enables our leadership teams to actively participate with system partners in the systems and place-based partnerships (Alliances). Our medium-term integrated delivery plan for the next three years has been developed in alignment with our partners. The development and approval of the operational plan was overseen by the Board of Directors, and considers the strategic, financial and operational implications of system working and ensures that partnership objectives are consistent with the Trust's priorities and responsibilities

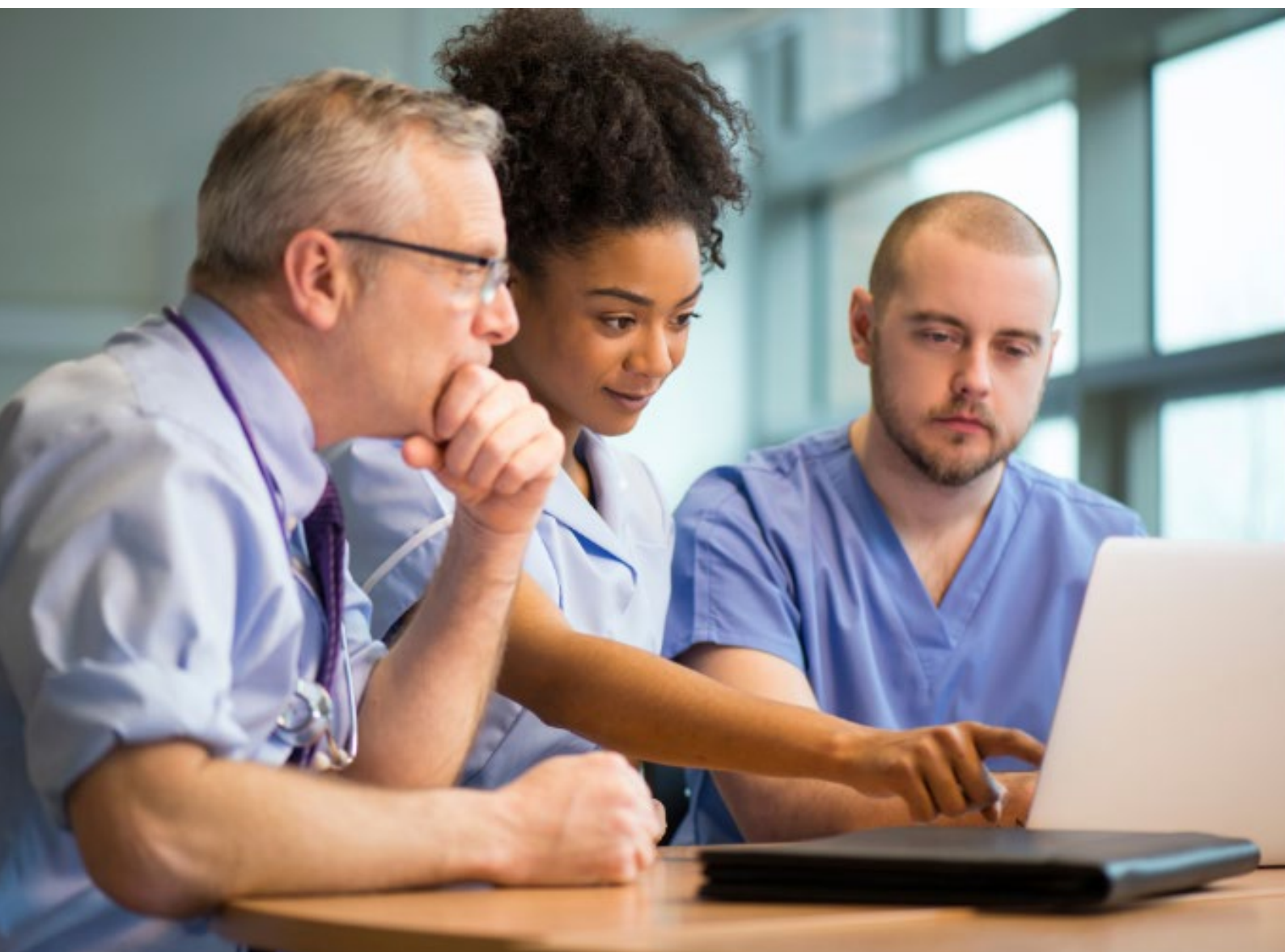
The Board of Directors retains oversight of the Trust's partnership arrangements and system working through collaborative governance arrangements. Seminar sessions on integrated care system developments, provider collaboratives and place-based partnerships, are a focus in Board seminars, providing identification of risks and opportunities arising from partnership working and inform Board discussion and decision-making.

The Board reviews significant partnership arrangements, including collaborative governance structures and major programmes, to ensure that appropriate accountability, risk management and assurance mechanisms are in place. Through this approach, the Board is able to provide effective oversight of the Trust's role within the wider system while maintaining accountability for the delivery. As detailed above we have established specific collaborative arrangements with other providers to develop shared plans and priorities.

The Mid and South Essex System has operated a System Investment Group, chaired by EPUT since October 2021. This forum has been used to discuss and recommend major capital investment cases to the System Finance Investment Committee (also the forum at which capital allocations and plans are reviewed and agreed). The forum has also provided oversight to NHS England Capital bids and delivery of funding across system partners.

The Trust has continued to take forward the development of a first of type in the UK Electronic Patient Record (EPR) Information Technology system with Oracle Health, a global leader in health systems. The "NOVA" system will build on current digital investments to create a single patient record system across hospitals, mental health and community services, delivered by Mid and South Essex Foundation Trust (MSEFT) and EPUT. The new system will improve how clinicians access patients' comprehensive health and care information and enhance patient experience by not having to re-tell their health or care history whenever they see a health professional. The EPR system forms part of the NHS commitment to modernise healthcare services through digital technology, improving patient care and increasing system-wide efficiency.

The Board of Directors has maintained oversight of the Trust's participation in system partnerships and collaborative arrangements, ensuring that these contribute effectively to the delivery of the Trust's strategy while maintaining clear accountability and governance.



Our Vision, Values and Purpose

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

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

Recognising that we are part of a complex system of health, care and wellbeing services and that we have a key role to play in making sure that service users can receive joined up care. We carried out extensive engagement with our service users, and their carers and families, as well as our staff and partners, to look at what we need to do to achieve those goals over the coming years.

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

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

We completed a review of our strategic plan this year at the mid-way point of its implementation. The review engaged with a range of stakeholders and other sources of data, concluding that our vision, values and strategic objectives remain relevant in the new healthcare context. The review identified that to achieve our vision of being a leading health and wellbeing service in the provision of health and community care, we agreed to make three shifts in focus:

1. Transforming work through Artificial Intelligence (AI)
2. Becoming a trauma-informed organisation.
3. Taking on Accountable Care delivery.

The three areas identified above have been taken forward through our planning framework and cultural review and will provide a key area of focus for us.

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

[Strategic Plan for 2023 to 2028](#)



Our Performance

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

The key ways in which the Trust measures performance include:

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

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

In our Quality Account for 2025/26, we provide further details of our performance against a range of quality related performance metrics and our Quality of Care Strategy.

Key Issues, Opportunities and Risks

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

Key issues

- The population we serve is growing.
- Full identification and recurrent delivery of efficiency schemes.
- Financial constraints with the Mid and South Essex Integrated Care System (MSE ICS).
- National standards for clinical services quality continue to rise and maintaining compliance is challenging in some areas e.g. compliance with CQC quality statements.
- Changing landscape of the NHS with the merger of NHS England back into the Department of Health and Social Care.

- Resourcing of our core participation with the Lampard Inquiry.
- Demand outstripping the right capacity in the right place to manage sustained system wide demand for mental health services, resulting longer average lengths of stay and inappropriate out of area placements.
- Unplanned costs and additional business case requirements including increasing backlog maintenance, as well as constrained operational capital through commitments such as the electronic patient record programme.

Opportunities

- The continued implementation of new ways of working with our lived experience ambassadors and co-production with our service users, their families and carers.
- The insights gained from the Lampard Inquiry for improving services.
- The changes to the Integrated Care Board (ICB) arrangements, creating a single system across Essex, providing the opportunity for more joined-up service delivery across the Trust's footprint.
- The shifts in focus identified in the review of our strategic plan, to embrace the use of AI, becoming a trauma informed organisation and taking on the principles of an accountable organisation.
- There are efficiency opportunities, both internally to the Trust, and those from greater collaboration with system partners, such as: out of area placement reduction, workforce development, commercial innovations and potential site rationalisation.
- We have completed the implementation of our Time to Care programme to transform mental health inpatient services. We now have the opportunity to transform community health services in the same way with our Community First Strategy, whilst also continuing to maintain and improve on the benefits realisation from Time to Care.
- The completion of a reflective cultural review and understanding where we can improve and delivering on those improvements.
- Developing neighbourhood health across the Essex localities with primary care and other key partners

Risks

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

- SR3: If EPUT does not adapt its infrastructure to support service delivery then it may not have the right estate and facilities to deliver safe, high-quality care resulting in not attaining its safety, quality and compliance ambitions. Key actions associated with the delivery of our

Estate Strategy through the investment in care environments and environmental sustainability (see page 35 for further information).

- SR4: If EPUT does not effectively address demands, then our resources may be overstretched resulting in an inability to deliver high quality safe care, transform, innovate and meet its partnership ambitions. Key actions associated with realising the benefits of our Time to Care programme, delivering the Community First programme and continuing to build and sustain relationships with system partners to deliver for our community (see pages 31 for further information).
- SR5: If EPUT is not open and transparent, with the correct governance arrangements in place then it will not serve the Lampard Inquiry effectively or embed learning from past failings resulting in undermining its safety ambitions (see page 22 for further information).
- SR6: If EPUT experiences a cyber-attack then it may encounter system failures and downtime resulting in a failure to achieve its safety ambitions, compliance, and consequential financial and reputational damage. Assurance on our delivery against the Data Security and Protection (and Cyber Security Framework) received substantial assurance from our internal auditors (see page 152).
- SR7: If EPUT does not have sufficient capital resource, e.g. digital and EPR, then it will be unable to undertake essential works or capital dependent transformation programmes, resulting in non-achievement of some of its strategic and safety ambitions. For further information on our capital spend see page 64.
- SR8: If EPUT (as part of MSE ICS) does not effectively and efficiently manage its use of resources, then it may not meet its financial control total, resulting in potential failure to sustain and improve services. Further information available within the Finance Review page 61.
- SR9: If EPUT does not have the required capability and expert knowledge to deliver the digital and data strategy, then the Trust may fail to achieve strategic ambition.
- SR10: If EPUT does not have workforce plans that support recruitment and development, then staff may not choose to remain at EPUT, resulting in associated skills deficit, reliance on temporary staffing, staff morale and its ability to provide high quality of care to our services users. Further information available within the Staff Report page 100.
- SR11: If EPUT does not effectively and efficiently manage a coherent staff retention strategy, then it will continue to effect staff and skills shortages in certain professions resulting in associated skills deficit, impact on staff morale and its ability to provide high quality of care to services users. Further information available within the Staff Report page 100.
- SR12: If EPUT does not have in place effective organisational development support to address cultural development and management of change, then it may not achieve a positive impact, resulting in suboptimal outcomes for staff and patient care.
- SR13: If EPUT does not have in place effective floor to Board quality governance and is not able to provide thorough insights into quality risks caused by the need to further develop and embed its governance and reporting (including triangulating a range of quality and

performance information), then this may result in inconsistent understanding of key risks and mitigating actions, leading to variance in standards.

The Trust's high-level operational risks are:

- CRR11: Suicide prevention – Delivery of the Suicide Prevention Framework as aligned to the Quality of Care Strategy, priorities for year two having an emphasis on a) self-harm reduction; b) STORM training; c) introduction of safety plans; and d) safe discharges.
- CRR2598: NOVA Programme – successful delivery of the electronic patient record system

De-escalated risks in year:

- CRR45: Mandatory training – The risk was reviewed and refocused on achieving continuous compliance with mandatory training requirements. New actions identified and overall risk score was reduced.
- CRR92: Addressing inequalities – Continuing to implement the Equality Diversity and Inclusion (EDI) framework aligned with the NHS England EDI plan. Implementation of the sexual safety charter now having clear reporting mechanisms in place for staff to recognise, report and address sexual safety issues; and the leadership behavioural toolkit having been in place for over a year and incorporated into training development. This risk was de-escalated from the Board Assurance Framework and subsequently closed by the directorate.
- CRR98: Pharmacy resource – Significant progress has been made in 2025-2026 and we continue with the recruitment campaign. Following commencement of all candidates who have been offered roles the vacancies will be down to 2.2 whole time equivalents and all business continuity plans will be lifted. This risk was de-escalated from the Board Assurance Framework and subsequently closed by the directorate.

Emergent risks:

- The merger of NHS England into the Department for Health and Social Care and planned regulatory reform.
- Rapid developments in technology and AI meaning there is a need to ensure readiness.
- Changing trends in stakeholder expectations, public opinion and population health trends leading to changes in demand and potential backlog.
- The Trust has increasing backlog maintenance requirements across an aging estate (c.114m)

Further detail on the principal risks, including performance against key indicators and in year changes, is provided in the Performance Analysis section (pages 22-62).

The Board's assessment of the effectiveness of risk management, internal control and assurance processes, including oversight of the Board Assurance Framework (BAF), is set out in the Annual Governance Statement (pages 141 - 157).

Going Concern Disclosure

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

The Directors of the Trust have considered whether there are any local or national policy decisions that are likely to affect the Trust's continued funding and provision of services. The Trust submitted a three-year revenue plan and five-year capital plan to NHS England on 18 March 2026, which included an adjusted breakeven position for 2026/27. The plan includes the continued provision of services by the Trust and/or within the WGA boundary. No circumstances were identified which caused the Directors to doubt the continued provision of NHS services.

Against the adjusted financial performance measure for 2025/26, the Trust has reported a surplus of £93k for the current financial year (2024/25: £3,821k deficit).

Our going concern assessment is made up to the end of June 2027. The Trust has prepared a cash forecast modelled on the above expectations for funding during the going concern period which shows sufficient liquidity for the Trust to continue to operate during that period.

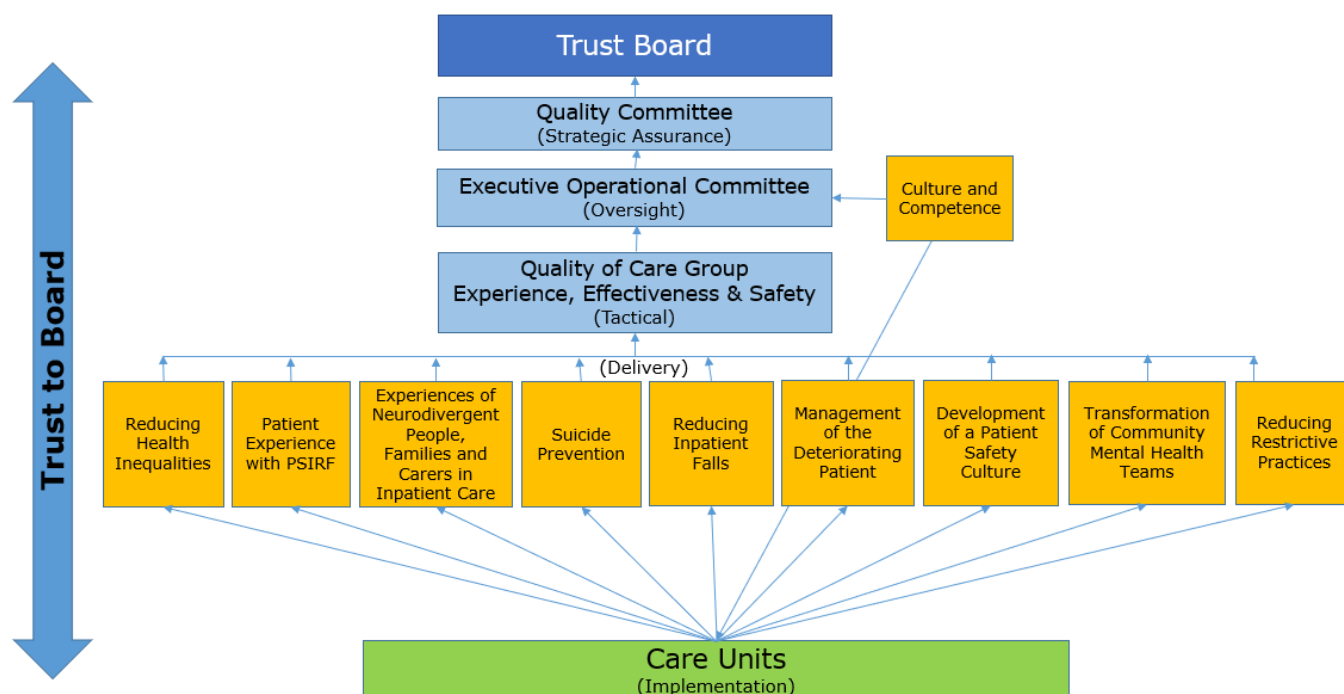
In conclusion, and after making enquiries, the Directors have a reasonable expectation that the services provided by the Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the Directors have adopted the going concern basis in preparing the accounts, following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

Performance Analysis

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

The Trust has a clearly defined clinical governance structure which supports oversight of quality and patient safety. The Board of Directors retains overall accountability for quality of care, with detailed oversight delegated to the Quality Committee.

The Quality Committee receives assurance from several supporting groups and governance forums, Quality of Care Group and its sub-groups, which oversee specific aspects of clinical governance and escalate risks and issues where appropriate.



The structure ensures that there are clear lines of accountability, with risks relating to quality and safety escalated through the committee / group structure to the Board, supported by regular reporting and triangulation of performance, assurance and risk information.

The Lampard Inquiry

The Lampard Inquiry into Mental Health Deaths in Essex from 2000 – 2023 continues to be a significant focus for the Trust. EPUT is one of the core participants in the Inquiry and represents the majority of cases within the Inquiry scope, as the current provider of mental health services across Essex, as well as the representative of former providers during the relevant period.

Progress to date - 2025/26

The Inquiry has been in place for over two years. During this time the Trust has responded to date to over 200 requests for evidence and has also sent Board level representation to all public hearings (which commenced in September 2024). Since February 2026 we have also responded to 49 draft Case Summaries. The remaining case summaries will be sent out over the Summer. Case Summaries are designed to include, in summary format, the concerns set out by families which the Inquiry has received to date through statements and oral evidence. They will also include previous findings and recommendations.

During 2025/26, we have undertaken a significant programme of work to strengthen our support to the Inquiry, including:

- The expansion of our dedicated Inquiry Programme Team, including adding specialist clinical, legal and programme management capacity.
- We have established a strengthened Programme Management Office (PMO) function, enabling improved tracking and escalation of quality assurance.
- We introduced revised governance arrangements, including enhanced oversight and detailed reporting.
- We implemented improved processes for managing Rule 9 responses, including earlier quality assurance and clearer accountability of the responses being provided to the Inquiry.

We implemented these changes in response to the recognised challenges in late 2025, which included the scale and complexity of information requests and the need to strengthen our organisational capacity. The impact of these changes have been demonstrated through measurable improvement in responding to the inquiry during the latter part of 2025/2026:

- We eliminated the backlog of overdue Inquiry responses/ In addition, between January and May 2026, we submitted 129 Rule 9 responses, which represented approximately 64% of all responses provided since the start of the Inquiry.
- As at 31 March 2026, we have responded to over 200 Rule 9 requests.
- We have also delivered all case summary responses in full compliance with the agreed deadlines during this period.

These improvements reflect our transition from a position of recovery and stabilisation, into a sustainable operating model, to ensure we meet our commitment to support the Inquiry.

Governance and Communication

The Trust has put in place clear Governance processes including Board oversight and accountability of the way in which the organisation is responding to the Inquiry. An Executive level Senior Responsible Officer has been in place throughout and regular update reports to the Executive Team and the Board of Directors.

A communication plan and strategy is in place to ensure that internal and external audiences are aware of the progress of the Lampard Inquiry and the role that the Trust plays in it, creating an open dialogue and regular sharing of information.

Engagement

We remain committed to doing all we can to provide information to Baroness Lampard and her team, it is vital that we and other providers of mental health care learn from the evidence submitted and listen to the moving accounts of family members, recognising both the scale of the Inquiry and the importance of learning from the evidence presented. We continue to carefully consider emerging evidence from the Inquiry, including themes relating to patient safety, clinical practice and organisational culture, and we are using this insight to inform ongoing service improvements and governance arrangements.

During the 2025/26 financial year three members of the EPUT Executive team gave oral evidence at the April 25 hearings and looking forward to the hearings scheduled for 2026/27 we will of course continue to engage fully with the Inquiry process – in terms of submitting written evidence, attending hearings and giving oral evidence.

We have established patient and staff support in the context of the Inquiry – both practical and psychological support in recognition of the importance of encouraging full participation and engagement with the Inquiry process.

Impact and Organisational Learning

The Inquiry continues to inform the Trust's broader improvement and transformation agenda. Learning identified through the Inquiry, alongside other sources such as patient safety investigations and service reviews, is being considered within existing quality governance structures to support continuous improvement in care, safety and organisational culture.

As an example of the improvements made, during 2025/26 the Trust's Time to Care programme was implemented in inpatient wards, designed in partnership with patients and their families the programme created an enhanced multi-disciplinary team at ward level, individual care plans and activities to support faster recovery and discharge to community mental health services. Looking forward we will be transforming community mental health services through our Community First programme which will be implemented during 2026/27.

Forward Look

Looking ahead, we expect continued high levels of Inquiry activity, including further hearings, case summaries and requests for evidence throughout 2026/27. We will continue to prioritise timely and transparent engagement with the Inquiry, while continuing embed sustainable improvements and transformation of services, supported by any learning from the Inquiry as it progresses.

Care Quality Commission (CQC) Registration

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

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

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

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

EPUT has not participated in any special reviews or investigations by the CQC during the reporting period.

The Trust is rated as 'Requires Improvement' with the CQC, with the rating for the caring domain being 'Good'.

During 2025/26, the CQC published three final reports pertaining to inspection activity carried out:

Forensic inpatient or secure wards

The CQC completed an unannounced inspection of Brockfield House in March - April 2024, with the final report published in April 2025. The service maintained an overall rating of "Good" which demonstrated the service is performing well and meeting the CQC's expectations. The report established that:

- The wards had enough qualified, skilled and experienced staff to ensure people's safety and meet their needs in a secure setting.
- The service had a proactive and positive culture of safety and minimised the use of restrictive practices.
- Staff assessed risks to patient's health and safety and mitigated those risks.
- Staff ensured medicines were managed safely. The service provided a range of treatments suitable to the needs of the patients cared for on a forensic ward.
- Staff actively sought information and listened to patients.
- The service valued a diverse workforce and worked towards an inclusive and fair culture by improving equality for staff.
- The Trust fostered a positive culture where staff felt that they could speak up. Leaders worked well with their partners across the local system. Concerns about safety were listened to by senior leaders and safety events were investigated and reported thoroughly.

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

Acute wards for adults of working age and psychiatric intensive care units

The CQC completed an unannounced inspection of nine wards in November – December 2024, with the final report published in July 2025. The service achieved an improved rating of “Requires Improvement” with the CQC noting that 23 of the previous 25 concerns raised had been addressed. The report established that:

- There were improvements in reporting and recording of incidents and the Trust ensured staff followed their updated observation policy.
- There were now enough regular staff working on wards, including psychology staff.
- Maintenance work had been completed so staff could observe patients from all areas.
- The trust ensured patients understood the use of the contact-free patient monitoring system and sought consent.
- Patients had access to nurse call alarms and all sites had an updated prohibited items list.
- Improvements were also made to ensure processes were in place to support staff working at night.
- The trust assessed and mitigated risks concerning the sexual safety of patients and incidents of racial abuse to staff were reported and appropriate actions taken.
- Informal patients were informed of their rights and were able to leave the ward safely. Wards now had separate search rooms or areas to conduct patient searches in private.
- The trust had conducted work to embed a restrictive practice reduction plan and reviewed and reduced blanket restrictions.
- The trust worked with staff to ensure they maintained professional boundaries and that staff were now up to date with mandatory training.

Areas of concern were identified pertaining to:

- Continued evidence of systems and processes not always being used safely, to prescribe, administer and record medicines.
- Continued concerns relating to staff supervision and appraisal rates,
- Concerns relating to safe prescribing, administration and recording of medicines which resulted in a breach in safe care and treatment. This further triggered a breach in governance due to the insufficient oversight of these issues.

Wards for people with learning disabilities or autism

The CQC completed an unannounced inspection of Byron Court in July 2025, with the final report published in November 2025. The service maintained a rating of “Requires Improvement” with the CQC noting that five of the previous six concerns raised had been addressed. The report established that:

- There were improvements in staffing; nothing that the service now had enough permanent regular nursing and support staff to keep people safe.
- The service had ensured that blood glucose machines were fully calibrated.
- The service had ensured that staff accurately recorded administration of medicines, and that consent to treatment forms were accessible.
- The service had ensured staff recorded people’s vital signs in the physical health observation charts.
- The service had ensured that staff had access to specialist learning disability and autism training.

One area of concern was identified pertaining to the governance system and audits at the unit were not effective in identifying or addressing the areas for improvement that the CQC identified at this inspection, in relation to care and treatment records.

In year, the CQC undertook an unannounced focused inspection of Long Stay Rehabilitation (November 2025). The CQC published the final report post year-end with the service achieving a rating of "Requires Improvement." The CQC noted that there were 5 breaches in relation to regulation 9 (person centred care), regulation 12 (safe care and treatment), regulation 13 (safeguarding), regulation 17 (good governance) and regulation 18 (staffing). A section 29A warning notice was issued to address concerns relating to regulation 13 (safeguarding) and regulation 17 (good governance) of the Health and Social Care Act (regulated activities) Regulations 2014 by 30 April 2026. The report established that:

- There were some improvements since the last inspection including a clinic room where patients could be examined.
- Staff read patients their rights under the Mental Health Act.
- Most patients felt safe at 439 Ipswich Road and all patients reported that staff were kind and respectful.
- Physical health was assessed on admission.
- Care plans were mostly individualised and included the physical and mental health needs of the patient.
- There was an occupational therapy team and an activity co-ordinator available with evidence of patient involvement in volunteering opportunities.
- Essential information was shared in handover meetings.

Areas of concern were identified pertaining to:

- Safeguarding referrals were not always completed when there was a safeguarding incident.
- Risks to people's health and safety were not always assessed
- Investigation of incidents by managers including how actions following investigations did not mitigate risk to patients.
- Learning from incidents that was not always identified and embedded.
- Concerns that leaders did not ensure that processes were in place to meet patients' needs on admission.
- Limited access to a consultant and a clinical psychologist.
- Effective and robust governance procedures to monitor and identify areas for improvement.
- Oversight of staff's compliance with supervision.
- Systems to monitor the assessment of risk and robust oversight of incidents.
- Effective management of the safety of the environment.

Further to this, the CQC also carried out the following activity:

- An unannounced inspection of the Trust Child Adolescent Mental Health Services (CAMHS), February – March 2026.
- An unannounced focused inspection to Ardleigh Ward, in January 2026.
- An announced inspection of Community Health Inpatients (Avocet Ward and Cumberlege Intermediate Care Centre) in December 2025.
- Fifteen Mental Health Act review visits across Trust services.
- A Well-Led Inspection of the Trust in March 2026.

At the time of writing, the final reports for all these inspections are awaited.

The Trust continues to hold an improvement plan, in response to inspection findings. The plan is implemented by local operational CQC Care Unit meetings with assurance reporting to the Quality Committee and the Trust Board. This year review undertaken by our internal auditors provided a substantial assurance opinion for our improvement plan governance.

As of July 2025, 97% of actions of the 2022 CQC Improvement Plan were reported as complete and closed through the evidence assurance process. Therefore, a new plan was developed for inspections completed from 2025, with the 3% of actions awaiting evidence assurance transferred to the new plan. This brought the CQC Improvement Plan 2022 to a close.

As at the end of 2025/26:

- There were 73 actions addressing 16 'must do' / 'should do' recommendations made by the CQC.
- 76% of actions in response to the CQC recommendations have been reported as complete by action owners.
- 1% have been through the evidence assurance process and closed.

As of 31 March 2026, there are fourteen sub-actions past the original stated timelines, and action is being taken to recover the position.

The full matrix of ratings for the services provided by EPUT is provided below

Service	Overall CQC Rating
Wards for people with learning disabilities or autism (November 2025)	Requires improvement
Acute wards for adults of working age and psychiatric intensive care units (July 2025)	Requires improvement
Forensic inpatient or secure wards (April 2025)	Good
Community health services for adults (July 2018)	Good
Community health services for children, young people and families (July 2018)	Good
Community health inpatient services (July 2018)	Good
Community end of life care (October 2019)	Outstanding
Child and adolescent mental health wards (July 2022)	Requires improvement

Service	Overall CQC Rating
Community mental health services with learning disabilities and autism (July 2018)	Good
Community-based mental health services for older people (July 2018)	Good
Community-based mental health services for adults of working age (July 2023)	Requires improvement
Mental health crisis services and health-based places of safety (July 2023)	Good
Long stay or rehabilitation mental health wards for working adults (April 2026)	Requires improvement
Wards for older people with mental health problems (July 2023)	Requires improvement
Substance misuse services (July 2023)	Good
Rawreth Court (Care Home) (November 2023)	Requires improvement
Clifton Lodge (Care Home) (February 2025)	Good

Our Performance

Table 1: Summary of 2025/26 performance against NHS Oversight Framework metrics or the equivalent where the Trust measures this differently.

NOF Indicator Description (or *Trust Equivalent)	National Median (Q3)	Latest Performance
Percentage of patients waiting over 52 weeks for community services	0.250%	0.014%
Percentage of inpatients with >60 day length of stay	23.2%	20.1%
Urgent Community Response 2-hour performance	86%	87%
% of 5 star IWantGreatCare responses*	No Target Set	90.6%
Percentage of patients in mental health crisis to receive face-to-face contact within 24 hours	65.99%	71.05% (Q3 2025/26)
Sickness absence rate* (Trustwide)	5.62%	5.40%

Table 2: Summary of 2025/26 performance against key performance indicators where the Trust submits data locally or nationally for monitoring and benchmarking purposes.

National Data Submission Metrics	Target	Latest Performance
CHS referral to treatment waits under 18 weeks (Mid and South Essex)	92%	93.7%
CHS referral to treatment waits under 18 weeks (West Essex)	95%	98.7%
The % of service users who are followed up within 72 hours of discharge from a psychiatric in-patient care	80%	89%
MHSDS DQMI Data Quality Score	95%	91%
NHS Talking Therapies Reliable Improvement	69%	73%
NHS Talking Therapies Reliable Recovery	51%	52%
NHS Talking Therapies 6 week wait	75%	100%
NHS Talking Therapies 18 week wait	95%	100%
Early Intervention in Psychosis: percentage of Service Users experiencing a first episode of psychosis who wait less than two weeks to start a NICE-recommended package of care	60%	100%
Inappropriate Out of Area placements active at end of period.	Reduction to 0 by March 2029	30

Time To Care Programme

The Time to Care Programme was established to release significant, measurable time for direct patient care on inpatient mental health wards. The programme has delivered a new engagement-led operating model, recruited the majority of the planned workforce, and initiated meaningful cultural change across services.

The five-year programme of change was a gross investment of £69.1m in our substantive workforce.

Key Achievements

- Introduction of a new operating model built around Purposeful Admission, Therapeutic Care, Trauma-Informed Care, and Safe and Effective Discharge, now implemented across inpatient and urgent care services, with a focus now on embedding changes.
- Implementation of 16 priority staffing initiatives, focusing on safe staffing and enhancing therapeutic capacity.
- Enhanced collaboration and team culture, with high-performing multidisciplinary teams and stronger cross-professional working reported in several Care Units.
- Valued co-production, with Lived Experience Ambassadors contributing meaningfully to programme design and delivery and Peer Support embedded in the workforce model.
- Successful recruitment of 333.7 WTE roles against a 339 WTE target, significantly strengthening inpatient Multi-Disciplinary Team capacity and introducing new roles such as peer support workers, activity coordinators, clinical site managers and additional AHP input.

The completion of the programme and the challenges experienced, including compressed timescales and delays in implementation, have led to a number of areas of learning being identified which will be used to improve delivery of future programmes. The programme will still remain active with any future benefits reported via our standing committees of the Board and contractual oversight meeting. The key programme for 2026/27 will be the Community First programme, which will look to improve flow and capacity in community services.

Service Developments in 2025/26

We continued to innovate and develop services throughout the year, working together with patients, their families and carers, our staff and partner organisations. Highlights include: We started the construction of two new **Mental Health Emergency Diversion Units**, one each at the Princess Alexandra Hospital in Harlow and at Colchester Hospital, located next to our existing mental health inpatient units on each site. The units will help adults in mental health crisis get the right care at the right time, in a calm and therapeutic space closer to home and away from the busy environments of hospital accident and emergency departments. The units are designed to provide rapid assessment, care and support in a space better suited to patients in distress and patients with neurodiversity and build on the experiences gained at our existing mental health urgent care department in Basildon.

Rawreth Court, our residential care home in Rayleigh launched a new sensory initiative to support older people with dementia. Residents at the care home benefit from a dedicated space that allows them to enjoy one-on-one time in a peaceful environment. The "Namaste Care" sensory experience includes soothing music, projectors, weighted soft toys, special lighting and sounds of nature. Each session is personalised depending on the resident's preferences and their backgrounds. Namaste Care is a person-centred, holistic approach focused on enhancing the quality of life for people with advanced dementia. It uses sensory-rich activities and meaningful interactions to promote comfort, reduce agitation and foster a sense of connection and wellbeing.

Sensory equipment is being offered to mums at our **Rainbow Mother and Baby Unit** in Chelmsford to enhance their emotional wellbeing. The equipment includes items such as fidget toys, migraine relief caps, sensory balls, games and mood lamps. Staff in the unit worked with patients to choose the equipment, which has been especially helpful for people diagnosed with ADHD, autism and anxiety. The sensory items are part of our ongoing commitment to provide therapeutic care that meets the individual needs of our patients.

We launched an employment programme to help unemployed young people develop skills to enter rewarding jobs in healthcare. The **Step Forward Programme** is for people aged 18 to 30 who live in the Southend and Basildon postcode areas and are unemployed or on a zero hours contract. Funded King's Fund, the four-week programme provides a skills assessment to identify people's strengths and interests as well as personalised support and career planning including core skills, learning about healthcare settings, creating tailored CVs and covering letters and the types of jobs they can apply for.

EPUT was also confirmed as a key partner in the **Essex Connect to Work** employment programme. Essex residents with long-term health conditions, disabilities and other barriers into work can now use the Government's Connect to Work employment programme, designed to give people confidence and opportunities to find meaningful and sustainable work. EPUT is delivering the national programme across Essex in partnership with the Shaw Trust and Essex Cares Ltd.

A **new clinic opened in Colchester for women struggling with substance misuse**, offering counselling and relapse prevention from alcohol and drugs. Staff from the Essex Specialist Treatment and Recovery Service (STaRS) work alongside addiction charity Open Road to hold the fortnightly at The Nest in Colchester. The clinic is staffed by female healthcare professionals wherever possible and builds on a female-only community clinic recently opened by Essex STaRs in Colchester.

Our **Personality Disorder and Complex Needs Service User Network (SUN)** has been holding Coffee and Connect meet-ups in Southend and Colchester. Following its success, the groups have expanded to other locations across Essex and are open to people receiving treatment and care from the service. The meet-ups are to help people who have been diagnosed with a personality disorder find friendly support and connection.

We offered a **Skills for Carers Programme** between March and April 2025 to provide help for carers of people diagnosed with personality disorder and complex needs to learn more about ways to support their loved one and themselves. The programme was offered on a weekly basis at MIND in West Essex and was open to carers across Essex who were able to attend the in-person sessions. Different topics were covered each week, such as what borderline personality disorder is, carers' rights, emotions and validation, the family environment and problem solving.

A new one-year pilot project has been launched in Colchester and Tendring to help people with severe and complex mental health needs stay connected with services and get the right support at the right time. The project introduces peer support workers into **community mental health assertive outreach teams**. These teams focus on reaching people who find it difficult to engage with traditional services, by offering support in places where they feel safe and building consistent, trusting relationships. Peer support has strengthened this approach by helping people feel they are understood rather than managed.

Patients on our mental health wards are being offered **family group conferencing** for the first time to help involve loved ones in decisions about their care and build stronger relationships. Family group conferencing enables patients, their friends and family to work through challenges, improve understanding of each other's needs, and plan how they can support the patient when they leave hospital. The approach has been used in community health services for 21 years and we started offering family group conferencing on wards from October 2025 as part of our Time to Care Programme. It is believed to be the first such service to be offered on mental health inpatient wards in England.

We appointed a new **specialist consultant psychiatrist** to help ensure autistic patients receive mental health care best suited to their needs. **Dr Catherine Dakin** is the first autism specialist consultant psychiatrist in Essex using her personal and clinical experience of autism to support neurodivergent patients of all ages receiving care in the community or on an inpatient ward.

A new **adult physical health community assessment and treatment unit** was established at St Margaret's Hospital in Epping to provide an alternative referral option for patients requiring urgent medical care. 200 patients were seen in the unit in its the first seven weeks, staying an average of five days and reducing pressure elsewhere in the urgent care system.

In summer 2025, **EPUT became the first UK location to begin recruiting patients for a major clinical trial to test whether a specific blood test can improve early and accurate diagnosis of Alzheimer's disease**. The landmark study is being led by University College London (UCL) and is recruiting people from memory clinics across the UK. The UCL team are investigating whether a blood test that measures the protein p-tau217 can improve the early and accurate diagnosis of Alzheimer's disease. The trial will examine whether providing the blood test results to patients and their clinicians near the start of an assessment for memory and thinking concerns is able to aid diagnosis and guide decisions on further investigations and treatments.

Service Visits

Governors, non-executive director and ICB colleagues undertake service visits across the Trust, speaking with patients and staff. The Trust launched a revised Quality Assurance Visit (QAV) programme in 2025/26 as a pilot. The aim of the programme was to undertake coordinated visits with a range of colleagues.

In 2025/26, 21 Quality Assurance Visits were undertaken, including governors, non-executive directors and ICB colleagues. In addition, 6, visits were completed by non-executive directors (in addition to attending the QAVs) and 37 by executive directors. There were also a number of visits from key stakeholders and MPs which were supported by Executives within the year.

Findings from QAVs are formally captured, analysed and reported through to the Quality Committee, including escalation to the Board of Directors where appropriate. Themes identified

through these visits have informed Board discussions and decision-making, particularly in relation to quality improvement priorities, environmental standards and patient experience.

Overseas Operations

The Trust did not undertake any overseas operations during the year 2025/26.

Mid and South Essex Community Collaborative

During 2025/26, the Mid and South Essex Community Collaborative (MSECC) continued to mature as a system-leading partnership. Established in 2021 to bring community providers together, MSECC strengthened its role as a trusted system partner during the year, operating with a clear shared purpose and a single, credible strategic voice within the wider Integrated Care System.

Operating under a well-established joint governance model – including a single contract, a Joint Committee and a Collaborative Executive – MSECC made tangible progress in aligning leadership, standardising operating models and embedding shared ways of working across operational, clinical, transformation and corporate functions. This enabled improved grip of delivery, clearer accountability and greater consistency across services.

The year saw meaningful progress in creating the foundations for neighbourhood-based working in partnership with the MSE Primary care collaborative, digital integration and service redesign, supporting the delivery of more joined-up care closer to home.

Priority programmes progressed across a wide range of services despite ongoing workforce and funding pressures. Key delivery achievements included standardised approaches to cardiovascular disease risk identification, implementation of Hybrid Closed Loop technology within diabetes services, and the rollout of respiratory remote monitoring. Virtual Wards, Urgent Community Response and Intermediate Care pilots demonstrated positive impacts on patient flow and discharge outcomes, while mobilisation of standardised offers across children and young people's asthma, bladder and bowel services were achieved.

Digital enablement through SystemOne remained a critical enabler throughout the year. Progress towards single, standardised digital units improved data quality, multidisciplinary working and operational consistency, with Adult Speech and Language Therapy and diabetes services successfully live and further services planned to follow.

While system dependencies, workforce capacity and reliance on wider funding decisions continued to affect pace in some areas, MSECC demonstrated resilience, pragmatism and growing maturity as a collaborative. The focus remained firmly on combining organisational strengths with the commitment of staff to improve outcomes for local populations.

Looking ahead to 2026/27, MSECC will continue to adapt and strengthen its operating model and partnerships, with a growing emphasis on neighbourhood health, left-shift and consolidation. The Collaborative will increasingly position itself as an integrator of community provision – not only across mid and south Essex, but as part of the wider Essex system – to support improved outcomes and sustainable transformation at scale.

Prevention of Future Death Reports

The Trust has received twelve prevention of future death reports in 2025/26. The actions identified are incorporated into the CQC Improvement Plan process and taken forward as part of the process highlighted in the CQC section above. The approach brings the actions together into a single action plan to ensure improvement actions are implemented and sustained together. The Board of Directors receives a report on the prevention of future death reports issued, the responses and the process in place to ensure action is taken and wider learning shared.

Sustainability and Environmental Stewardship

Leadership, Governance and Strategic Commitment

Essex Partnership University NHS Foundation Trust (EPUT) recognises climate change as a significant and escalating global risk, with far-reaching consequences for the environment, the economy and human health. Evidence from the Intergovernmental Panel on Climate Change confirms that human activity is the primary driver of climate change, with impacts already being felt through rising temperatures, extreme weather events and increased pressure on public services. These impacts disproportionately affect vulnerable populations and present direct risks to healthcare delivery.

In recognition of our community, statutory responsibilities, regulatory obligations and the operational risks climate change poses to the provision of care, the Trust has placed sustainability at the centre of its strategic decision-making. In March 2026, EPUT launched its second Green Plan, setting out a clear and deliverable framework to reduce the environmental impact of our operations while safeguarding clinical quality and financial sustainability. The Plan aligns with national NHS ambitions to achieve net zero by 2040 and supports our overarching objective of helping our communities to thrive:

- Net zero by 2040 for the emissions the NHS controls directly (the NHS Carbon Footprint), with an 80% reduction by 2028 to 2032.
- Net zero by 2045 for the emissions the NHS can influence (the NHS Carbon Footprint Plus), with an ambition to reach an 80% reduction by 2036 to 2039.

Figure 1: Carbon emissions by scope

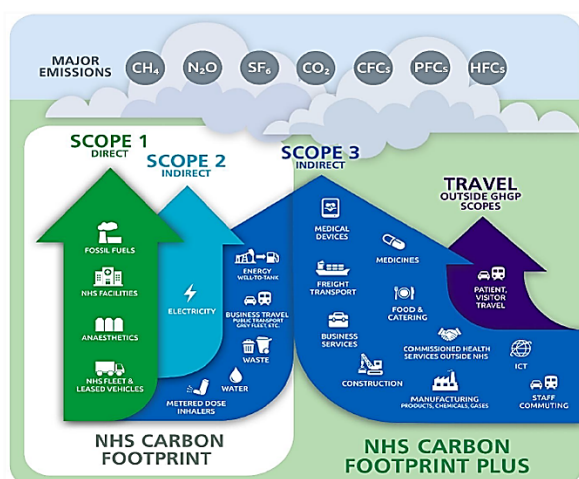
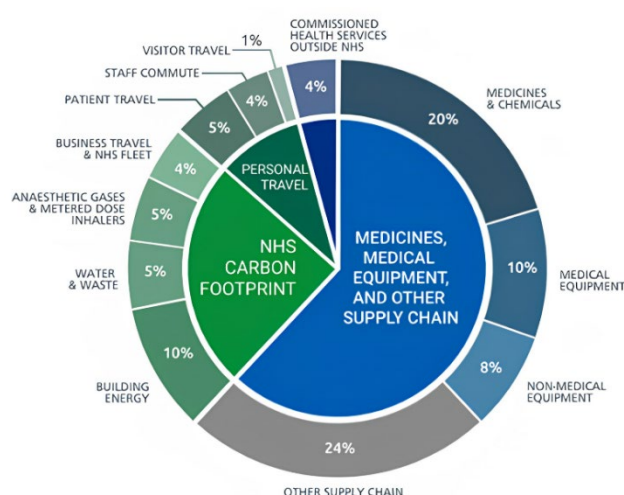


Figure 2: EPUT Carbon Emissions by scope (2021)



Since the implementation of the 1st Green Plan the Trust has achieved:

Additional Sustainability Funding:

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

Solar Panels - £833k funding for solar panels has been awarded for Clough Road, Rochford and Linden Centre

Building Management Systems (BMS) - £123K of funding has been awarded for upgrading on the BMS for Rochford, King's Wood and Thurrock

Projected costs savings

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

Carbon emissions reduction

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

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

Notwithstanding the above, work has already started on implementing the actions from the 2026 Green Plan, with projects on reducing energy consumption already underway. These projects use the latest technology to monitor energy consumption. It is anticipated that project likes this will reduce carbon emission, through reduction in energy consumption, with the added benefit of also reducing expenditure on utilities.

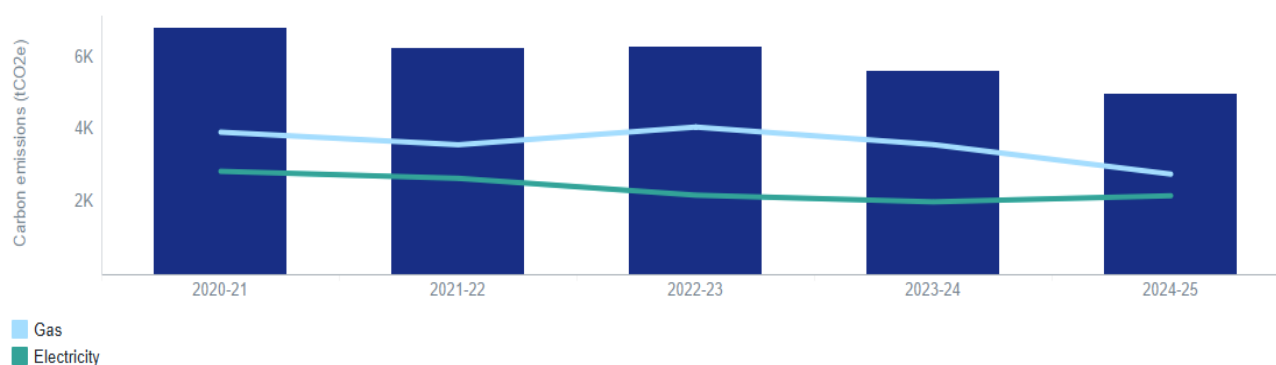
The Trust's sustainability programme continues to deliver measurable reductions with continued investment and system partnership working, essential to maintaining momentum and achieving net zero by 2040.

The 2026 Green Plan

EPUT's 2026 Green Plan is a practical roadmap for achieving measurable environmental improvement while ensuring resources are used efficiently and funding is not diverted from frontline services. Since the introduction of our first Green Plan in 2021, the Trust has invested significantly in capital projects to reduce carbon emissions, including air source heat pumps, LED lighting, building management system optimisation and electric vehicle infrastructure, representing investment of approximately £3 million.

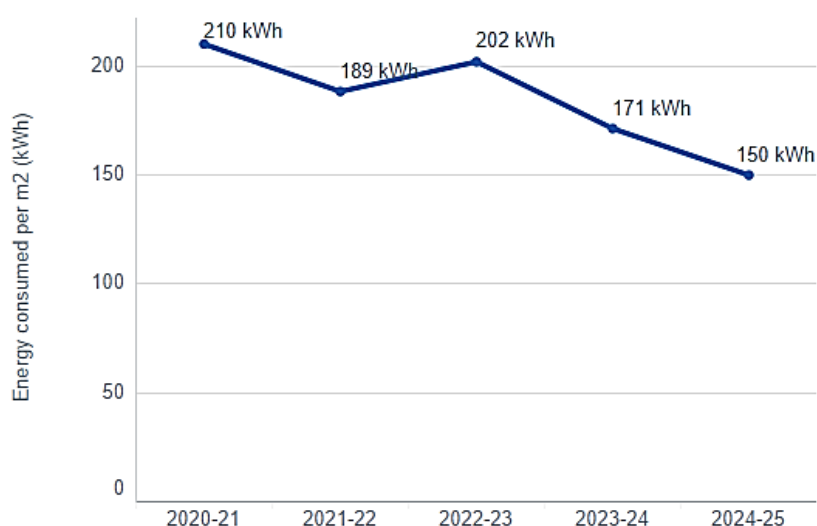
Fig 3 below shows a decline in emissions from the consumption of gas and electricity, with a steady reduction since 2021.

Figure 3: Carbon Emission Gas and Electricity 2021 to 2025



Despite operating a geographically dispersed estate of approximately 152 sites, more than half of which are over 40 years old, the Trust has delivered meaningful progress in reducing energy consumption, improving asset efficiency and lowering operating costs.

Figure 4: Energy consumption per m² 2021 to 2025



As the Trust continues with its strategy of generating its own renewable energy through the installation of solar panels at selected sites, it is anticipated that further reduction in energy consumptions and related emissions will occur.

The Green Plan also acts as an enabling strategy, supporting our wider priorities for digital innovation, quality of care, social impact and partnership working. It underpins the Trust's Estate Strategy, providing a long-term, forward-looking approach to estate development over the next decade, ensuring our buildings are resilient to climate risks and fit for modern healthcare delivery.

In autumn of 2025 the Trust was recognized for its investment and achievements being awarded Bronze in the National NHS England Excellence in Waste Management – Best Reuse Initiative of the Year.

Strategic Themes and Delivery

The new Green Plan is structured around key sustainability themes Fig 4, each supported by defined objectives, delivery plans and performance indicators. These include:

- Decarbonisation of the estate and operations
- Climate change mitigation and adaptation
- Waste reduction and circular resource use
- Water conservation
- Green spaces and biodiversity
- Sustainable procurement

Together, these themes support the creation of a sustainable estate that enhances patient and staff wellbeing, improves air quality, reduces emissions and contributes to wider public health outcomes.

The Plan is a living document, underpinned by the Estate Decarbonisation Strategy and the Travel and Transport Strategy, and will evolve as the Trust responds to emerging risks, regulatory change and technological innovation.

Figure 5: 2026 Green Plan Priorities

Priorities	Green Plan 2026 to 2040
1	Electric Vehicle Charging Infrastructure
	<ul style="list-style-type: none"> • Trust will only be able to lease or purchase electric vehicles from 2027 • Salary sacrifice vehicles can only be electric from 2027 • Capital costs/Funding • Priority locations i.e. priority 1 sites first • Income generation potential
2	Renewable Energy Generation
	<ul style="list-style-type: none"> • Identify potential opportunities i.e. photovoltaic, private wire to reduce costs & carbon • Capital costs/Funding availability • Potential savings to be made
3	Heat Decarbonisation
	<ul style="list-style-type: none"> • Capital Cost/Funding availability • Heat Decarbonisation Plan Completed • Age of heating system • Backlog maintenance prioritisation • 80% reduction in carbon emissions required between 2028 and 2032
4	Climate Change Mitigation and Adaptation
	<ul style="list-style-type: none"> • Capital Cost/Funding availability • Risk profile of property portfolio and service provided • Backlog maintenance prioritisation for climate change mitigation and adaptation

Governance and Risk Management

Strong governance and leadership are central to the successful delivery of the Trust Green Plan. Executive oversight is provided by the Executive Chief Finance and Resources Officer, supported by a Non-Executive Director with responsibility for sustainability and the Senior Director of Estates and Facilities. Operational delivery is coordinated through the Sustainability and Environmental Management Committee, which reports into the Finance and Performance Committee, a standing committee of the Board.

Climate-related operational and strategic risks are recorded within the Estates and Facilities Risk Register and incorporated into the Trust's Corporate Risk Register. This ensures climate risks, including those associated with extreme weather, flooding and overheating, are actively monitored and managed.

The Trust complies with the Task Force on Climate-Related Financial Disclosures (TCFD) requirements on a comply-or-explain basis, with governance, risk management processes and performance metrics disclosed within the [Green Plan](#).

Climate Change Adaptation and Resilience

The Trust operates across the East of England, a region particularly vulnerable to the impacts of climate change, including increasing temperatures, heatwaves, heavier rainfall and surface water flooding. Risk assessments undertaken by the Trust and NHS England have identified flood and overheating risks affecting Trust sites.

The risk profile for each site is regularly reviewed and remains as follows:

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

EPUT has robust emergency planning, incident reporting and business continuity arrangements in place to respond to climate-related risks, prioritising patient and staff safety. During 2025/26 there were no reported climate-related incidents that disrupted the delivery of healthcare services at the Trust to its communities.

However, whilst the Trust has not been subject to any climate change related disruption we continue with our assessment and mitigation.

The Trust as part of its Climate Change Adaptation and Resilience work has been selected to take part in [Satellite Applications Catapult](#).

For EPUT the primary outcome of the project is to shape a specific opportunity for using space data to support the Trust with climate related overheating, including identifying facilities which may be particularly vulnerable, based on historical satellite data and predictive modelling for climate change temperature increase predictions.

The project is designed in such a way as to encourage industry leaders to find technical solutions to climate related problems impacting on the ability of the Trust to deliver healthcare services to the communities it serves.

Engaging Our People



Staff engagement remains a cornerstone of our sustainability approach. The Trust actively involves staff, system partners and stakeholders in shaping and delivering the Green Plan. Our Green Champions network provides a forum for staff to contribute ideas, promote best practice and support local sustainability initiatives.

To support staff the Trust has provided in-post sustainability apprenticeships. These are apprenticeships are fully funded are funded through the growth and skills levy and support the Trust aspirations to become an accredited Carbon Literate Trust.

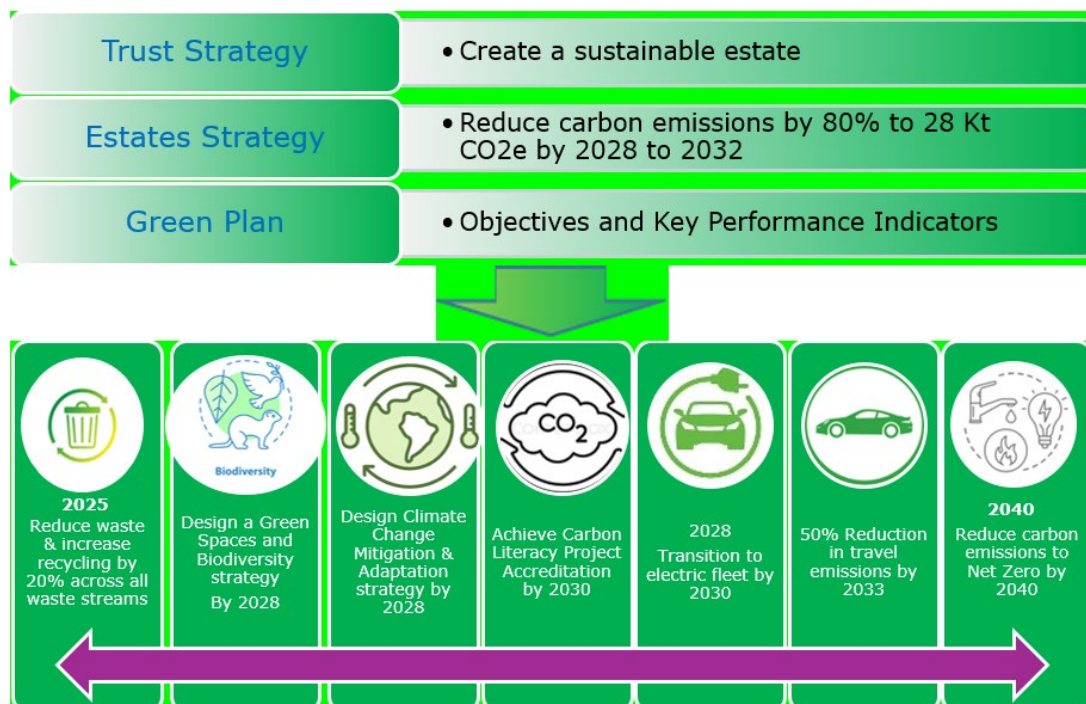
In addition to in-post sustainable healthcare apprenticeships, staff can access a range of free training on the Greener NHS training hub.

Inpatient care includes therapeutic activities which supports biodiversity across the Trust, this includes but is not limited to the creating of patient maintained gardens and vegetable growing activities.

Measuring Progress

Progress against the Green Plan is measured using defined metrics covering energy, carbon emissions, waste, water, travel and governance Fig 5. These measures demonstrate compliance with statutory obligations, inform investment decisions and provide assurance to the Board that sustainability risks and opportunities are being effectively managed.

Figure 6: Performance Monitoring – Delivering the Green Plan



The Trust will continue to work collaboratively with Integrated Care System partners to reduce its environmental impact while delivering high-quality, accessible and sustainable healthcare services to our communities.

Water and Wastewater to foul

The Trust continues with its strategy or reducing water consumption and wastewater to foul. Fig 6 demonstrates a consistent reduction in water consumption with a corresponding reduction in wastewater to foul Fig 7 following the introduction of water reduction of interventions:

Figure 7: Trust wide water consumption 2024 to 2026

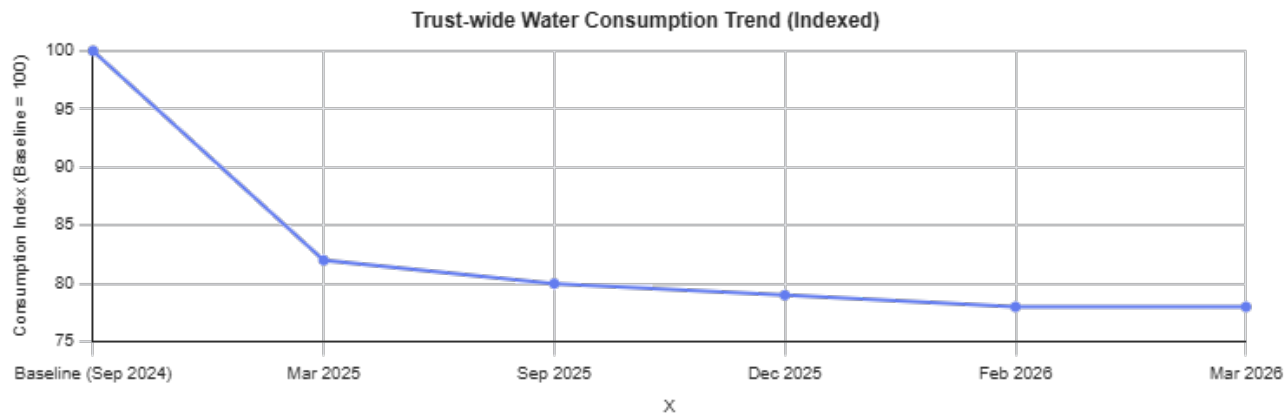
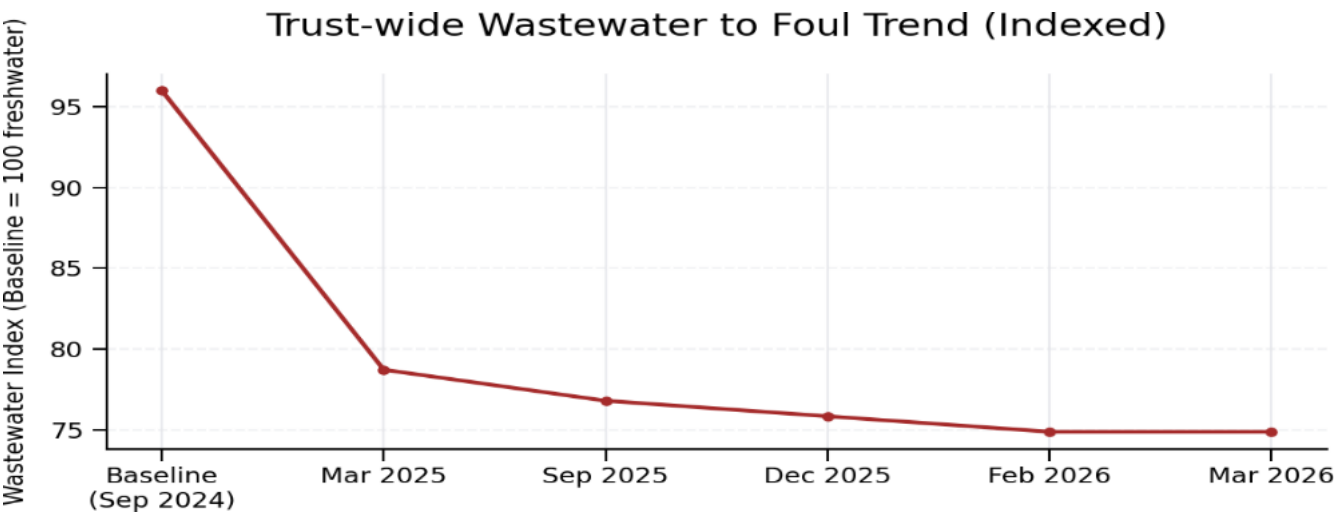


Figure 8: Trust-wide Wastewater to Foul 2024 to 2026



The water and wastewater interventions have resulted in improvements in data collection, monitoring and actions to reduce water leaks as well as reducing water consumption and wastewater to foul and the associated expenditure on water and wastewater.

Waste and the Circular Economy

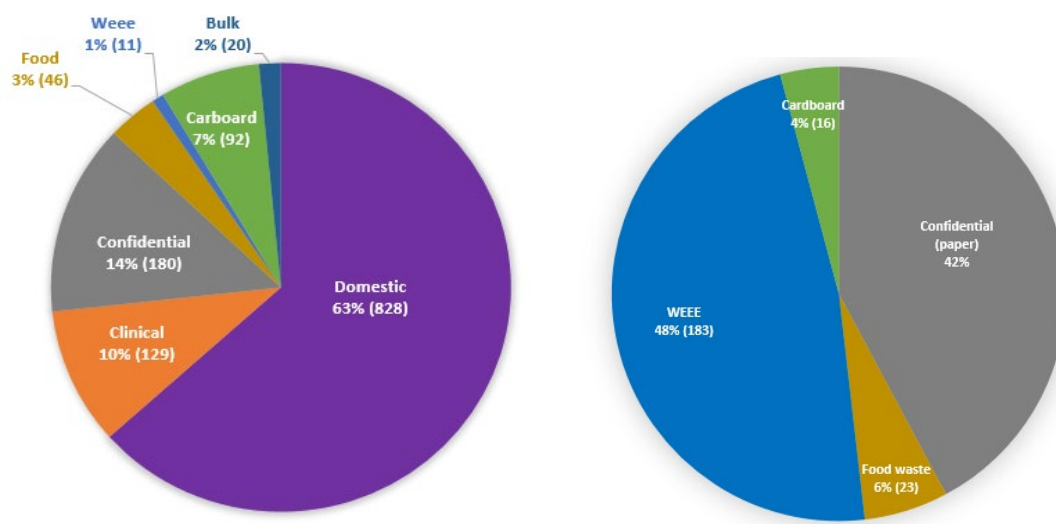
The Trust complies with its statutory obligations to dispose of all waste properly and in line with the guidance issued in [Health Technical memorandum HTM 01-07 \(2023\)](#). In March 2026 the Trust reviewed its waste policy, taking account of changes in the legal framework for the disposal of waste.

The Trust produces waste in the following categories:

- Domestic waste
- Clinical/medical waste
- Confidential Waste
- Food waste
- Weee waste

Of all the waste produced by the Trust, 63% (828 tonnes) is categorised as domestic waste, of all the waste produced circa 25% is recycled. Furthermore, assets which can be used again, typically furniture is also recycled within the Trust or donated to a local charity.

Figure 9: Waste produced by category 2025/26 (tonnes) Fig 10 CO₂e avoided (tonnes) from recycling



Travel, Transport and Air quality

The Trust is committed to achieving reductions in travel related emissions as outlined in the Fig 13. To support this ambition and in preparation for changes in national policy the Trust has expanded its Electric Vehicle (EV) Charging infrastructure across its Estate. The Trust has increased the number of EV charging facilities from 27 (2022) to 65 (2026), these charging facilities are strategically positioned across the Trust's operational geography. We continue to expand our network of EV chargers in preparation for NHS England policy changes which come into force in January 2027; the policy change mandates that from January 2027 the Trust will only be able to purchase and or lease low or zero emissions vehicles, this includes vehicles provided for staff via the NHS salary sacrifice scheme.

To promote sustainable travel the Trust facilitates the use of its chargers by staff and the public at selected locations to support our staff and the general public's transition to electric vehicles. The Trust is currently transitioning its own fleet of 71 vehicles. In 2023 the Trust's fleet

predominantly consisted of diesel engine vehicles (74%), which have a detrimental impact on internal and external air quality, public health and the environment. In 2026 the Trust has:

- 33 low, zero emissions vehicles
- 25 Petrol engine vehicles, and
- 13 diesel vehicles

Staff remain committed to using public transport, during 2025/26 staff undertook 3,984 journeys using various modes of public transport; 67% of all journeys undertaken were by rail, 26% by bus, this represents a significant commitment by staff to sustainable travel.

EPUT is committed to reducing its impact on the environment and community, and supports [Essex County Council Air Quality Strategy](#) As part of the Trust work in improving internal and external air quality across the Estate.

During March and April 2026, the Trust undertook a staff commuting survey for the 2nd year running. The purpose of running the travel survey each year is to gain an understating of how staff travel to work and what modes they use. Understanding staff commuting informs strategic decision making in respect to supporting staff transition to a more sustainable travel options, including supporting staff health and wellbeing.

Figure 10: 2024/25 Travel survey by mode

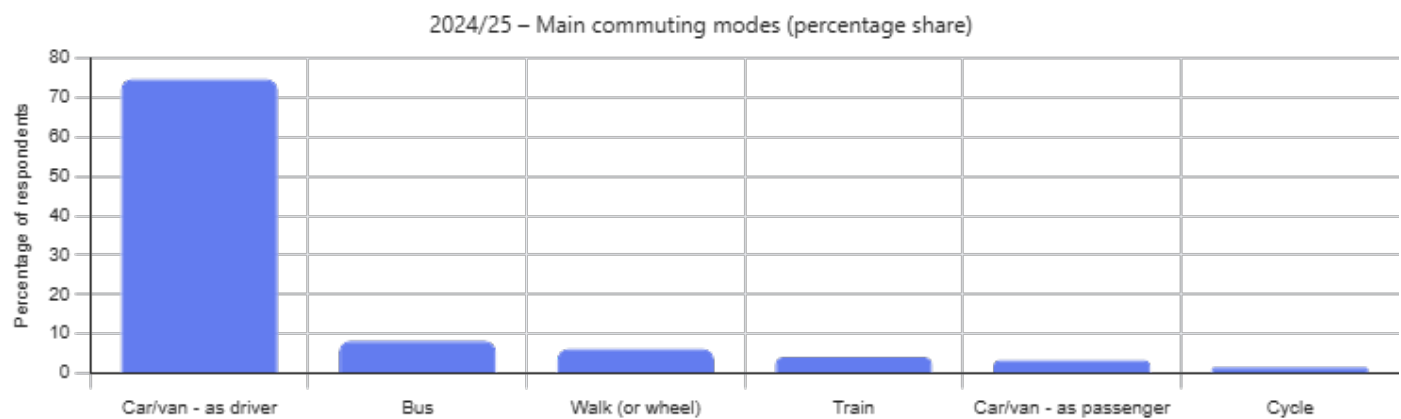
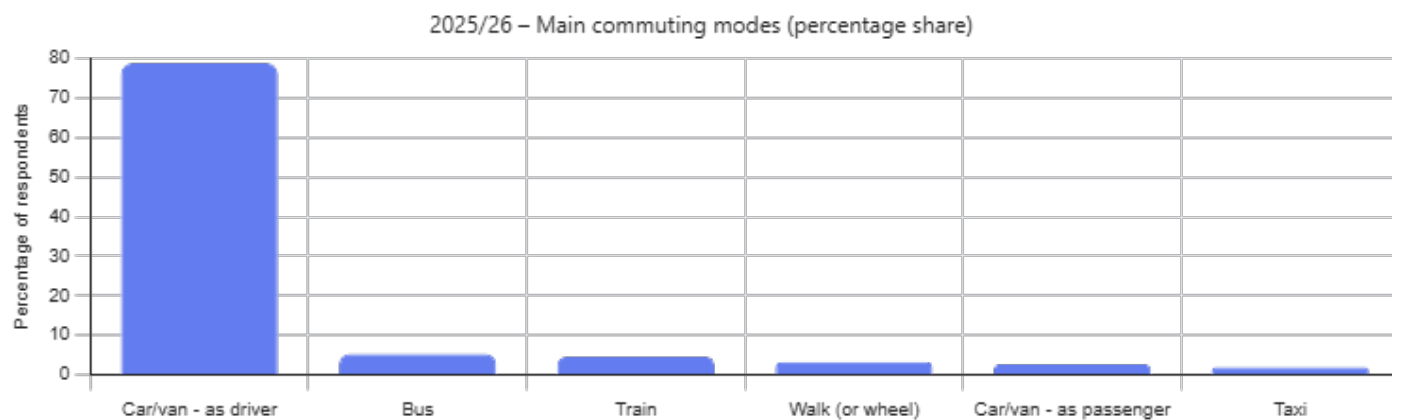


Figure 11: 2025/26 Travel survey by mode



In summary:

- Car remains the dominant mode in both years
- Active travel (walk, cycle, e-bike) forms a small but visible share
- Public transport represents a smaller proportion in 2025/26

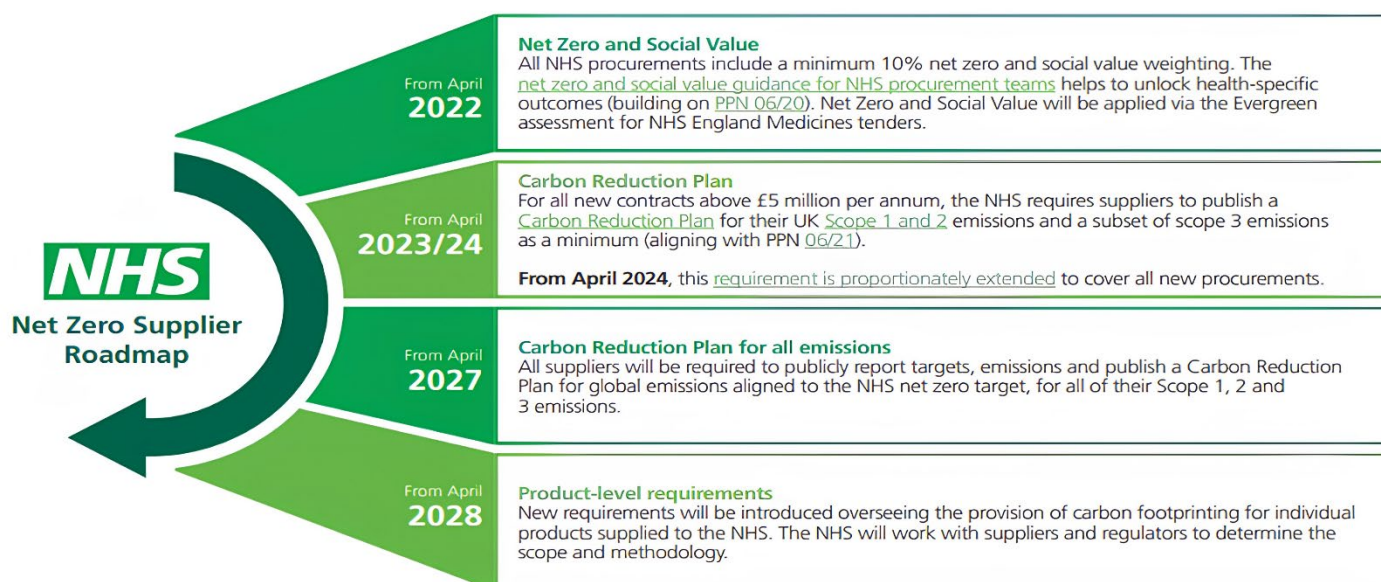
Currently the Trust provides a range of support to staff wishing to use sustainable modes of commuting, including but not limited to:

- Public transport season ticket loans
- Electric vehicle charging facilities
- Cycle shelters
- Access to cycle purchasing schemes, including Love to Ride Essex
- Hybrid working.

Procurement

The Trust remains committed to sustainable procurement and complies with the public procurement rules for the [NHS](#). Fig 16 Provides a road map for procurement activities. From April 2027 all suppliers to the NHS will be required to publicly report targets, emissions and publish a Carbon Reduction Plan for global emissions aligned to the NHS England net zero target for all their scope 1, 2 and 3 emissions. This should have a significant impact on reducing the Trust scope 3 emissions for procurement activities across the Trust.

Figure 12: NHS England Net Zero Supplier Roadmap



Patient-Led Assessment of the Clinical Environment (PLACE)

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

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

- **Cleanliness:** the domain covers all items commonly found in healthcare premises, including patient equipment. Examples are baths, toilets and showers, furniture, floors and fixtures and fittings.
- **Food and Hydration:** the domain includes a range of organisational questions relating to catering services available for patients, for example choice of food, 24-hour availability, meal times and access to menus. It also includes an assessment of food at ward level, including taste, texture and appropriateness of serving temperature.
- **Privacy, Dignity and Wellbeing:** the domain includes infrastructure and organisational aspects such as the provision of outdoor and recreational areas, changing and waiting facilities and access to television, radio, internet and telephones. It also includes the practicality of male and female services e.g. sleeping, bathroom and toilet facilities, and ensuring patients are appropriately dressed to protect their dignity.
- **Condition, Appearance and Maintenance:** the domain includes various aspects of the general environment including décor, condition of fixtures and fittings, tidiness, signage, lighting (including access to natural light), linen, access to car parking, waste management, the external appearance of the buildings and the maintenance of the grounds.
- **Dementia and Disability:** this domain ensures assessments for the other domains are made with a view to the needs of a person living with dementia or a disability, for example wheelchair access, hearing loops and accessible information.

The following tables detail the Trust's scores against the national average benchmark from 2025, based on the 1,080 assessments undertaken in 2025 – figures from NHS England.

Table 3: The Trust performance in PLACE 2025 compared to 2024 and the national Average

Domain	EPUT 2025	EPUT 2024	National Average 2025
Cleanliness	99.36%	96.79%	98.55%
Ward Food	92.93%	92.65%	92.13%
Condition, Appearance and Maintenance	97.74%	95.21%	97.00%
Dementia	90.81%	91.94%	85.68%
Disability	90.76%	89.30%	87.12%
Privacy, Dignity and Wellbeing	97.74%	94.99%	89.37%

Overall, the trust performed well against the national average in 2025 and improved in almost all domains apart from 'dementia'. The most significant improvement areas between 2024 and 2025 were 'Cleanliness', 'Privacy, Dignity, and Wellbeing', and 'Condition, Appearance, and Maintenance'. Some dementia-related PLACE scores may appear lower because a number of our services, such as CAMHS and working age adult services, are not designed for or routinely used by people living with dementia, which can affect how relevant certain assessment criteria are in these settings.

The 2025 PLACE results will be used to make clear, practical improvements across our sites, focusing on what matters most to patients such as cleanliness, food, privacy, dignity, and the environment. We will use feedback from patient assessors to guide these changes and make sure they are visible and meaningful. By the time of the 2026 visits, we want returning patient assessors to be able to see the difference their input has made and how it has helped improve our services.

Patient and Public Involvement

The Trust has continued its implementation of the *Working in Partnership* strategy, and the following provides key highlights and achievements for 2025/26. As we move into year 4 of the strategic implementation there is now compelling evidence that:

- Coproduction is happening across services
- People are involved in decision-making
- Community partnerships are strengthening Coproduction

Co-Production

Over the past year, there has been a clear shift in how the Trust collaborates with people and communities. Traditionally, involvement was often something undertaken alongside services. For example, asking for feedback after care had been delivered. Over the last few years, the approach has shifted towards co-production, meaning services are designed and improved *with people, not for them*.

During 2025/26, this has continued to evolve across the Trust into a more mature approach where people with lived experience are actively shaping:

- Service design
- Decision-making
- Quality improvement

An example of this is people with lived experience being involved in recruitment panels for senior roles and have shaped major programmes such as Time to Care, ensuring services better reflect real-world experience. The shift has also supported the Trust ambition to deliver care that is more personalised, equitable and effective.

During 2025/26, the number of people involved in supporting and improving services has continued to grow:

- 820 people are now part of the lived experience and volunteer community
- 459 Lived Experience Ambassadors (LEAs)
- 361 volunteers

This means more people are contributing their experiences to improve services than ever before. The impact of this in practice is:

- More patient and family voices are influencing decisions
- Services are better able to understand diverse needs and make reasonable adjustments
- There is greater visibility of what is working well and what needs to improve.

The annual co-production conference was held in partnership with Essex County Council and focused on how working in partnership with patients, their loved ones and the wider community is vital to delivering better health and care services. Colleagues, lived experience ambassadors, and partners heard about the national Culture of Care programme, which aims to change the culture of inpatient care, reasonable adjustments in the workplace, and the experiences of mental health care by older people in racialised communities. Over 175 people from across Essex attended the conference on World Mental Health Day.

EPUT & ECC Coproduction Conference 2025



Lived Experience, Volunteering and the Peer Workforce

Peer Support Workers are people with lived experience who are employed within services to support others going through similar challenges. Due to shared experiences, peer workers are better able to strike a connection based on understanding, support people due to their own lived experience, and advocate for people's needs. During 2025/26 peer roles have become a core part of inpatient services following a successful pilot. Transitioning away from the pilot has required considerable time and effort from the Peer Leadership Team. The peer workforce is now contributing to day-to-day care delivery across a number of inpatient services.

There are a number of areas of good practice from this approach, with peer support workers supporting patients during difficult moments, help to de-escalate situations and encourage engagement with care and recovery. This has often led to improvements in trust between patients, families and staff, reduced incidents, better patient experience and improved outcomes. In addition to this, family and carer ambassadors are improving the way we support families and carers of people in our care.

The Trust will continue to build on the achievements so far, including expanding substantive roles, developing career pathways for peer support workers and embedding lived experience across more services.

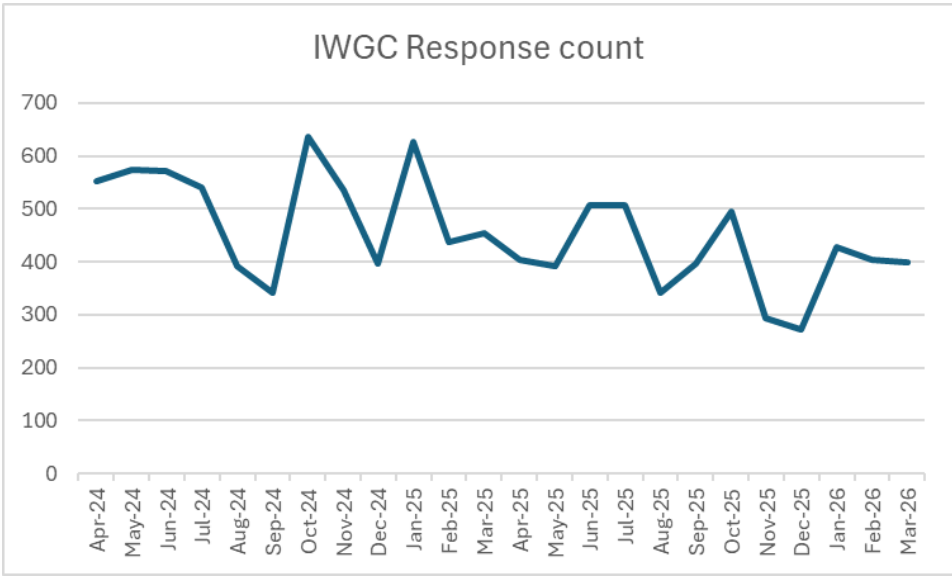


Patient Experience

I Want Great Care (IWGC)

The total responses since the launch of IWGC in January 2022 is 16,543, however, there has been a decline in the number of responses for 2025/26 (4,800* compared to 6,055 in 2024/25. The decline in responses will be reviewed and action taken to promote IWGC, supporting staff to collect feedback, developing new ways for feedback to be provided and monitoring low response rates more closely to take more localised action.

Figure 13: IWGC Monthly response count April 2024 to March 2026



The feedback demonstrates a high-quality patient experience, with average ratings consistent at 4.8 out of 5 and 94% positive feedback across all domains. The range of response methods demonstrates the accessibility of the system, with 48% of feedback coming from offline sources, 42% online and the remaining 10% through the use of QR codes, SMS or tablets. The feedback did provide some improvement areas such as "Listening" and "Understanding" as having the highest number of negative reviews and this will continue to be an area of focus for the Trust.

Friends and Family Test

The Friends and Family Test (FFT) provides a key mechanism for demonstrating how the Trust listens to and understands patient experience in real time. By capturing feedback at the point of care through multiple accessible routes (e.g. SMS, QR codes, paper, and digital platforms),

services are able to gather both quantitative ratings and qualitative comments that highlight what matters most to patients. This feedback is routinely reviewed at team level to identify themes such as communication, safety, and responsiveness, and is used to drive immediate and longer-term improvements. For example, FFT comments about lack of updates have led to the introduction of regular staff check-ins and clearer communication processes on inpatient wards. Importantly, closing the loop through “You Said, We Did” approaches ensure patients and families can see how their feedback has directly influenced change, demonstrating that the Trust not only listens, but understands and acts on what people tell us.

Reducing Health Inequalities (PCREF & Health Equity)

Health Inequalities means differences in access to services, experiences of care and outcomes based on an individual’s ethnicity, socioeconomic status and geography. The Trust has made considerable progress in 2025/26 in building infrastructure to address inequalities, particularly through the Patient and Carer Race Equality Framework (PCREF). The following key achievements have been made during 2025/26:

- Introducing a data dashboard to track inequalities
- Developing cultural awareness training
- Launching the COMPASS pilot
- Improving access to perinatal services
- Embedding smoking cessation support

The development of a data dashboard has allowed the Trust to understand the health inequalities experienced, such as the proportion of people detained under the Mental Health Act and lengths of stay on our inpatient wards. The data will now be utilised to develop action at care unit level, ensure consistent delivery across services and build trust with local communities.

The Compass Programme

COMPASS is a co-produced peer mentoring and advocacy programme designed to support people’s recovery while reducing demand on NHS services. Delivered in partnership with VCSE organisations, it connects individuals with trained peer mentors to develop personalised goals, strengthen independence, and improve wellbeing. Whilst in the early stages of implementation, evidence suggests that lived experience, when embedded within care pathways, can enhance engagement, support more personalised care, and contribute to improved outcomes for individuals and the wider system.



Patient Advice and Liaison Service (PALS) and Complaints

Patient Advice and Liaison Service (PALS) and formal complaints provide distinct routes for people to raise concerns and seek support. PALS offers early resolution and advice for issues that can often be addressed quickly and informally, while the formal complaints process is used where a more detailed investigation and written response is required. Together, these mechanisms help the Trust to identify learning, improve services, and ensure concerns are appropriately escalated and responded to.

Table 4: Concerns and complaints

	2024/25	2025/26
Formal complaints	249	327
PALS concerns	603	500
MP concerns	73	97
Locally Resolved concerns	59	79
Compliments	1,545	1,350

Within the year, there were 86 complaints referred to the Parliamentary and Health Services Ombudsman (PHSO), which was a 12% increase on the previous year (77). Four cases were accepted for investigation, of which one remains outstanding and three were completed during the year. One investigation was subsequently discontinued by the PHSO, and two were partly upheld.

Equality and Inclusion

The Trust recognises its responsibilities under the Human Rights Act 1998 and is committed to upholding the rights, dignity and wellbeing of all patients, services users and staff and our communities. Human rights considerations are embedded within the Trust's governance, quality, workforce and inclusion frameworks. This includes ensuring fair access to services, freedom from discrimination, respect for dignity and autonomy, and the protection of individuals from harm. The Trust delivers this through its equality, diversity and inclusion approach, safeguarding arrangements, Freedom to Speak Up processes, and continuous improvement in patient experience and workforce culture.

EPUT is committed to meeting its responsibilities under the Public Sector Equality Duty and its wider obligations under the Human Rights Act 1998 by embedding equality, inclusion and participation within its quality, safety and population health priorities. The Trust recognises that patient, family and carer experience is a fundamental component of care quality and that addressing inequalities in access, experience and outcomes is essential to delivering safe, effective and compassionate services.

The Trust's approach is aligned to the 'principles set out in its Quality Account and Annual Report, which emphasise learning from experience, continuous improvement, and reducing unwarranted variation in care. Equality and health inequalities are not treated as standalone areas of work but are integrated within the Trust's wider quality governance framework. This ensures that consideration of the Public Sector Equality Duty is embedded in decision-making, service planning, transformation activity and assurance processes.

Assurance in relation to the patient and carer component of the Public Sector Equality Duty is provided through both the Quality Committee which receives regular reports on patient

experience, health inequalities, equality performance and progress against key national frameworks like the Patient and Carer Race Equality Framework and CORE20PLUS5. Executive leadership is provided by the Chief Nursing Officer, who holds responsibility for patient experience, participation and quality governance. The Quality Committee provides formal assurance to the Trust Board through established reporting routes, including integrated quality and performance reporting and the annual Quality Account. This ensures that the Board maintains oversight of how the Trust is meeting its statutory responsibilities and addressing inequality in practice.

Strategic leadership and coordination of patient experience, health equity, population health, co-production and participation is provided by the Director of Patient Experience and Participation through the Patient Experience and Participation portfolio. This portfolio provides assurance that lived experience insight informs policy development, service transformation and quality improvement, and that equality considerations are consistently applied across the organisation through things like the quality and safety meetings and accountability framework. This governance structure ensures that the Trust can demonstrate due regard to the three elements of the Public Sector Equality Duty in a systematic and accountable way.

Eliminating unlawful discrimination

The Trust recognises that unlawful discrimination may be experienced by patients, families and carers through barriers to accessing services, ineffective or inappropriate communication, failure to make reasonable adjustments, or care pathways that do not adequately reflect cultural, racial or socio-economic needs. Such experiences can undermine trust, reduce engagement with services and negatively impact health outcomes. Eliminating discrimination is therefore a core component of the Trust's quality and safety agenda.

To mitigate this risk, Equality and Health Inequality Impact Assessments (EQUIAs) are routinely applied to new policies, service developments and transformation programmes. The use of EQUIAs ensures that potential disproportionate impacts on people with protected characteristics and underserved groups are identified at an early stage and that mitigating actions are built into service design. This process is embedded within governance arrangements and supported through the quality and safety directorate, working in partnership with clinical services, transformation teams and the Trust's data and intelligence functions.

EQUIAs should be informed by a combination of population health data, patient and carer feedback, lived experience insight and local intelligence. This strengthens their effectiveness and ensures that they reflect the realities experienced by the communities the Trust serves. The quality and consistency of EQUIAs are subject to review through governance processes, providing assurance that they are applied meaningfully and not solely as a compliance exercise.

Learning from complaints, the Patient Advice and Liaison Service (PALS), patient surveys (I Want Great Care) and other experience feedback mechanisms is routinely analysed to identify themes that may indicate discrimination, exclusion or inequity. This learning is triangulated with clinical quality and safety data and reviewed through the Trust's quality governance arrangements. Where themes or risks are identified, actions are taken at both service and organisational level to address root causes and reduce the likelihood of recurrence.

Progress and areas of risk relating to discrimination are reported through the Quality Committee, with escalation to the Trust Board where appropriate. This provides assurance that

the Trust maintains oversight of equality risks and that action is taken to improve practice where required.

Advancing equality of opportunity

Advancing equality of opportunity is central to the Trust's population health approach and its commitment to improving outcomes for patients, families and carers. The Trust recognises that different people and communities have different starting points and levels of need, and that equitable outcomes require services to respond flexibly and proportionately.

The Trust applies the Core20PLUS5 framework as a key mechanism for identifying and addressing health inequalities. This framework supports a focus on people living in the most deprived communities, alongside other population groups at risk of experiencing poor access, experience and outcomes. Core20PLUS5 is used alongside local population health intelligence and learning from patient experience to inform service priorities and resource allocation.

Equality of opportunity is further advanced through place-based working and partnership with voluntary, community and social enterprise organisations, carers' networks and wider system partners. These partnerships support improved access to services, earlier intervention and more joined-up support, particularly for people who may face barriers in engaging with traditional NHS provision. This approach is consistent with the Trust's Quality Account commitments to partnership working and community engagement.

Reasonable adjustments are a key element of advancing equality of opportunity. The Trust works to ensure that patients and carers are supported to identify their individual needs and that services respond appropriately. This includes adjustments to communication methods, appointment arrangements, environments and care planning processes. Feedback from patients and carers is used to inform continuous improvement in how reasonable adjustments are identified, recorded and delivered.

Progress in advancing equality of opportunity is monitored through established quality and performance reporting arrangements and is considered by the Quality Committee as part of its oversight of patient experience, health inequalities and quality improvement. This ensures that the Trust Board receives assurance that action is being taken to reduce inequalities in access, experience and outcomes.

Fostering good relations

The Trust recognises that fostering good relations between people from different backgrounds is essential to building trust, improving patient and carer experience, and supporting effective engagement with services. Positive relationships between patients, families, carers, communities and staff underpin the delivery of safe, compassionate and inclusive care.

EPUT has invested in the development of a strong co-design and co-production infrastructure, ensuring that patients, families and carers are actively involved in shaping service design (i.e. Time to Care), delivery (i.e. Inpatient Peer Workforce) and evaluation (i.e. Patient Led Assessments of Care Environments). This approach reflects the Trust's commitment, as set out in its Quality Account, and strategy, to learning from experience and embedding improvement through meaningful engagement. From a patient and carer perspective, this ensures that involvement is not tokenistic but leads to visible change and shared ownership of decisions.

Lived experience roles, including peer workers, lived experience ambassadors and volunteers, play a central role in fostering good relations between services and communities. These roles support people to feel understood, represented and supported by individuals who have personal experience of using mental health services. They also contribute directly to service improvement by bringing insight that cannot be gained through data alone. The Trust recognises the peer workforce as a key asset in reducing stigma, strengthening engagement and improving cultural understanding within services (i.e. Recovery Café at Brockfield, Community Clothes Cycle across inpatient services).

The Trust's implementation of the Patient and Carer Race Equality Framework (PCREF) further strengthens its approach to fostering good relations and addressing racial inequalities. PCREF provides a structured mechanism for identifying disparities in access, experience and outcomes for racialised communities and for ensuring that these communities have meaningful influence over service design and improvement. This includes strengthening governance arrangements, improving the collection and use of ethnicity data, and supporting culturally responsive models of care.

Progress in relation to PCREF is monitored through established governance structures and reported through quality assurance routes. The Reducing Health Inequalities Group meets monthly, is co-chaired by a person with lived experience, and reports into the Quality of Care Group. The co-chair of the RHI group is the Trusts coproduction lead for the PCREF and has personal lived experience of racial stigmatisation and mental health issues. The Quality Committee receives updates on progress and provides assurance to the Trust Board that actions are being taken to reduce racial inequalities and improve relationships with communities who have historically experienced disadvantage or exclusion. Furthermore, the PCREF is being used to drive improvements across the Trust (i.e. spiritual care assessments pilot in forensics through the chaplaincy service).

Through this work, the Trust aims to build greater trust, transparency and collaboration with the communities it serves, supporting improved engagement, better experiences of care and more equitable outcomes. Working towards becoming a truly anti-racist organisation.

Co-design, co-production and due regard

Co-design and co-production are fundamental to how the Trust demonstrates due regard under the Public Sector Equality Duty. The Trust is committed to ensuring that patients, families and carers are involved throughout the service lifecycle, from understanding need and designing services, through to implementation, evaluation and improvement. The trust now has circa 400 Lived Experience Ambassadors involved in dozens of activities to improve its services by sharing their lived experience perspective and feedback. Further, the Trust routinely captures lessons learned from PALS, complaints, and patient and carer feedback to drive continuous improvement in identifying and addressing discrimination.

This approach supports all three elements of the duty. It helps to identify and address discrimination by bringing to light issues that may not be visible through quantitative data alone. It advances equality of opportunity by ensuring that services are designed in ways that respond to the needs of different communities and groups. It fosters good relations by building trust, mutual understanding and shared ownership of change (i.e. Perinatal services work with disadvantaged communities).

Leadership and coordination of co-production activity are provided through the Patient Experience and Participation portfolio, which ensures that involvement is embedded within strategic planning, service transformation and quality improvement. This includes providing guidance, support and assurance to services to ensure that engagement is meaningful, inclusive and proportionate to the level of change being undertaken.

The effectiveness of co-design and co-production is monitored through quality governance arrangements and contributes to the Trust's overall assurance in relation to equality and participation. Reporting through the Quality Committee enables the Trust Board to maintain oversight of how lived experience insight is influencing decision-making and improving care.

This approach supports the Trust's commitment to human rights by ensuring that patients and carers are actively involved in decisions about their care and that services are designed in a way that respects individual needs and preferences.

Population health approach and reducing inequalities

The Trust's approach to the Public Sector Equality Duty is closely aligned with its population health ambitions. EPUT recognises that many of the inequalities experienced by patients, families and carers are driven by wider social, economic and environmental factors and that addressing these requires a coordinated, system-wide approach.

Population health principles are applied across service planning and transformation activity, enabling the Trust to identify where inequalities are most pronounced and where targeted action is required. This includes the use of population health data, learning from patient experience and insight from community partners to inform priorities and resource allocation (i.e. the Community First programme).

The Trust's focus on Core20PLUS5 provides a consistent framework for addressing inequalities, ensuring that action is directed towards communities and groups experiencing the greatest disadvantage. This approach supports the Trust's wider quality objectives by reducing unwarranted variation and improving outcomes for people who are most at risk of poor health and poor experience.

Partnership working with voluntary, community and social enterprise organisations, local authorities, Integrated Care System partners and community groups is central to this approach. These partnerships enable the Trust to reach communities that may be less likely to engage with statutory services and to develop more holistic, preventative and community-based responses to need (i.e. COMPASS with Start Change, Resilience Workshops with Heads2Minds, Learning Arena with Sports for Confidence).

Assurance in relation to the Trust's population health approach is provided through reporting, with oversight from the Quality Committee and escalation to the Trust Board as required. This ensures that equality, health inequalities and population health remain visible and prioritised at the highest level of organisational governance.

Workforce and culture

The Trust recognises that delivering equitable, inclusive care depends on the knowledge, skills and behaviours of its workforce. Creating a culture that values equality, diversity and lived experience is essential to meeting the Public Sector Equality Duty in practice.

Learning from patient and carer experience, including feedback relating to discrimination, communication and cultural competence, informs workforce development activity. This includes training, reflective practice and leadership development, ensuring that staff are supported to deliver care that is respectful, compassionate and responsive to individual need.

The involvement of people with lived experience in workforce development activity (i.e. induction, Buddy scheme, Oliver MacGowan), including training and service improvement, recruitment (i.e. interview panels and recruitment policy change), strengthens understanding and supports cultural change. This approach reinforces the Trust's commitment to shared power, mutual learning and continuous improvement.

Workforce equality and experience data are monitored through established governance processes and contribute to the Trust's overall assurance framework. This ensures that issues relating to culture, inclusion and equality are addressed alongside clinical quality and safety.

Equality, data and intelligence

The Trust recognises that robust data and intelligence are essential to understanding inequality and demonstrating compliance with the Public Sector Equality Duty. Accurate, timely and meaningful information supports the identification of variation in access, experience and outcomes, and enables the Trust to target action where it is most needed.

Equality data is considered alongside patient experience, quality and safety information within the Trust's Quality of Care reporting framework. This includes analysis of protected characteristics like, ethnicity, age, gender, and disability and other relevant factors that may influence experience and outcomes. This approach reflects the Trust's Quality Account commitment to using intelligence to drive improvement and reduce unwarranted variation.

Learning from data is strengthened through triangulation with qualitative insight from patients, families and carers. Feedback gathered through complaints, PALS, surveys, co-production activity and lived experience forums is used to add depth and context to quantitative information. This ensures that assurance is based not only on performance indicators, but on an understanding of how care is experienced in practice.

Reports relating to equality and health inequalities are reviewed through the Quality Committee, which provides challenge and assurance on progress and areas of risk. The Quality Committee escalates key issues to the Trust Board through established reporting mechanisms, ensuring that equality remains a visible and accountable part of organisational governance.

Use of Equality and Health Inequality Impact Assessments

Equality and Health Inequality Impact Assessments are a core mechanism through which the Trust demonstrates due regard under the Public Sector Equality Duty. Their routine use ensures that equality considerations are embedded in service design, policy development and transformation activity.

EQUIAs are informed by population health data, patient and carer feedback, and lived experience insight. They are used to identify where proposed changes may disadvantage particular groups and to ensure that mitigating actions are built into plans from the outset. This approach supports safer, more inclusive service development and strengthens organisational accountability.

The quality and application of EQUIAs are monitored through governance processes, with assurance provided through the Quality Committee. This ensures that EQUIAs are used as meaningful tools for improving equity, rather than solely as compliance documentation.

Peer workforce and lived experience leadership

The Trust recognises the peer workforce as a key component of its approach to equality, inclusion and addressing inequity. Peer workers lived experience ambassadors and volunteers bring unique insight and understanding that supports more person-centred, culturally responsive and compassionate care.

The peer workforce contributes to all three elements of the Public Sector Equality Duty. It supports the identification of discrimination through lived experience insight, advances equality of opportunity by improving access and engagement, and fosters good relations by strengthening trust between services and communities.

The development and support of lived experience roles are overseen through the Patient Experience and Participation portfolio, ensuring that these roles are embedded within governance, supported appropriately and aligned with the Trust's quality objectives. Progress and impact are monitored through quality assurance arrangements and reported through the Quality Committee and the People Committee.

Modern Day Slavery

The Trust Modern Day Slavery Statement can be found on our website at:
<https://www.eput.nhs.uk/about/compliance-and-assurance/modern-day-slavery-statement/>

Social Impact Strategy

The Board approved a five-year Social Impact Strategy in September 2023. Delivery of this strategy continues to represent one of the main ways in which we fulfil our strategic ambition to help our communities thrive. Now in its third year of delivery, social impact has become further embedded across the Trust's enabling strategies, operational priorities, and emerging neighbourhood delivery model.

During 2025/26, delivery has continued with focus and impact despite a shifting strategic and financial context. Progress remains strong across Tier 1 and Tier 2 activity, with wider recognition across the system of EPUT's role as an anchor organisation. The Trust has strengthened its position as a community enabler, improving access to quality work, supporting inclusive economic participation, and collaborating with partners to address the wider determinants of health.

The Estates Strategy and the People & Education Strategy continue to position social impact as integral to how EPUT uses its buildings, workforce, and partnerships to support local communities. Work has also accelerated through the Trust's environmental sustainability programme, inclusive recruitment initiatives, and targeted pathways that help local people overcome barriers to employment.

In December 2025, following a full mid-point review of the Social Impact Strategy, the Board endorsed a refreshed governance model to evolve delivery for the remainder of the strategic period in a changing context. This updated approach embeds the Trust's social impact commitments within emerging neighbourhood and accountable care models across Essex, ensuring our contributions align closely with local priorities and inequalities.

Key changes include:

- **Neighbourhood-aligned delivery:** EPUT now contributes to social impact priorities identified within neighbourhood partnerships, with a stronger focus on community assets, VCSE collaboration, and addressing local drivers of health inequalities.
- **Streamlined internal structure:** Tier 1 and Tier 2 initiatives continue to be delivered through core services and existing enabling strategies, with clear reporting through the Strategic Impact framework.
- **System-first approach:** Wider determinants and population-level work are now delivered collaboratively with system partners, reducing duplication and increasing local reach.
- **Enhanced insight and measurement:** Work is underway to incorporate national NHS social value guidance and automate reporting, including exploring AI-enabled monitoring.

This model strengthens delivery by positioning EPUT where impact is greatest—within local communities and in collaboration with partners—while retaining focus on core areas where the Trust can most influence outcomes. The updated governance model provides a stable foundation for the next phase of delivery, ensuring EPUT remains a committed and effective anchor organisation for the communities it serves.

Overview of initiatives in planning or delivery

Tier	Examples of initiatives in planning or delivery
1: Enhancing the social impact of core business operations	Programme of inclusive recruitment events; continued review of recruitment documentation; embedding social value considerations within procurement; VCSE accommodation on Trust sites where feasible.
2: Medium-scale, locally focused projects (1–3 years)	Delivery of Multiply on inpatient wards and in prison settings (final phase completed 2025); Step Forward and HALO employability pathways; widening access to apprenticeships.
3: Longer-term, larger-scale ambitions (5-year horizon)	Ongoing development through neighbourhood and accountable care models; scoping of system-aligned community asset models and digital innovation to improve population health.

Delivery across the social impact pillars in 2025/26

- **Widening access to quality work:** The Trust continued its programme of inclusive, local recruitment events in partnership with colleges, Job Centres, and the HCA Academy. These events support people facing barriers to employment into roles within the NHS and help strengthen local talent pipelines.
- **Supporting local economic participation:** 89% of EPUT staff now live and work within the same county, reinforcing the Trust's role as an employer committed to local opportunities. Procurement with local suppliers reached 30% of total spend by mid-year.
- **Using estates as community assets:** Work progressed on reviewing community assets, utilisation, and partnership opportunities. The planned redevelopment of Bernard Ward at Clacton District Hospital will create a mental health wellbeing hub with VCSE co-location, supporting community access to early help services.
- **Environmental sustainability and reducing waste:** The Trust avoided over 81,000 kg of CO₂e emissions through waste reduction initiatives, expanded electric vehicle infrastructure, and continued delivery against its Net Zero commitments.
- **Working more closely with local partners:** Active participation in the national neighbourhood programme in North East and West Essex has strengthened collaboration across statutory and VCSE partners. This includes grassroots engagement and joint work on housing, employment pathways, and social determinants.

Case study: Step Forward – supporting vulnerable adults into meaningful work

The Step Forward programme has become an important part of EPUT's commitment to widening access to high-quality employment and addressing health inequalities through inclusive economic participation. Over the last eight months, **35 learners** have been supported across **eight cohorts**, many of whom faced significant and multiple barriers:

- 63% reported mental health challenges
- 57% declared a disability
- 46% lacked Level 2 qualifications.

The programme offers personalised support in Maths, English, employability skills, and broader life skills, underpinned by a trauma-informed approach and tailored reasonable adjustments. This "overcoming barriers" focus has enabled learners to progress into sustainable employment and education pathways.

Programme impact:

- **13 learners (37%)** have secured employment in health or social care roles
- **10 of these** moved into ICB-funded work placements with EPUT, NELFT, or a local provider (Forget-Me-Not Care)
- **3 learners** secured employment outside health/social care (primarily retail)
- One learner has been accepted onto **two nursing degree programmes** and secured employment as a Care Assistant

For learners not yet in work, referral into the HALO programme provides continuity of support beyond March 2026. Step Forward demonstrates how inclusive employment pathways can actively reduce inequalities and build local resilience.

Enable East

Since Enable East was established in 2010 the team have worked with a range of stakeholders and community partners to deliver large scale, grant funded programmes aimed at improving public wellbeing and the social determinants of health including education, social support and employment.

These programmes, including Step Forward, Multiply and HeadsUp, helped local people to gain new skills, improve their well-being and provided training to help them into work-based placements and employment.

Strengthening measurement and evidence of impact

The Trust continues to refine its approach to measuring the impact of social value activity. Work is underway to integrate "distance travelled" metrics with the UCL Partners "How Strong is Your Anchor?" model, ensuring impact is captured at both organisational and neighbourhood levels.

Strategic Objective 4 metrics show strong performance at mid-year, including high levels of local employment, sustained reductions in waste, and continued hosting of apprenticeships.

Consultation with local groups and organisations

Engaging with local Members of Parliament, relevant local authority committees and other key stakeholders continues to be a priority in our work to be a valuable partner in the health and care systems we work in. During the year, we consolidated our relationships with MPs across Essex, particularly those who were newly elected in 2024, providing briefings, updates and visits to our services. We issued four routine written updates to MPs, covering routine operational and strategic issues, the Lampard Inquiry and recent news stories from across the Trust. All MPs also continue to routinely receive copies of press releases when they are issued to the media. We held online briefings for MPs, including dedicated briefings on the Lampard Inquiry, as well as continuing to welcome several MPs on visits to our services, which our operational teams enjoy. These visits are a valuable opportunity to demonstrate the work of the Trust, to increase MPs' understanding of our services and any local issues and priorities and to deepen our relationships with them. MPs also contact the Trust with enquiries, concerns and complaints on behalf of their constituents, and we received and responded to around 150 such enquiries during the year.

We continued with our programme of routine attendance at and briefings for the health scrutiny committees and health and wellbeing boards of the three Essex upper tier local authorities – Essex County Council, Southend City Council and Thurrock Council – as well as responding to enquires from local councillors on a range of issues raised with them by local people.

Our routine written briefings for a range of stakeholders, including Healthwatch, local voluntary sector organisations, safeguarding boards, local NHS organisations, higher education institutions and other partners, continue to be well received, with four briefings being issued during the year. We also attended the AGM of the South Woodham Ferrers Health and Care Group with system partners and met with local councillors, residents and the local primary school in the neighbourhood around Brockfield House and The Lodge in Runwell



Financial Review

Overview

This part of the Performance Report provides commentary on the financial results and performance. The Trust's annual report and accounts cover the period of 1 April 2025 to 31 March 2026. Annual Accounts have been prepared in accordance with directions issued by NHS England (NHSE) under the National Health Service Act 2006. Accounts are also prepared in accordance with International Financial Reporting Standards (IFRS) and are designed to give a true and fair view of the Trust's financial activities.

Financial Performance

During the financial year the Trust agreed an adjusted breakeven plan (which performance is measured against) with NHSE. Against this target the Trust delivered an actual adjusted surplus of £93k after receiving £20.5m of deficit support funding.

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

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

Table 5: Summary of statement of comprehensive income

	2025/26 £000	2024/25 £000
Total Income	687,732	608,683
Operating Expenses	(677,234)	(637,044)
Finance Costs / Other Gains and Losses	(8,393)	(10,180)
Surplus / (Deficit) for the year from continuing operations	2,105	(38,541)
Exclude: I & E Impairments / (Reversals)	148	27,515
Exclude: IFRS to UK GAAP PFI accounting	(268)	(239)
Exclude: Local Government Pension Scheme	69	86
Exclude: I & E Impact from Donated / Peppercorn Assets	(1,961)	(1,293)
Impact of prior period adjustment	-	8,651
Adjusted Surplus / (Deficit) for the year ^{1,2}	93	(3,821)

¹ The 2025/26 adjusted surplus includes deficit support funding of £20.5m.

² The 2024/25 results include £14.1m of deficit support funding and the impact of the PPA of £8.651m

Income from healthcare activities

Total income from all sources was £687.7 million, of which income received from patient care activities totalled £657.3 million with other income of £30.4 million. Income is reported in line with the requirement of section 43 (2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

Section 43 (3A) of the NHS Act 2006 also requires NHS Foundation Trust's to provide information on the impact that other income it has received on the provision of the health service in England. The majority of other income relates to education and training income for our staff of £18.9 million. This has no impact on the provision of goods and services for the purposes of the health service in England.

Operating expenditure

The total operating expenditure was £677.2 million. The largest area of spend related to staff costs of £436.3 million (64%).

Efficiency

The Trust achieved savings of £30.1 million through a combination of both recurrent and non-recurrent measures.

Finance costs

The Trust is required to pay the Treasury dividends in respect of Public Dividend Capital (PDC). Dividends are determined at a rate set by Treasury (currently 3.5%) on the average relevant net assets of the Trust. Dividends are paid twice a year in September and March. Average relevant net assets are based on the opening and closing balances of the Statement of Financial Position, and therefore a debtor or creditor may exist at year end between the Trust and Treasury. For the 2025/26 financial year, the Trust paid dividends of £4.8 million, with a debtor balance of £0.3 million.

In addition, the Trust incurred finance costs in respect of PFI obligations for the Trust's properties at Rawreth Court, Clifton Lodge and Brockfield House. This included interest charges of £2.4 million and remeasurement of the lease liability from change in RPI / indexation of £1.3 million. The Trust also holds loans of £1.6 million with the Department of Health which incurred in-year interest costs of £39k.

The Trust also paid finance costs in respect of the right of use assets of £0.5 million during the year.

Local Government Pension Scheme (LGPS)

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

The operational cost, finance income, and finance costs of the scheme for 2025/26 have been reflected in the Trust's Statement of Comprehensive Income and reduced the Trust's adjusted deficit position by £69k. At the end of the year, the Trust is recording a net defined asset of £475k within the Trust's non-current assets.

Revaluation of investment property

In accordance with accounting guidelines, the Trust has undertaken an annual revaluation of its investment properties. There was no change to the resulting value of investment properties held in the Statement of Financial Position.

Impaired value of land and property

During 2025/26, the Trust instructed Montagu Evans LLP to undertake a desk-based interim valuation of the estate, including a right of use peppercorn asset and assets held for sale. This resulted in a net increase in land and buildings of £5.5 million and an increase in right of use assets of £0.7 million. The total increase of £6.2 million has been reflected in the Trust's Statement of Financial Position.

This net position includes a number of revaluations (increase in values) and impairments (reduction in values) which are chargeable to either the Statement of Comprehensive Income as part of operating expenses or taken to the Revaluation Reserve in the Statement of Financial Position. Any impairment reported within the Statement of Comprehensive Income is excluded as a technical item in the adjusted financial position against which the Trust is monitored and for the 2025/26 financial year totalled £148k.

Table 6: Summary of statement of financial position

	2025/26 £000	2024/25 £000
Non-Current Assets	303,536	281,337
Current Assets (excluding cash)	26,317	24,221
Cash and Cash Equivalents	45,263	28,077
Current Liabilities	(87,888)	(74,448)
Non-Current Liabilities	(81,063)	(80,805)
Total Assets Employed	206,165	178,380
Total Taxpayers Equity	206,165	178,380

Capital investment

During the year, the Trust invested £43.7 million on capital expenditure, of which £18.7 million was funded from Department of Health and Social Care Public Dividend Capital. This performance was consistent with forecast outturn expectations. The Trust continues to heavily invest to improve facilities, estates, digital infrastructure, and equipment requirements. Investments are prioritised on a risk-based approach with clinical and operational leadership driving these priorities. The total capital spend for the year included the following:

- £9.1m on Critical Infrastructure and Backlog Maintenance schemes across the estate including electrical works, asbestos removal, door and window replacements, fire safety works, roof replacements, and boiler replacements;
- £16m investment in leases including new leases for the Training, Clinical and Corporate hub, Bayman Ward, as well as the renegotiation of lease terms on Basildon Mental Health Unit;
- Construction is ongoing to complete the Mental Health Emergency Department Diversion Units at Derwent Centre and Kingswood Centre – at a total investment of £5.3m;
- Work continues on our Unified Electronic Patient Record project (EPR) £5.5m spend in year including the development of the system, hardware, and infrastructure replacement;
- £2.7m on ICT including shared records programme, Wi-Fi infrastructure, Windows 11 upgrade, business intelligence, and data platforms;
- Strategic Estate refurbishments in Landermere, Basildon MHU, CAMHS services and Ipswich Road totaling £2.8m;
- £1.3m on Medical Equipment replacement, including ECG and Vitals monitors to support standardisation and improved patient safety across the Trust;

- £1.0m on refurbishment of the Lakes ECT suite, to meet clinical accreditation requirements for the unit;
- £0.8m on sustainability schemes including solar panels at Linden Centre and Clough Road, with ongoing installation on the Rochford site.

Within non-current assets on the face of the Statement of Financial Position, the Trust now holds intangible assets, plus property, plant and equipment totaling £241.2 million as at the end of March 2026.

Right of use assets

In addition to property, plant, and equipment, a further £50.7 million of right of use assets are also held within non-current assets.

In line with other property, plant and equipment, the right of use assets are depreciated in-year which is charged to the Statement of Comprehensive Income within operating expenses. The Trust also incurred an interest charge on the lease liability of £0.5 million, which is charged as part of finance expenditure.

Investment property

The Trust also holds a number of investment properties within the classification of non-current assets totaling £11 million. These properties are leased out to various organisations including other NHS bodies, housing associations, and private individuals.

During the year, properties at Weymarks, Laindon were bought back into operational use and reclassified from investment properties to property on the face of the Statement of the Financial Position.

Assets held for sale

As at the end of the 2025/26 financial year, the Trust held four assets in preparation for disposal. Of these, three were reclassified from property to investment properties during the year at a total value of £2.6 million.

Non-current liabilities

In line with International Financial Reporting Standard (IFRS) 16 Leases, the liabilities held in respect of the PFI properties were remeasured during the year increasing by £1.3 million. The Trust's other leases which are supported by a right of use asset, were similarly remeasured and increased in value by £0.1 million.

Capital repayments against the PFI liability and lease liability for the year totalled £10.7 million.

Working capital and liquidity

The Trust has robust cash management and forecasting arrangements in place and is required to cash projections to NHSE on a monthly basis. The Trust also routinely reports cash position into its Finance and Performance Committee. This Committee was chaired by a Non-Executive Director and included further Non-Executive Directors and the Executive Chief Finance Officer. The Trust invests surplus cash on a day-to-day basis in line with the Operating Cash Management Policy and Procedure and has maximised interest generated from cash

management activities by placing longer term investments with the National Loans Fund (a government bank). During the year the Trust earned interest of £1.9 million.

Policy and payment of creditors

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

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

The Trust's performance on its creditor payments for the 2025/26 financial year is detailed below:

Table 7: Performance on creditor payments 2025/26

	NHS		Non-NHS		Total	
	Number of Invoices	Value £000	Number of Invoices	Value £000	Number of Invoices	Value £000
Invoices paid within 30 days	598	73,044	49,068	235,289	49,666	308,333
Invoices paid in excess of 30 days	253	18,505	7,758	24,450	8,011	42,955
Total invoices that were or should have been paid in 30 days	851	91,549	56,826	259,739	57,677	351,288
	70.3%	79.8%	86.3%	90.6%	86.1%	87.8%

The Trusts combined performance on payment of supplies is 86.1%.

During the year, the Trust incurred actual interest charges on the late payment of invoices of £343.

Taxpayers' equity

As at the end of 2025/26, the Trust holds Public Dividend Capital of £167 million including new PDC capital received during the year of £18.7 million to support capital investment.

Taxpayers equity also includes reserves for income and expenditure surpluses and deficits generated over the years, and from asset revaluations or impairments arising from the impact of the valuations of the Trusts estate. The total of these represents the level of taxpayers' equity in the Trust of £206.2 million.

Accounting policies

The Trust has detailed accounting policies which comply with the NHS Foundation Trust Annual Reporting Manual. These have been thoroughly reviewed by the Trust with policies shown on pages 167 to 190 of the 2025/26 annual accounts.

Cost allocation and charging requirements

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

NHS pensions and directors' remuneration

The accounting policy in relation to employee pension and retirement benefits and the remuneration report is set out on pages 80 to 96.

Charitable funds

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

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

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

The Board of Directors act as Corporate Trustee for the Charity and is further supported by the Charitable Funds Committee. The Committee consists of two Non-Executive Directors, (one of which is the Chair), the Executive Chief Finance Officer and Executive Director of Major Projects and Programmes. Due to materiality, the charity accounts are not consolidated into the Trust's main accounts for the 2025/26 financial year.

A copy of the charity's Annual Report and Accounts for 2025/26 will be available from January 2027 upon request to the Executive Chief Finance Officer.

Political donations

The Trust did not make, nor receive any political donations from or to its exchequer or charitable funds during 2025/26.

Financial risk management

The Trust's financial performance is assessed by NHS England, based on the NHS Oversight Framework.

The Trust has a robust risk management process into which any identified financial risks are included and monitored on a regular basis.



Paul Scott
Chief Executive Officer
24 June 2026

Accountability Report

Directors' Report

The Directors' Report comprises the details of the individuals undertaking the role of director during 2025/26 and the statutory disclosures required to be part of that report. It is presented in the name of the following directors who occupied positions during the year.

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

The main roles of the Board are to:

- Provide active leadership of the Trust within a framework of prudent and effective controls which enable risk to be assessed and managed.
- Set the Trust's strategic objectives, taking into consideration the views of the Council of Governors, ensure that financial resources and staff are in place for the Trust to meet its objectives and review management performance.
- Ensure the quality and safety of all healthcare services, education and training delivered by the Trust and to apply the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission and other relevant NHS bodies.
- Ensure compliance by the Trust with its provider license, its constitution, mandatory guidance issued by NHS England, relevant statutory requirements and contractual obligations, and regularly review the performance of the Trust in these areas against regulatory requirements and approved plans and objectives.

The Board of Directors has access to independent professional advice where it considers it necessary to discharge its responsibilities effectively. Arrangements are in place to enable Directors to obtain independent advice at the Trust's expense, subject to approval by the Chair.

These arrangements are communicated and covered to Directors on appointment as part of their induction, issue of governance documents (e.g. the Scheme of Reservation and Delegation) and ongoing governance support.

Requests for independent advice may be made by any Director and are considered on a case-by-case basis, ensuring that appropriate external expertise can be accessed to support decision-making. External advice is sought where additional specialist knowledge or independent assurance is required, including in relation to governance, audit, financial reporting, clinical quality, legal matters or other areas of complexity.

Non-Executive Directors



Hattie Llewelyn-Davies

Trust Chair

Appointed: 01 April 2025

Term of Office: Expires 31 March 2028

A voting member of the Board, Hattie has extensive experience as chair of a number of NHS organisations including Hertfordshire Partnership NHS Foundation Trust (HPFT), Buckinghamshire Healthcare NHS Trust and most recently The Princess Alexandra Hospital NHS Trust. She also sits on the steering group of the Disabled NHS Directors Network (DNDN).

Before joining the NHS, Hattie had a number of chief executive and senior management roles in the housing and homelessness sector and was awarded an OBE for services to homeless people in 2004. Hattie also chairs Eastlight Community Homes, a housing association based in Essex, and works with a wide range of housing organisations on governance, strategy and resident involvement.



Dr. Mateen Jiwani

Non-Executive Director and Senior Independent Director

Appointed: 31 December 2020

Term of Office: Expires 31 December 2026

A voting member of the Board, Mateen is a practicing GP in London and Essex. He previously worked as an Executive Medical Director with experience across regions in London and organisations including Barking, Havering and Redbridge University Hospitals NHS Trust and NHS Enfield Clinical Commissioning Group.

Mateen has a passion for technology and innovation, is a regular broadcaster on new and innovative healthcare approaches and sits on a number of boards in the private and public sector.



Diane Leacock

Non-Executive Director

Appointed: 04 December 2023

Term of Office: Expires 31 December 2026

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

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

Currently, Diane is a fractional Chief Financial Officer, working with

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

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



Loy Lobo

Non-Executive Director and Vice Chair

Appointed: 31 March 2021

Term of Office: Expires 31 March 2027

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

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

Loy has served on a number of high-profile government panels and academic collaborations to promote the adoption of technology and decision science in healthcare. He runs a health innovation company that applies design, digital, and decision science to transform healthcare. He serves on the Board of the North West London Acute Provider Collaborative with roles on the Trust Standing Committees for London North West University Healthcare NHS Trust and Imperial College Healthcare NHS Trust.



Elena Lokteva

Non-Executive Director

Appointed: 01 July 2023

Term of Office: Expires 23 May 2028

A voting member of the Board, Elena has more than 25 years of board level experience in executive and non-executive capacities. Her experience includes front line and board level volunteering at mental health charities. Originally working in the private equity sector, Elena has been a partner in a financial institution with responsibility for financial and legal affairs and has also worked as a restructuring CEO in portfolio companies.

Elena is currently a non-executive director at Moorfields Eye Hospital NHS Foundation Trust.

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



Dr Ruth Jackson
Non-Executive Director
Appointed: 12 February 2024
Term of Office: Expires 31 August 2027

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

Ruth returned to the NHS in 2020 as Executive Chief People Officer for Mid and South Essex Integrated Care Board, leading on workforce and educational strategy for the system.

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



Richard Spencer
Non-Executive Director
Appointed: 28 April 2025
Term of Office: Expires 28 April 2027

A voting member of the Board, Richard Spencer is a former BT director whose career in the UK and abroad spanned commercial business development, strategy, partnerships, corporate social responsibility, organisational culture and leadership development.

Since 2018, Richard has held a portfolio career, including serving as an advisor to Ofcom as a member of the Communications Consumer Panel and Advisory Committee for Older and Disabled People and as Senior Independent Director of East Suffolk and North Essex NHS Foundation Trust (ESNEFT). He was appointed a member of the Legal Services Consumer Panel in April 2026.

Richard has also been a trustee of two Colchester-based charities providing supported housing to homeless people, his current involvement focusing particularly on young adults who have found themselves in crisis.



Sarah Teather
Non-Executive Director
Appointed: 12 May 2025
Term of Office: Expires 12 May 2027

A voting member of the Board, Sarah Teather is a charity leader, experienced Board member and former government Minister. She served in Parliament for 12 years and was the Minister of State for Children and Families from 2010-2012.

Sarah is currently chief executive of a national children's charity that supports young people, families and schools to tackle bullying. She serves on the Board of Barts NHS Trust, where she chairs the Strategy and Partnerships Committee and is a Maternity Safety Champion for the Board.

Sarah's previous experience includes leading a refugee charity providing a range of services including legal advice and accommodation.

Sarah was appointed to the House of Lords as a life peer for the Liberal Democrats.



Doug Field
Associate Non-Executive Director
Appointment: 11 August 2025
Resigned: 31 January 2026

A non-voting member of the Board, Doug has more than 20 years' board-level experience leading complex organisations through transformation and growth, including 16 years modernising the East of England Co-op. A Chartered Accountant (FCA) with Big 4 training, he brings financial discipline and strong stakeholder leadership to regulated environments.

Doug also plays an active role in the community as a volunteer director with Green Light Trust and Suffolk Chamber of Commerce, and as a member of the Suffolk Business Board. He has previously chaired the New Anglia Local Enterprise Partnership.



Jenny Raine
Non-Executive Director (until October '24) and then Associate Non-Executive Director (from October '24)
Appointment: 02 January 2024
Term of Office: Expired 31 May 2025

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

Jenny is now the Bursar at Corpus Christi College Cambridge and sits on

the Joint Wellbeing Committee for the collegiate University, which oversees the implementation of the recently agreed Mental Health Strategy.

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

Executive Directors



Paul Scott
Chief Executive Officer
Appointment: September 2020

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

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

Paul represents mental health and community services at the former Mid and South Essex Integrated Care Board and now at Essex Integrated Care Board.



Alex Green
Deputy Chief Executive and Executive Chief Operating Officer
Appointed: December 2020

A voting member of the Board, Alex Green's portfolio of services includes mental health services, community physical health and learning disabilities across the Trust.

Alex was previously Director of Health and Care Delivery for West Essex at EPUT and Essex County Council. She has a wealth of experience, having worked in health and social care for more than 25 years, originally qualifying as an occupational therapist.

Alex represented EPUT on the former Hertfordshire and West Essex Integrated Care Partnership.



Dr. Milind Karale
Executive Medical Director to 1 December 2025
Appointed: August 2017

A voting member of the Board, Dr Karale is a Consultant Psychiatrist who has worked in many different mental health settings across services at EPUT and its predecessor organisations. Dr Karale served as Executive Medical Director and Caldicott Guardian from August 2017 to December 2025.

Dr Karale is a Fellow of the Royal College of Psychiatrists and has a Postgraduate Diploma in Clinical Forensic Psychiatry (merit) from the Institute of Psychiatry at King's College London.



Nigel Leonard
Executive Director of Major Projects and Programmes until 31 July 2025
Appointed: August 2017

A voting member of the Board, Nigel Leonard has worked in the NHS for over 30 years in a variety of planning, governance and project management roles in acute, community and mental health organisations. He served on the Board of EPUT from August 2017 to July 2025. He has worked as a Programme Director delivering changes in mental health services in Essex and led the roll out of the Covid-19 Vaccination Programme across the Mid & South Essex and Suffolk & North East Essex Clinical Commissioning Groups.

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



Andrew McMenemy
Executive Chief People Officer
Appointed: May 2024

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

Andrew is passionate about developing inclusion, well-being and staff development in the NHS. His portfolio includes human resources, organisational development, payroll, medical staffing, training and development, workforce planning and equality and diversity.



Ann Sheridan
Executive Chief Nurse
Appointed: 09 February 2024

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

Ann joined EPUT in 2023 from Central and North West London NHS Foundation Trust where she was Managing Director of Divisional Mental Health Services.



Trevor Smith
Deputy Chief Executive and Executive Chief Finance and Resources Officer
Appointed: September 2020

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

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

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



Denver Greenhalgh
Executive Director of Governance
Appointed: February 2022

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

Her first leadership role was as a District Chief Podiatrist in 2002, since when she has worked in operational management and leadership roles in both community and hospital based services. Denver has an MSc in Integrated Healthcare Governance and has been a Director of Governance for the past 10 years. Prior to joining EPUT, she was Director of Governance at East Suffolk and North Essex NHS Foundation Trust.



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

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

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

Prior to joining EPUT, Zephan was Director of Strategy Transformation for NHS England's East of England region where his responsibilities included the regional mental health programme, the regional learning disability and autism programme, Integrated Care System development and strategic change.



Dr Kallur Suresh
Executive Chief Medical Officer

Appointed: 01 December 2025 (interim); 1 February 2026 (substantive)

A voting member of the Board, Dr Kallur Suresh is EPUT's Executive Chief Medical Officer and Caldicott Guardian. He is a Consultant Psychiatrist for Older Adults and has worked in Essex for many years, holding various medical leadership roles, most recently Deputy Medical Director for the Trust's West Essex Care Unit.

Dr Suresh has worked for the Royal College of Psychiatrists as Chair of the Eastern Division and is co-leading on an International Diploma in Older Adults' Mental Health. During his MSc in Leadership in Quality Improvement, he has worked on self-management in dementia patients and their carers.

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

Responsibilities of directors for preparing the Annual Report and Accounts

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

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

- Apply on a consistent basis, for all items considered material in relation to the accounts, accounting policies contained in the NHS Foundation Trust Annual Reporting Manual issued by NHS England
- Make judgements and estimates which are reasonable and prudent, and ensure the application of all relevant accounting standards and adherence to UK generally accepted accounting practice for companies, to the extent that they are meaningful and appropriate to the NHS, subject to any material departures being disclosed and explained in the accounts

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

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

The Directors are required to confirm that:

- As far as they are aware, there is no relevant information of which the Trust's auditor is unaware
- They have taken all steps they ought to have taken as a Director in order to make themselves aware of any such information and to establish that the auditor is aware of that information.

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

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

NHS England's Well Led Framework

The Well-led Framework distils the favourable characteristics required to ensure the provision of quality services. We continue to use the accountability framework as an executive management system to oversee performance and gain assurance in an integrated, consistent and transparent way of our operational service directorates. The framework covers five domains:

- Quality and safety
- Operational performance
- Workforce and culture
- Finance
- Strategy, Transformation and External Relations.

The culture at EPUT will influence how we deliver quality and safe clinical services supported by an effective infrastructure of support services. It is therefore recognised that the development of leaders will influence the culture and support an environment that allows staff to meet the Trust values.

Following the independent well-led development review conducted in 2024, we have continued to focus on culture across the organisation.

In particular, the Trust developed a dedicated function that supported organisational development and culture. This includes supporting effective recognition and well-being of our staff as well as enhancing the equality, diversity and inclusion agenda. However, the foundation for significant and sustained change of culture will be achieved through our new framework for leadership development.

In order to fully appreciate the culture and inform the leadership develop offer the Trust commissioned an independent cultural review. This was led by BRAP/Kings Fund in partnership with the Organisation Development & Culture team.

In addition to supporting the wellbeing of our staff through compassionate leadership, we continue to focus on accountability listening to and supporting our teams through the Accountability Framework meetings with Care Units and Corporate Service Directorates. Throughout 2025/26 we continued to mature this approach, including the continued development of data to inform performance management.

We have continued to ensure leadership visibility across the services providing a clear feedback loop to staff. And, put in place clarity on roles and responsibilities for quality, workforce and operational duties within care units (further embedding the leadership triumvirate).

We have also continued to provide the RISE programme and will have a new middle managers training programme delivered 2026/27.

The CQC have also completed a well-led review of the Trust in March 2026 and feedback is now awaited.

NHS Oversight Framework

NHS England's *NHS Oversight Framework 2025/26* is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to one of five 'segments'.

Segmentation indicates performance and whether improvement is required, from high-performance across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4, combined with a low capability to improve is allocated segment 5.

NHS England's oversight response to an organisation is based on:

- a) Its segment derived from scored metrics under five performance domains (being access to services, effectiveness of care, patient safety, people and workforce, and finance and productivity).
- b) Considering financial override which may limit a segment to be no better than 3.
- c) Contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality) and
- d) Capability assessments which consider the organisation's leadership and governance.

The Trust is currently placed in Segment 3 of the mental health and community trusts league table as at Quarter 4 2025/26. The Trust scored well in areas such as patient safety, patient experience, waiting times for community services, length of stay and relative differences in costs. The Trust scored less well in urgent community response, the annual change in children and young people accessing services and finance, with deficit support funding withheld in Q3 although now received in Q4.

The key drivers for the Trust for improvement include strengthening our operational and financial performance, reducing waiting times in community and mental health pathways, improving flow and capacity management, delivering against our agreed recovery trajectories, and continuing to improve quality standards. This is line with our operational plan and longer-term strategies. We will continue to engage constructively with our system partners and NHS England to address these priorities and work towards earning greater autonomy as our performance improves.

This segmentation information is the Trust's position as at Quarter 3 2025/26. Current segmentation for NHS trusts and foundation trusts is published on the NHS England website : <https://www.england.nhs.uk/nhs-oversight-framework/segmentation-and-league-tables/>. The trust is included on the mental health and community health dashboard.

Code of Governance for NHS provider trusts

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

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

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

For the period 1 April 2025 to 31 March 2026, the Trust was compliant with all provisions of the Code of Governance. "For the period 1 April 2025 to 31 March 2026, the Trust was compliant with all provisions of the Code of Governance."

Remuneration Report

Annual Statement on Remuneration

Executive directors (including the Chief Executive Officer)

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

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

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

The Trust follows the NHS England guidance of pay for very senior managers (VSMs) pay framework issued in May 2025, prior to this the Trust followed the guidance issued March 2018.

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

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

Non-executive directors (including the Chair)

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

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

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

in the Trust, the performance of the Trust, and the time commitment and responsibilities of the non-executive directors and Chair, as well as succession planning requirements.

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

Decisions made during 2025/26

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

- Approval of the quarterly contractual due payment for the Chief Executive Officer for Quarter 4 2024/25 and subsequent agreement for the payment to be consolidated into the overall salary.
- Approval of the Senior Director of Governance role to be aligned to Executive Officer status following the stepping-down of the Executive Director of Major Projects and Programmes.
- Approval of the 3.25% salary uplift for Very Senior Managers (VSM), including Executive Directors.
- Approval of the Mutually Agreed Redundancy (MARS) application for the Executive Director of Major Projects and Programmes and Executive Medical Director.

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

- Approval of Non-Executive Director objectives for 2025/26.
- Approval of the Non-Executive Director appraisal process to be undertaken for 2025/26.



Loy Lobo
Acting Trust Chair
24 June 2026

Senior Managers' Remuneration Policy

Remuneration package components

The executive directors' (including the Chief Executive Officer) remuneration package consists of salary and the entitlement to NHS pension benefits or a Retention Bonus Scheme should they have reached their lifetime allowance and opted to withdraw from the NHS Pension Scheme. Executive directors pay is inclusive of other payments such as overtime, long hours, on-call and stand by payments which do not feature in executive directors' remuneration.

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

Remuneration package

Each executive director's salary is a 'spot' salary within an agreed remuneration framework. The salary levels are set to attract and retain appropriately skilled executives. In 2025/26, the Trust employed five executive directors on Very Senior Manager (VSM) terms and conditions who are paid more than £170,000.

In 2025/26, the Trust applied a 3.25 per cent salary increase to executive director salaries in line with the NHS England 2025/26 annual pay increase recommendation for Very Senior Managers (VSMs).

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

The Trust follows the NHS England guidance on pay for Very Senior Managers (VSMs) pay Framework issued in May 2025 which replaced previous guidance issued in March 2018. Thus, for any new appointments above the threshold of £170,000 per annum, the provisions within that guidance have been enacted.

Executive director contracts stipulate that if monies are owed to the Trust, the post-holder will agree to repay them by salary deduction or by any other method acceptable to the Trust. The Trust may withhold payment in circumstances of unauthorised absence. This policy applies to all executive directors. For the 2025/26 financial year, there are no instances of monies owed to or by the Trust in respect of executive directors.

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

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

- Salary - The Trust appoints executive directors on a range of spot salaries within an agreed remuneration framework, i.e. salaries with no incremental progression.
- Notice period - Executive directors are expected to give six months' notice of termination of employment. This is in recognition of the need to have sufficient time to recruit a replacement or alternatively to appoint to a different post.

Pay review - the Board of Directors Remuneration Committee determines whether or not to award cost of living pay awards to executive directors.

Non-executive directors (including the Chair)

The remuneration policy for the Trust's Non-executive directors is to ensure remuneration is consistent with market rates for equivalent roles in Foundation Trusts of comparable size and complexity. The policy takes into account the *Structure to align remuneration for chairs and non-executive directors of NHS trusts and foundation trusts* published by NHS England in November 2019, whilst maintaining the ability for governors to set the remuneration levels of the Chair and non-executive directors. The remuneration levels take into account the pay and employment conditions of staff in the Trust, the performance of the Trust and the time commitment and responsibilities of non-executive Directors and Chair, as well as the skills, knowledge and experience required of the Board to meet business needs and succession planning.

Service contract obligations

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

Policy on payment for loss of office

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

Executive directors are covered by the same policy in terms of conduct and capability as other Trust staff. If found to have engaged in gross misconduct or committed any act or omission which breaches the trust and confidence of the Trust, they can be summarily dismissed, i.e. their contract would be terminated without notice and/or compensation. In cases of termination due to organisational change, Executive Directors are covered by the national Agenda for Change arrangements for redundancy for NHS staff. This states that one month's pay will be provided for each complete year of reckonable service in the NHS without a break of 12 months or more. Limits are set on this payment. A month's pay for this purpose is subject to a total

annual earnings floor of £23,000 and a cap of £80,000. The payment cannot exceed a maximum of 24 months' pay.

Statement of consideration of employment conditions elsewhere in the Trust

The Trust's Board of Directors Remuneration and Nominations Committee carries out an annual review of pay and terms and conditions for executive directors. This includes having regard to salary and the remuneration package as a whole. Salary levels are set taking into account the need to recruit and retain able directors and balancing that against a proper regard for use of public funds. In setting salary levels, the Remuneration Committee satisfies itself that the salary is competitive with other NHS providers of a similar constitution. The Remuneration and Nominations Committee will also review the pay progression framework in light of the current and emerging economic environment. There is no performance based progression in place in the Trust, although performance is managed by a robust appraisal and supervision framework. Executive directors are subject to capability arrangements including annual appraisal and 360 degree appraisal feedback.

Annual report on remuneration

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

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

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

Board of Directors Remuneration and Nominations Committee

Membership of the Committee wholly comprises non-executive directors who are viewed as independent, having no financial interest in matters to be decided. The Committee is chaired by the Trust Chair. The Chief Executive Officer will attend meetings of the Committee if invited to do so by the Chair of the Committee but may not receive any papers in relation to or be present when their remuneration or conditions of service are considered. The Executive Chief People Officer will normally attend the meetings in an advisory capacity as required, depending on the agenda items to be discussed. The Senior Director of Corporate Governance (or their deputy) is the Committee Secretary. The Committee may commission independent professional advice if considered necessary. No consultants were commissioned during 2024/25 in respect of remuneration business.

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

The Committee meets when necessary but at least annually.

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

Table 8: Board of Directors Remuneration and Nominations Committee Membership and Meeting Attendance 2025/26

Name	Role	Meetings Attended (actual/possible)
Hattie Llewelyn-Davies	Chair	5/5
Dr Ruth Jackson	Non-Executive Director	3/5
Dr Mateen Jiwani	Non-Executive Director	5/5
Diane Leacock	Non-Executive Director	3/5
Loy Lobo	Non-Executive Director	4/5
Elena Lokteva	Non-Executive Director	4/5
Richard Spencer	Non-Executive Director	2/4
Sarah Teather	Non-Executive Director	2/4

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

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

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

- Approval of the Executive Chief Medical Officer appointment.
- Approval of interim changes to the portfolio of the Executive Director of Strategy and Transformation to support the implementation of the NOVA electronic patient record programme.

Council of Governors Remuneration Committee

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

In addition, the Committee leads on the process to receive assurance on the performance evaluation of the Chair, working with the Senior Independent Director, and Non-Executive Directors, working with the Chair. The Council of Governors agreed at its meeting on the 8 October 2025 to merge the Remuneration and Nominations Committee.

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

No consultants were commissioned during 2025/26. At the invitation of the Committee, the Executive Chief People Officer and Senior Director of Corporate Governance will attend the meeting in an advisory capacity.

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

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

Table 9: Council of Governors Remuneration and Nominations Committee Membership and Meeting Attendance

Name	Role	Meetings Attended (actual/possible)
Hattie Llewelyn-Davies	Chair	2/2
Stuart Scrivener	Lead Governor	2/2
John Jones	Lead Governor	1/1
Zisan Abedin	Staff Governor	1/1
David Finn	Public Governor	1/2
Paula Grayson	Public Governor	1/1
Pam Madison	Public Governor	1/1
James McCarthy	Public Governor	2/2
Helen Semoh	Staff Governor	0/2

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

- Received assurance that the end of year appraisal process for Non-Executive Directors for 2024/25 had been satisfactorily completed in line with the performance review process agreed by the Council of Governors.
- Received assurance that appropriate objectives for 2025/2026 for the Chair and non-executive directors were in place.

Table 10: Service contracts: Executive directors

Name	Role	Contract Start Date at Predecessor Trusts	Interim Board Contract Start Date	Substantive Board Contract Start Date
Paul Scott	Chief Executive Officer	n/a	n/a	24-Aug-20
Alex Green	Deputy Chief Executive Officer & Executive Chief Operating Officer	n/a	n/a	10-Dec-20
Denver Greenhalgh	Executive Director of Corporate Governance	n/a	n/a	14-Feb-22
Dr Milind Karale (until 15/03/2026)	Executive Medical Director	30-Jul-12	01-Apr-17	25-Aug-17
Dr Kallur Suresh	Executive Medical Officer	N/a	01-Dec-25	16-Mar-26
Nigel Leonard (Until 18/01/2026)	Executive Director of Major Projects and Programmes	01-Feb-14	01-Apr-17	25-Aug-17
Andrew McMenemy	Executive Chief People Officer	n/a	n/a	13-May-24
Ann Sheridan	Executive Nurse	n/a	n/a	09-Feb-24
Trevor Smith	Deputy Chief Executive Officer & Executive Director of Finance and Resources	n/a	n/a	18-Sep-20
Zephan Trent	Executive Director Strategy, Transformation and Digital	n/a	n/a	01-Apr-22

Table 11: Service contracts: Non-executive directors

Name	Role	**Period of Office	Contract Start date at Predecessor Trusts	Start Date	End Date
Hattie Llewelyn-Davies	Chair	3 years	n/a	01-Apr-25	01-Apr-27
Loy Lobo	Deputy Chair from 01-Mar-24	6 years	n/a	31-Mar-21	31-Mar-27
Dr Mateen Jiwani	NED	6 years	n/a	18-Jan-21	18-Jan-27
Jenny Raine	NED	3 years	n/a	02-Jan-24	31-May-25
Diane Leacock	NED	3 years	n/a	04-Dec-23	04-Dec-26
Elena Lokteva	NED	5 years	n/a	20-Feb-23	23-May-28
Ruth Jackson	NED	3 years	n/a	12-Feb-24	01-Aug-27
Douglas Field	Associate NED	6 years	n/a	11-Aug-25	31-Jan-26
Richard Spencer	NED	3 years	n/a	28-Apr-25	28-Apr-28
Sarah Teather	NED	3 years	n/a	12-May-25	12-May-28

Table 12: Non-executive directors' remuneration

Name	Role	Remuneration	Working Days	Additional Fees
		£0		£0
Hattie Llewelyn-Davies	Chair	51-55	11 per month	Nil
Loy Lobo	Deputy Chair	15-20	4.5 per month	Nil
Dr Mateen Jiwani	NED	15-20	4 per month	Nil
Jenny Raine	NED	15-20	4 per month	Nil
Diane Leacock	NED	15-20	4 per month	Nil
Elena Lokteva	NED	15-20	4.5 per month	Nil
Ruth Jackson	NED	15-20	4 per month	Nil
Douglas Field	Associate NED	5-10	2 per month	Nil
Richard Spencer	NED	15-20	4.5 per month	Nil
Sarah Teather	NED	15-20	4.5 per month	Nil

Executive and non-executive directors' expenses

Total Executive and Non-Executive Directors expenses incurred by the Trust during 2025/26 totalled £17,086 and were claimed by 17 Directors in post during the year (2024/25: £10,879 claimed by 16 Directors).

Table 13: Senior Managers Pay (Subject to audit)

		2025/26							
		Salary1	Other Remuneration2	All Taxable Benefits3	Annual Performance Related Bonus4	Long Term Performance Related Bonuses	All Pension Related Benefits5	Exit Package6	Total
		£000	£000	£	£000	£000	£000	£000	£000
Paul Scott	Chief Executive	225 - 230	0	700	0 - 0	0	122.5 - 125.0	0	350 - 355
Alexandra Green	Deputy Chief Executive and Executive Chief Operating Officer	175 - 180	0	0	0	0	52.5 - 55.0	0	225 - 230
Trevor Smith	Deputy Chief Executive and Executive Chief Finance and Resources Officer	180 - 185	0	0	0	0	75.0 - 77.5	0	255 - 260
Dr Milind Karale	Executive Chief Medical Officer (up to and including 14/12/2025)	160 - 165	10 - 15	500	0	0	67.5 - 70.0	80	325 - 330
Dr Kallur Suresh	Executive Chief Medical Officer (from 01/12/2025)	80 - 85	10 - 15	500	0	0	42.5 - 45.0	0	135 - 140
Nigel Leonard	Executive Director of Major Projects & Programmes (up to and including 17/07/2025)	55 - 60	0	0	0	0	0	80	135 - 140
Ann Sheridan	Executive Nurse	160 - 165	0	0	0	0	92.5 - 95.0	0	255 - 260
Zephan Trent⁷	Executive Director of Strategy, Transformation & Digital (from 01/09/24, shared post with MSEFT 50:50)	85 - 90	0	0	0	0	20.0 - 22.5	0	110 - 115
Andrew McMenemy	Executive Chief People Officer	160 - 165	0	0	0	0	52.5 - 55.0	0	215 - 220
Denver Greenhalgh	Executive Director of Corporate Governance	165 - 170	0	0	0	0	52.5 - 55.0	0	220 - 225
Hattie Llewelyn-Davies	Chair (from 01/04/2025)	50 - 55	0	0	0	0	0	0	50 - 55
Loy Lobo	Deputy Chair	15 - 20	0	0	0	0	0	0	15 - 20
Diane Leacock	Non-Executive Director	15 - 20	0	0	0	0	0	0	15 - 20
Dr Mateen Jiwani	Non-Executive Director	15 - 20	0	0	0	0	0	0	15 - 20
Dr Ruth Jackson	Non-Executive Director	15 - 20	0	0	0	0	0	0	15 - 20
Elena Lokteva	Non-Executive Director	15 - 20	0	0	0	0	0	0	15 - 20
Richard Spencer	Non-Executive Director (from 28/04/2025)	10 - 15	0	0	0	0	0	0	10 - 15
Sarah Teather	Non-Executive Director (from 12/5/2025)	10 - 15	0	0	0	0	0	0	10 - 15
Douglas Field	Non-Executive Director (from 11/08/2025 until 31/01/2026)	0 - 5	0	100	0	0	0	0	0 - 5
Jenny Raine	Associate Non-Executive Director (until 31/05/2025)	0 - 5	0	0	0	0	0	0	0 - 5

Table 14: Comparative table showing salary and allowances of senior managers

		2024/25							
		Salary1 £000	Other Remuneration2 £000	All Taxable Benefits3 £	Annual Performance Related Bonus4 £000	Long Term Performance Related Bonuses £000	All Pension Related Benefits5 £000	Exit Package6 £000	Total £000
Paul Scott	Chief Executive	210 - 215	0	700	10 - 15	0	62.5 - 65.0	0	285 - 290
Alexandra Green	Executive Chief Operating Officer	170 - 175	0	0	0	0	45.0 - 47.5	0	220 - 225
Trevor Smith	Executive Chief Finance Officer	175 - 180	0	0	0	0	15.0 - 17.5	0	190 - 195
Dr Milind Karale	Executive Medical Director	230 - 235	20 - 25	900	0	0	180.0 - 182.5	0	430 - 435
Nigel Leonard	Executive Director of Major Projects & Programmes	185 - 190	0	0	0	0	0.0	0	185 - 190
Ann Sheridan	Executive Director of Nursing	145 - 150	0	0	0	0	62.5 - 65.0	0	210 - 215
Zephan Trent	Executive Director of Strategy, Transformation & Digital (from 01/09/24, shared post with MSEFT 50:50)	120 - 125	0	0	0	0	40.0 - 42.5	0	160 - 165
Marcus Riddell	Acting Executive Director of People & Culture (until 12/05/2024)	15 - 20	0	0	0	0	22.5 - 25.0	0	35 - 40
Andrew McMenemy	Executive Director of People & Culture (from 13/05/2024)	135 - 140	0	0	0	0	185.0 - 187.5	0	325 - 330
Denver Greenhalgh	Senior Director of Governance & Corporate Affairs	145 - 150	0	0	0	0	12.5 - 15.0	0	160 - 165
Professor Sheila Salmon	Chair (until 31/03/2025)	50 - 55	0	0	0	0	0.0	0	50 - 55
Loy Lobo	Vice Chair	15 - 20	0	0	0	0	0.0	0	15 - 20
Diane Leacock	Non-Executive Director	15 - 20	0	0	0	0	0.0	0	15 - 20
Dr Mateen Jiwani	Non-Executive Director	15 - 20	0	0	0	0	0.0	0	15 - 20
Dr Ruth Jackson	Non-Executive Director	10 - 15	0	0	0	0	0.0	0	10 - 15
Elena Lokteva	Non-Executive Director	15 - 20	0	0	0	0	0.0	0	15 - 20
Jenny Raine	Associate Non-Executive Director	5 - 10	0	100	0	0	0.0	0	10 - 15
Rufus Helm	Non-Executive Director (until 01/08/2024)	5 - 10	0	0	0	0	0.0	0	5 - 10

Note 1 - Due to the demands and challenges placed on the NHS many staff, although encouraged to do so, were unable to take their full annual leave entitlement. The Trust made the decision to give staff the opportunity to sell some of their annual leave, which one Executive Director opted to do so (2024/25: two Directors). This has increased their salary in excess of the agreed pay award.

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

Note 3 – Taxable expenses relate to home to base mileage.

Note 4 - When appointed in August 2020, the externally agreed salary package for the Chief Executive contained a contractual non-pensionable quarterly element of £2,500 dependent upon successful delivery against objectives, as determined by review undertaken by the Board of Directors Remuneration and Nominations Committee. During 2025/26, one payment was approved in respect of quarter 4 2024/25, which will be paid during 2026/27.

Note 5 - The value of pension benefits accrued during the year (column entitled 'all pension related benefits' in the Senior Manager Pay Table above), is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

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

Note 6 – During the year the Trust launched a Mutually Agreed Resignation Scheme (MARS) with two Directors receiving exit payments of £80k.

Note 7 – The post of Executive Director of Strategy, Transformation and Digital is a shared post with 50% being charged to Mid and South Essex NHS Foundation Trust (MSEFT). The equivalent full time banded salary is £175,000 to £180,000.

Total pension entitlement

Table 15: Total pension entitlement (subject to audit) 2025/26

		2025/26						
		Real increase in pension at pension age £000	Real increase in lump sum at pension age £000	Total accrued pension at 31 March 2026 £000	Lump sum at pension age related to accrued pension at 31 March 2026 £000	Cash equivalent transfer value at 31 March 2025 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31 March 2026 £000
Paul Scott	Chief Executive	5.0 - 7.5	7.5 - 10.0	65 - 70	175 - 180	1,378	131	1,554
Alexandra Green	Deputy Chief Executive and Executive Chief Operating Officer	2.5 - 5.0	0.0 - 0.0	35 - 37.5	0 - 0	522	48	600
Trevor Smith	Deputy Chief Executive and Executive Chief Finance and Resources Officer	2.5 - 5.0	2.5 - 5.0	90 - 95	240 - 242.5	2,141	102	2,302
Dr Milind Karale	Executive Chief Medical Officer (up to and including 14/12/2025)	2.5 - 5.0	2.5 - 5.0	80 - 82.5	190 - 195	1,748	81	1,920
Dr Kallur Suresh	Executive Chief Medical Officer (from 01/12/2025)	0.0 - 2.5	2.5 - 5.0	75 - 77.5	185 - 187.5	1,617	51	1,822
Ann Sheridan	Executive Nurse	5.0 - 7.5	0.0 - 0.0	40 - 45	0 - 0	639	87	756
Zephan Trent	Executive Director of Strategy, Transformation & Digital	0.0 - 2.5	0.0 - 0.0	10 - 15	0 - 0	108	9	148
Andrew McMenemy	Executive Chief People Officer	2.5 - 5.0	2.5 - 5.0	60 - 62.5	145 - 150	1,215	58	1,313
Denver Greenhalgh	Executive Director of Corporate Governance	2.5 - 5.0	2.5 - 5.0	65 - 67.5	170 - 172.5	1,424	72	1,530

Table 16: Comparative table showing total pension entitlement 2024/25

		2024/25						
		Real increase in pension age	Real increase in lump sum at pension age	Total accrued pension at pension age at 31 March 2025	Lump sum at pension age related to accrued pension at 31 March 2025	Cash equivalent transfer value at 31 March 2024	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2025
		£000	£000	£000	£000	£000	£000	£000
Paul Scott*	Chief Executive	2.5 - 5.0	5.0 - 7.5	60 - 65	165 - 170	1,212	76	1,378
Alexandra Green	Executive Chief Operating Officer	2.5 - 5.0	0	30 - 35	0	431	41	522
Trevor Smith	Executive Chief Finance Officer	0.0 - 2.5	0	85 - 90	230 - 235	1,955	34	2,141
Dr Milind Karale	Executive Medical Director	7.5 - 10.0	15.0 - 17.5	70 - 75	185 - 190	1,423	201	1,748
Ann Sheridan	Executive Director of Nursing	2.5 - 5.0	0	35 - 40	0	526	58	639
Zephan Trent	Executive Director of Strategy, Transformation & Digital	0.0 - 2.5	0	5 - 10	0	67	6	108
Marcus Riddell	Acting Executive Director of People & Culture (until 12/05/2024)	0.0 - 2.5	0	10 - 15	0	134	0	160
Andrew McMenemy	Executive Director of People & Culture (from 13/05/2024)	7.5 - 10.0	15.0 - 17.5	55 - 60	140 - 145	947	163	1,215
Denver Greenhalgh	Senior Director of Governance & Corporate Affairs	0.0 - 2.5	0	60 - 65	160 - 165	1,294	20	1,424

Information for some Directors is excluded from the Total Pension Entitlement tables due to Directors choosing not to be covered by the pension arrangements during the reporting years.

* Prior year figures for the cash equivalent transfer value as at 31 March 2025 have been revised by NHS Business Services Authority for the Chief Executive Officer only. Prior year figures have therefore been restated.

Fair pay multiple (subject to audit)

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

The banded remuneration of the highest paid Director in the Trust in the financial year 2025/26 was £270,000 to £275,000 (2024/25: £250,000 to £255,000). This is an increase between years of 7.9% (2024/25: 10.4% increase). This increase includes impact of national pay award and change in postholder during the year.

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

For employees of the Trust as a whole, the range of annualised full-time remuneration in 2025/26 was from £15,835 to £430,192 (2024/25: £4,000 to £315,000). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is an increase of 4.9% including impact of national pay awards (2024/25: 9.9% increase). 12 employees (of which 11 are agency staff) have calculated remuneration in excess of the highest-paid director in 2025/26 (2024/25: 11 employees of which 9 are agency).

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

Table 17: 2025/26 Pay Ratio

	25 th Percentile	Median	75 th Percentile
Salary component of pay	£26,598	£33,487	£47,810
Total pay and benefits excluding pension benefits	£26,598	£34,347	£47,928
Pay and benefits excluding pension: pay ratio for highest paid Director	10:1	8:1	6:1

Table 18: 2024/25 Pay Ratio*

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

** prior year figures included Non-Executive Directors now excluded for 2025/26 as per NHS Foundation Trust Annual Reporting Manual.*

Loss of office payments (subject to audit)

During the year, two Executive Directors received a payment for loss of office under a Mutually Agreed Resignation Scheme (MARS) that was open to all eligible non-clinical staff across the Trust.

MARS is a form of voluntary severance payment, designed to enable individual employees, in agreement with their employer, to choose to leave their employment voluntarily in return for a severance payment.

Severance payments are calculated based on length of NHS service capped at 12 months salary, with a minimum of 3 months salary for those who have between 1 and 6 years of service. A salary cap of £80k also applies.

Both Executive Directors received a total payment of £80k based on capped arrangements. No other termination payments were made.

The payments made to the two Executive Directors are detailed in table 90.



Paul Scott
Chief Executive Officer
24 June 2026

Staff Report

Staff Costs (Subject to audit)

During 2025/26, the Trust incurred total staffing costs of £438.8 million which can be analysed as follows between permanent staff and other staff:

Table 19: Staff costs 2025/26

	Permanent Staff £000	Other Staff £000	Total Staff £000
Salaries and Wages	320,397	4,301	320,397
Social Security Costs	41,964	-	41,964
Apprenticeship Levy	1,576	-	1,576
Pension Cost (employer contributions to NHS Pension Scheme)	36,824	-	36,824
Pension Cost (employer contributions paid by NHSE on provider's behalf at 9.4%)	24,140	-	24,140
Termination Benefits	1,071	-	1,071
Temporary Staff – agency / contract staff	-	8,607	8,607
Total Staff Costs	425,972	12,908	438,880

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

Average Staff Numbers (subject to audit)

During 2025/26, the Trust employed an average of 7,349 staff as follows:

Table 20: Average staff numbers 2025/26

	Permanent staff (WTE*)	Other staff (WTE*)	Total staff (WTE*)
Medical and Dental	315	79	394
Ambulance Staff	7	-	7
Administration and Estates	1,696	3	1,699
Healthcare Assistants and Other Support Staff	2,015	4	2,019
Nursing, Midwifery and Health Visiting Staff	2,139	34	2,173
Nursing, Midwifery and Health Visiting Learners	4	-	4
Scientific, Therapeutic and Technical Staff	911	7	918
Social Care Staff	135	-	135
Total average staff numbers	7,222	127	7,349

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

Workforce Analysis

Our workforce profile is similar to many NHS Foundation Trusts in that 47 per cent of our staff are over the age of 46 and our workforce is predominantly female. This is detailed further in the table below:

Table 21: Workforce profile

Staff group:	Total	Gender		Age			
		Female	Male	<25	26-45	46-65	>65
Board of directors	16	8	8	0	2	13	1
Senior managers	44	27	17	0	11	31	3
Doctors and dentists	355	186	169	1	224	118	12
Nursing	2164	1706	458	53	933	1040	49
Other healthcare staff	2885	2244	641	179	1497	1154	55
Support staff	1832	1426	406	73	678	945	136
All employees	7296	5597	1699	306	3334	341	255
Percentage		76.7%	23.3%	4.2%	45.7%	46.6%	3.5%

Table 22: Ethnic diversity

Percentage difference between Board voting members and its overall workforce			Percentage difference between the Board Executive membership and its overall workforce		
	White	BME		White	BME
Board Members	75%	25%	Board Members	87.5%	12.5%
Overall Workforce	65%	35%	Overall Workforce	65%	35%
Percentage Difference	2.8%	1.3%	Percentage Difference	22%	-22%

Sickness Absence

In accordance with Treasury guidance, all public bodies must report sickness absence data on a consistent basis per calendar year, in order to permit aggregation across the NHS. The Trust is required to use the published statistics, which are produced using data from the Electronic Staff Record (ESR) Data Warehouse. The latest publication, covering the period to December 2025, is available from the [NHS Digital Website](#).

Table 23: Sickness absence

Figures Converted by DH to Best Estimates of Required Data Items			Statistics Produced by NHS Digital	
Average FTE 2025	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days
6,303	76,388	12.1	2,300,744	123,918

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

Period covered: January to December 2025

The number of FTE-days available has been taken directly from NHS Digital.

The number of FTE-days lost to sickness absence has been taken directly from NHS Digital.

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

An average of 12.1 working days were lost per staff member in a 12-month period. This is a decrease on the previous year's reported figures which reported an average of 12.4 days per FTE. The figures have been calculated on a 12-month basis between January 2025 to December 2025 based on the latest data available from NHS Digital. This data therefore does not fully align to the Trust's financial year, which starts on 1st April 2024 and ends on 31 March 2025.

The Trust remains committed to supporting the health and well-being of colleagues. A dedicated Health and Wellbeing page on the Trust intranet provides clear and accessible information on the wide range of resources available to both colleagues and managers. This is supported by the Trust's Health and Wellbeing Toolkit, which promotes self-care and supports compassionate and effective management conversations. Individual Wellness Plans are embedded within the Trust's 1:1 Support Policy, ensuring wellbeing considerations are a routine part of manager-colleague discussions.

Where colleagues are absent due to ill health, the Trust's Management of Sickness and Ill Health Procedure ensures that absence is managed appropriately and consistently. The procedure aims to minimise the impact of ill health on both the individual and Trust services, while supporting recovery, return to work where possible, and sustained attendance.

The Trust has a Reasonable Adjustments Procedure and Passport in place to ensure it meets its legal, moral and social obligations under the Equality Act 2010. These arrangements support

individuals with disabilities or long-term health conditions by enabling reasonable adjustments to be identified, recorded and implemented effectively.

Line managers are required to complete sickness absence management training as part of the Trust's management development programme. In addition, regular Sickness Task and Finish Groups operate within services and are supported by Human Resources colleagues, providing focused oversight and support for managing employee wellbeing and sickness absence at an operational level.

Turnover

For further details on the Trust's average turnover in 2025/26 please refer to data on the [NHS Digital Website](#).

Board Oversight of Culture and Workforce Wellbeing

The Board of Directors maintains active oversight of organisational culture, workforce wellbeing and staff experience through the People Committee (a standing committee of the Board). The People Committee receives regular reports on staff survey outcomes, Freedom to Speak Up activity, workforce metrics, equality indicators and wellbeing initiatives.

The Board receives assurance through formal reporting from the People Committee. The Board actively challenges areas of underperformance, sets expectations for improvement and monitors delivery of actions. This ensures that culture and workforce experience are considered alongside quality, operational and financial performance in Board decision-making.

Workforce Equality and Inclusion

EPUT is committed to providing services and working conditions which have equality and inclusivity at their core. We have a diverse workforce and service users, and our commitment to equality and inclusion is vital to us providing high quality care:

- We are finalising a new People Strategy, building on the NHS Equality, Diversity and Inclusion (EDI) Improvement Plan which closes in 2026. This will have four priorities:
 1. Compassion
 2. Attract
 3. Retain
 4. Empower

Equality and inclusion will be a focus throughout all areas of focus in these four priorities. Specific measures of success from an EDI perspective will include the improvement of WDES metrics and WRES indicators, and increased participation and impact in staff networks.

- Supporting this strategy will be the further embedding of our Behavioural Framework, which is well recognised and received by the organisation. The framework has underpinned much of our work to improve incivility and unprofessional behaviours throughout the organisation, including the piloting of an Unprofessional Behaviours and Sexual Safety workshop
- A new Staff Engagement and Inclusion Group (SEIG) has been formed, which includes a wide range of stakeholders and operational engagement. This replaces the Equality and Inclusion Committee, and reports into the People Committee.
- The newly formed Staff Experience Team have continued to support Conduct Concerns Panel meeting to provide oversight to conduct proceedings, ensuring bias or discrimination does not feature in decision making.
- Equality Impact Assessments are mandatory as part of EPUT policy and procedure.

- In line with the Public Sector Equality Duty, we publish workforce data and demographics, as well as regularly submit reports to NHS England and ensure this data is available to members of the public and our commissioners. The reports listed below are all available in full on our Trust internet page:
 - **WRES:** EPUT has seen improvements in two out of the nine WRES indicators. with the remaining eight being close to national averages.
 - **WDES:** We have seen improvement in three out of ten Metrics, with the remaining seven being close to national averages.
 - **EDS:** We remain a “developing” organisation but have seen a decline in score from 20.21 to 12.7 out of a possible 33.
 - **PSSED:** We publish our workforce demographic data on a yearly basis.
 - **Pay Gap Reporting:** Our Gender Pay Gap is 12.26%, meaning men on average are being paid 2.29% higher in the organisation than females. The Trust also measures pay gap for race and disability. The Race Pay gap is a -6.93% pay gap, meaning colleagues from a BME background are paid 5.32% more than white colleagues. The Disability Pay Gap is 2.14%, meaning non-disabled colleagues are paid 1.65% more than colleagues with a disability.
- We have piloted and are rolling out an Unprofessional Behaviours and Sexual Safety training programme, with a bespoke ‘Check in and Step Up’ model. This focuses on changing culture and challenging unprofessional behaviour in a constructive way, where teams learn how to handle workplace conflicts and sexual safety concerns. The programme has been rolled out to over 400 staff including leaders and focuses heavily on equality and inclusion.

Involvement and Recognition

The Trust has strengthened its staff recognition schemes with the introduction of a new free digital platform which allows easier and more accessible access to view, give and receive recognition across the workforce. We are also looking at improving our current Quarterly Staff Recognition Awards, where any member of staff can nominate a colleague or team in one of five categories. The Quality and Excellence awards were also held this year, recognising the dedication of our workforce in its efforts to deliver high quality patient care.

The retirement scheme was enhanced. Our long service scheme is undergoing review, with a view of improving how we mark major milestones for colleagues with long service in the NHS.

The Trust has four active staff equality networks, which are supported by our Communications Team, newly formed Staff Experience Team, and Executive Sponsors. These networks are key to us engaging our whole workforce in our ambition for an inclusive culture:

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

In addition to these networks, two cafés have been launched which provide an informal space for staff to connect and provide peer support:

- Carer’s Lounge
- Neuroinclusive Café

These forums support our work to mitigate discrimination, harassment, and victimisation within the organisation, through sharing lived experience of staff members and encouraging participation.

In the 2025 NHS Staff Survey, we added an additional local question which captured prevalence of neurodivergence amongst our staff population and will inform future work to improve the experience of staff with neurodiverse conditions.

Staff Concerns

The Trust recognises the importance of raising concerns at work and is committed to promoting a culture where staff feel safe and supported to raise concerns openly and transparently as part of day-to-day practice. This approach plays a key role in improving service user experience, patient safety, and the delivery of high-quality, compassionate care.

All staff are expected to raise any concerns relating to safety, clinical practice, malpractice or wrongdoing that may affect patients, the public, colleagues or the organisation. Every manager has a responsibility to ensure that staff are able to express concerns through all appropriate management channels and that concerns are addressed thoroughly, fairly and without delay. Staff who raise concerns must not be subject to any detriment as a result of doing so.

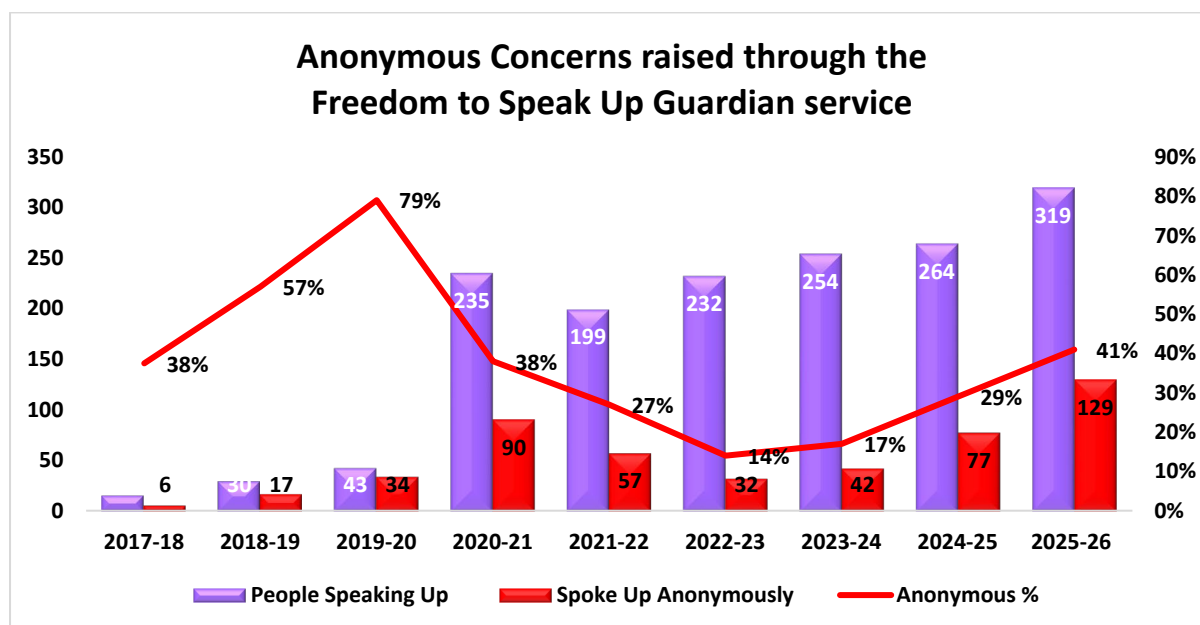
All staff have a responsibility to safeguard confidential information, particularly information relating to individual service users. Confidentiality must be maintained at all times in line with the requirements of the **General Data Protection Regulation (GDPR) 2016** and Trust policy.

Freedom to Speak Up

EPUT aims to cultivate a working environment where colleagues can speak up about issues that concern them, be listened to and appropriate learning and action taken as a result.

The Freedom to Speak Up (FTSU) movement supports the protection of human rights within the workforce through the development of a safe, open culture for people to raise concerns about patient / worker safety or any other work issues getting in the way of them performing their role. The Freedom to Speak Up Guardian Service is an additional safety net to other day-to-day reporting routes for colleagues to raise their concerns through. The service is overseen by an Executive Director, Non-Executive Director and Senior Leaders.

The number of concerns raised through the FTSU service has increased* year on year, as well as the number of colleagues speaking up anonymously over the last few years. The majority of whom preferring to Speak Up via an Anonymous Online Form.

Figure 14: Anonymous Concerns raised through the Freedom to Speak Up Guardian service.**Table 24:** Freedom to Speak Up Activity 2025/26

	People Speaking Up	Patient Safety	Worker Safety / well-being	Bullying & Harassment	Inappropriate Behaviours / attitudes	Spoke Up as Anonymous
Q1	98	22	68	20	34	55
Q2	80	8	42	17	19	31
Q3	76	23	46	16	37	31
Q4	65	11	30	12	31	12
Total	319	64	186	65	131	129

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

Freedom to Speak Up activity is reported regularly to the People Committee and escalated to the Board of Directors to provide assurance on organisational culture and psychological safety. The Board reviews trends, themes and levels of anonymous reporting and seeks assurance that concerns are appropriately investigated and actions are taken to address the identified issues. The Principal Freedom to Speak-Up Guardian attends the Board meetings to present these reports.

The oversight forms a key component of the Board's assessment of the Trust's culture, openness and responsiveness to staff concerns.

Informing and Consulting with Staff

The Trust has a Joint Partnership Agreement in place which sets out the principles of effective partnership working between the Trust, recognised Trade Unions and local staff side representatives. The agreement provides a formal framework for consultation and negotiation, promoting constructive engagement and co-operation on matters of mutual concern, with the objective of supporting the best interests of the workforce.

The Trust informs, consults with and negotiates through established partnership structures. This includes the Joint Partnership Committee (JPC), which meets monthly, and the Joint Local Negotiating Committee (JLNC) for medical and dental staff, which meets bi-monthly. These forums ensure regular, structured dialogue with staff side representatives.

Both committees include local and regional representation and provide oversight of workforce strategy, policy development, quality of service delivery and service transformation. In addition, the Trust operates a Policy Sub-Committee, which meets monthly to review and agree policies and procedures in partnership prior to ratification, ensuring staff side involvement throughout the policy development process.

The Trust has a robust Organisational Change Policy, which was reviewed and updated in March 2024 in partnership with staff side representatives. The policy establishes a clear and consistent framework for managing organisational change, supporting a shared understanding among managers, staff and staff side colleagues.

The core principles underpinning the Trust's approach to organisational change are to:
Consult and communicate in a meaningful and timely way

- Maximise staff involvement and participation throughout the change process
- Ensure decision-making is based on clear, consistent and fair criteria
- Implement measures aimed at avoiding redundancy wherever possible
- Ensure equality of opportunity through the application of best practice in employment law
- Recognise the skills, experience and competencies of all staff
- Provide appropriate support and development opportunities for staff during periods of change

NHS Staff Survey

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

In 2025, EPUT's response rate was 52% against a median of 52% for peer organisations in our Benchmark Group. This is a large increase in response rate compared with prior years (2022: 42.11%, 2023: 43.67%), 2024: 41%.

Scores for each indicator together with that of the survey benchmark group (Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts) are presented below (**Table 25**).

Indicators (‘People Promise’ elements and themes)	2025/26		2024/25		2023/24	
	Trust Score	Benchmark Group Score	Trust Score	Benchmark Group Score	Trust Score	Benchmark Group Score
People Promise:						
We are compassionate and inclusive	7.56	7.61	7.46	7.55	7.56	7.58
We are recognised and rewarded	6.35	6.37	6.31	6.35	6.37	6.41
We each have a voice that counts	6.87	6.89	6.86	6.94	6.99	7.01
We are safe and healthy	6.35	6.34	6.30	6.40	6.46	6.39
We are always learning	6.06	5.83	5.97	5.93	5.96	5.93
We work flexibly	6.77	6.84	6.78	6.83	6.85	6.84
We are a team	7.22	7.17	7.11	7.15	7.21	7.18
Staff engagement	7.01	7.02	6.97	7.07	7.17	7.11
Morale	6.17	6.12	6.13	6.20	6.29	6.17

Of the nine Staff Survey elements, EPUT performed above average compared when compared to the Benchmark Group in four areas; ‘We are safe and healthy’, ‘We are always learning’, ‘We are a team’ and ‘Morale’.

We performed in line with the benchmarking average in three areas including ‘We are recognised and rewarded’, ‘We each have a voice that counts’ and ‘Staff engagement’.

EPUT performed below average compared with the Benchmark Group Average in the following areas: ‘We are compassionate and inclusive’ and ‘We work flexibly’.

Five priorities continue to be the focus to improve staff experience across all areas of the organisation:

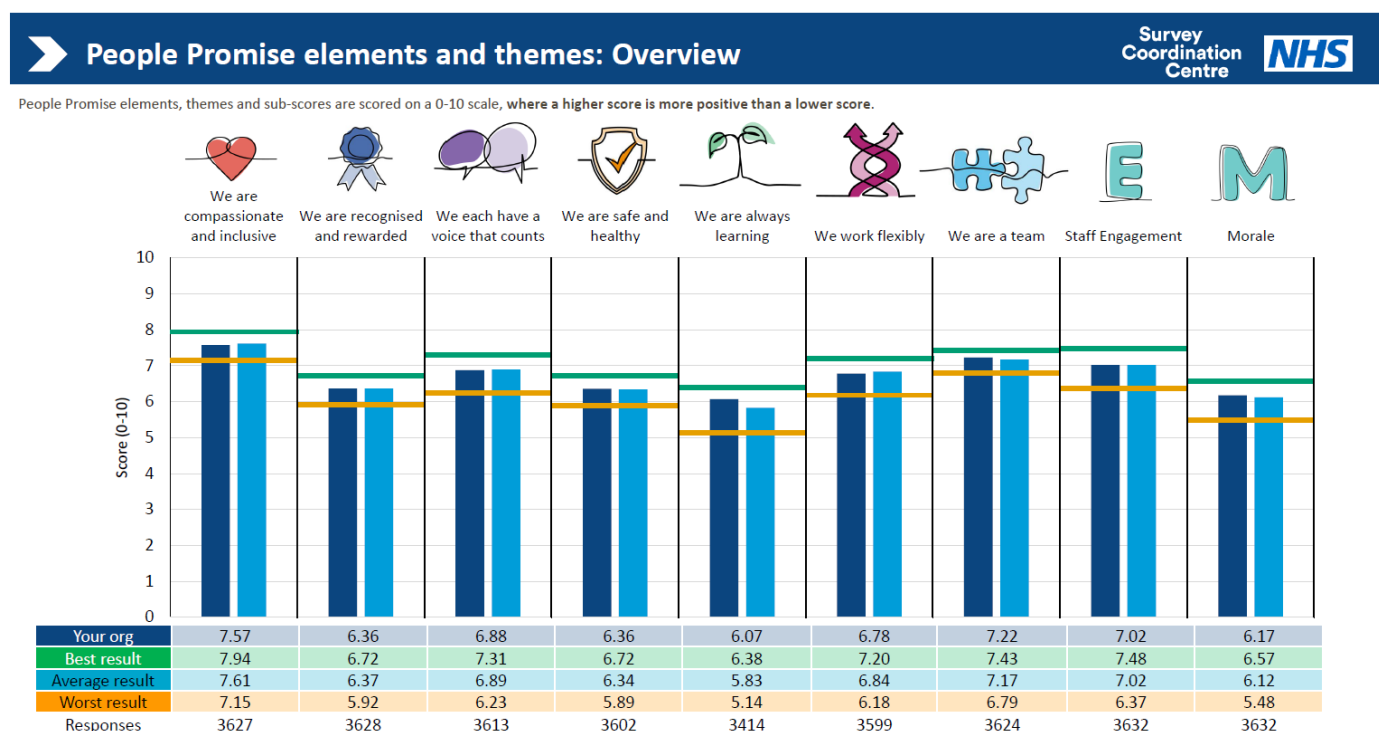
1. Compassionate and inclusive leadership and management
2. Celebrating and recognising staff
3. Addressing workload and factors leading to burnout
4. Improving psychological safety and a culture of safety
5. Enhancing appraisals and clinical supervision.

The Trust has continued its approach with local actions through care units / corporate business units to review the results and identify improvement actions that could be taken in the local area. A model of Care Unit led ‘Big Conversation’ feedback events has been agreed and will take place throughout the year before the next survey period.

Operational oversight on progress with Trust plans will be provided through the Executive Team and assurance through the People Committee and Board of Directors across the year. This will

include updates on the National Quarterly Pulse Surveys results, the five priority Trust actions and outputs from the 'You Said, We Did' campaign. This will ensure clear line of sight between workforce feedback and the continuous improvements that need prioritising and delivering against.

Figure 15: 2025 People Promise Results



The results of the staff survey are formally reviewed by the People Committee and the Board of Directors, with particular focus on areas below benchmark. The Board has agreed a set of organisational priorities in response to the survey findings, including improvements in compassionate leadership, recognition, workload management and becoming a trauma informed organisation (psychological safety). Progress against these priorities is monitored through the accountability framework and reported to the People Committee, ensuring sustained focus.

National Quarterly Pulse Survey (NQPS)

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

Table 26: Survey response rates

NQPS Window	2025/26	2024/25 Response
Q1 (April)	570	390
Q2 (July)	892	696
Q4 (January)	396	492

- NQPS results are communicated across the organisation via all-staff communication channels.
- Survey engagement rates improved this year except for Q4 which saw a slight decrease.
- Feedback from NQPS is incorporated into Staff Survey planning.

Gender Pay Gap

As a Trust, we work to reduce the Gender Pay Gap for our employees, and publish our reporting for this on our website [Pay Gap Reports - Essex Partnership University NHS Foundation Trust](#)

Health and Safety

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

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

- Health and Safety at Work Act 1974
- Management of Health and Safety at Work Regulations 1992
- Workplace (Health, Safety, and Welfare) Regulations 1992
- Violence Prevention and Reduction Standards 2021.

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

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

- Adverse Incident Policy
- Control of Substances Hazardous to Health (COSHH)
- Corporate Statement and Policy on Health and Safety
- Display Screen Equipment Policy
- Employee Well-being, Sickness and Ill Health Policy
- Fire Safety Policy
- First Aid Policy
- General Workplace Risk Assessment Policy
- Health and Safety of Young Persons Policy
- Latex Policy
- Ligature Environmental Risk Assessment and Management Policy

- Lockdown Policy
- Lone Worker Safety Policy
- Manual Handling Policy
- Safety Alert Bulletin Policy
- Search Policy
- Therapeutic and Safe Interventions and De-escalation Policy (TASID)
- Violence Abuse Prevention and Reduction (VAPR) Policy
- Work-related Driving Policy

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

To enable staff to understand their roles and responsibilities, the Trust has health and safety training programmes which includes a fit for work e-learning programme, this was refreshed and updated to the Health, Safety and Welfare Level 1 course in December 2025. As at 31 March 2026, 98% of staff had completed this training.

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

A total of 98 health and safety site inspections were completed across Trust premises between 1 April 2025 and 31 March 2026, in accordance with Trust policy and in line with legislation and guidance. Inspection results were shared with staff and corrective action identified to minimise risk. This process supports continuous improvement, helps to minimise identified risks and contributes to maintaining a safe and compliant working environment across all sites.

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

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

The ligature inspection process aims to assess the risk posed by potential ligature anchor points. Inspections are carried out jointly between the Health and Safety/VAPR Team, a representative from each ward and the Estates Team, taking joint responsibility for highlighting and managing risk posed. Each ward is provided with a detailed report outlining the assessed risks for each room inspected, along with an action plan to address any identified concerns. Potential risks identified are either removed, replaced with a reduced ligature solution or included in a capital works programme; Risks which cannot be addressed in this way are highlighted to staff to allow them to mitigate those risks, taking them into account

when planning care for vulnerable patients.

46 ligature risk assessment inspections (annual) were completed between 1 April 2025 and 31 March 2026. There is a further Ligature support visit completed approximately 6 months post annual inspection.

This year the team has successfully piloted a digital inspection tool using the Trust Tendable audit system. The pilot aimed to enhance the efficiency and reliability of ligature inspections by replacing a manual process that was time-consuming and subject to inconsistency.

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

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

The Health and Safety/VAPR team supports the Trust's capital projects programme by providing specialist advice and guidance on refurbishment and improvement works across multiple sites, ensuring that health and safety considerations are prioritised throughout all stages of delivery.

A clear and well-defined governance framework remains in place to prevent and reduce violence and abuse against Trust staff, aligned to the NHS Violence Prevention and Reduction Standards (VPRS). These standards were revised by NHS England in December 2024 and over the past year the Trust has focused on embedding the revised requirements into operational practice, assurance processes and governance arrangements.

During the reporting period, the Trust's priority has shifted from policy development to delivery, assurance and continuous improvement. Key work has included implementation of the updated Violence, Abuse Prevention and Reduction Policy, refinement of the Datix reporting system to strengthen the quality and consistency of VAPR-related data and continued direct support to staff affected by violence and aggression. This has enabled more robust analysis of patterns, trends and risk factors, supporting targeted preventive action. As of 31st March 2026, the Trust has achieved compliance with 45 out of 54 KPI's set within the revised standards, resulting in an overall 73.2% compliance, with a clear delivery plan in place and compliance projected to exceed 90% during 2026/27.

A significant development this year has been the establishment of the Violence and Abuse Safety Group (VASG). This multi-disciplinary group provides a dedicated forum for oversight of violence and aggression risks across the organisation, bringing together operational, clinical, corporate and training leads. The group strengthens collective ownership of VAPR actions, improves escalation and decision-making, ensuring learning from incidents, audits and external intelligence are translated into practical controls at ward, service and Trust-wide level.

Partnership working has continued to be a central component of the Trust's approach. Close collaboration with Essex Police and other system partners has supported a shared understanding of risk, accountability and response arrangements. The Trust has actively embedded the Right Care Right Person (RCRP) principles into its operating model, supported by Essex-wide memoranda of understanding and updated local procedures. This has reinforced clear boundaries around organisational responsibilities, while maintaining effective joint working where there is risk of serious harm, criminality, or public safety concerns.

The Trust has continued to invest in practical safety controls to support staff. Body Worn

Cameras (BWCs) remain a key component of the violence prevention toolkit, supporting de-escalation, evidential capture and post-incident investigation. During the year an upgrade of the BWC estate was undertaken aiming to address end-of-life equipment risks, improving reliability, usability and securing longer-term value for money. This upgrade strengthens staff confidence in the technology and ensures continuity of coverage in high-risk environments. Lone Worker Devices also continue to be used across community and outreach services, with ongoing monitoring of usage data to inform further improvements.

Throughout the year, the Health and Safety and VAPR Team has provided direct support to staff affected by violence and abuse, including practical advice and liaison with police. This approach has reinforced a culture of reporting, visibility and support, alongside clear expectations around unacceptable behaviour.

In the coming year, we will focus on: enhancing triangulation of health and safety data digitisation of: a review and pilot of new style lone worker devices; and a project to enhance explore how the organisation can be more proactive in relation to violence and aggression.

Staff Health and Wellbeing

The health and wellbeing of our workforce is fundamental to the delivery of high-quality care for patients and service users. We are committed to supporting staff health and wellbeing through delivering against all seven domains of the NHS Health and Wellbeing Framework. A positive health and wellbeing culture improves workforce measures such as retention and engagement, as well as the service provided to patients.

Health and wellbeing support includes:

- Virtual wellness sessions, both live and recorded at lunch times
- Act for You Training, supporting staff with resilience whilst under pressure – open to all staff
- A neuro-inclusive café, for staff to support one another with strengths and challenges associated with neurodivergence
- Support for staff with caregiving responsibilities via a staff carer's lounge
- Psychological and emotional support through our award-winning psychological support service, 'Here for You'
- Wellbeing conversation training for managers, as part of our Management Development Programme (MDP)
- Access to fast-track physiotherapy support via our Occupational Health provider
- A comprehensive health and wellbeing toolkit for all staff, and dedicated health and wellbeing intranet resources
- A Disability and Mental Health Network, supporting colleagues with a range of long-term conditions and disabilities
- A dedicated staff wellbeing intranet page, with regular staff communications and events
- An employee assistance programme (EAP) and managed occupational health service
- Guidance documents and toolkits for managers and staff – for example, support with flexible working requests, reasonable adjustments guidance
- Domestic abuse toolkit and support pathway
- Staff sexual safety helpline and support process
- A range of staff benefits to support financial wellbeing, including cycle to work schemes, car loan schemes and the opportunity to buy and sell annual leave.

The Trust has also invested approximately £20,000 into improved staff rooms across the organisation, funding secured through NHS Charities Together. Improvements to facilities and

equipment will support staff having more restful breaks.

Occupational Health and Employee Assistance Programme

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

PAM and EPUT hold bi-monthly and review meetings to drive performance and efficiencies, so we are effectively supporting the health of our workforce.

Expenditure on Consultancy

During 2025/26, the Trust spent £0.2m on consultancy expenditure in respect of the provision of objective advice and assistance to the Trust in delivering its purpose and objectives. There are no connections between the external consultancy utilised by the Trust and Trust Directors.

Off Payroll Arrangements

In line with HM Treasury guidance, the Trust has put controls in place around the use of off-payroll arrangements. These engagements are only entered into on the basis of the provider's relevant skills, experience and knowledge and are supported by individual contracts. All contracts are signed by both parties and include such terms as services to be provided, amount payable per day and responsibility for tax and national insurance contributions.

Table 27: Highly paid off-payroll worker engagements as of 31 March 2026 earning £245 per day or greater

Number of existing engagements as of 31 March 2026	0
Of which	
Number that have existed for less than one year at time of reporting	0
Number that have existed for between one and two years at time of reporting	0
Number that have existed for between two and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting.	0

Table 28: All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2026 earning £245 per day or greater

Number of off-payroll workers engaged during the year ended 31 March 2026	0
Of which...	
Not subject to off-payroll legislation*	0
Subject to off-payroll legislation and determined as in-scope of IR35*	0
Subject to off-payroll legislation and determined as out-of-scope of IR35*	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

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

Table 29: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026

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

Staff Exit Packages (subject to Audit)

During the year the Trust has incurred termination costs of £1,290k in respect of 43 individuals. There were no special severance payments that required HM Treasury approval made in the year.

Table 30: Staff exit packages 2025/26

	Compulsory redundancies		2025/26 Other departures agreed		Total termination costs	
	Number	£000	Number	£000	Number	£000
< £10,000	3	17	10	77	13	94
£10,001 - £25,000	6	82	8	128	14	210
£25,001 - £50,000	1	31	6	231	7	262
£50,001 - £100,000	2	152	5	328	7	480
£100,001 - £150,000	2	244	-	-	2	244
£150,001 - £200,000	-	-	-	-	-	-
Total	14	526	29	765	43	1,290

Table 31: Staff exit packages 2024/25

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

The increase in staff exit package costs in 2025/26 is due to the launch of a Mutually Agreed Resignation Scheme (MARS) during the year.

Staff Exit Packages – non-compulsory departure payments

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

Table 32: Non-compulsory departure payments 2025/26

	2025/26	
	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	29	765
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval*	-	-
Total	-	-
Of which:		
Non contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-

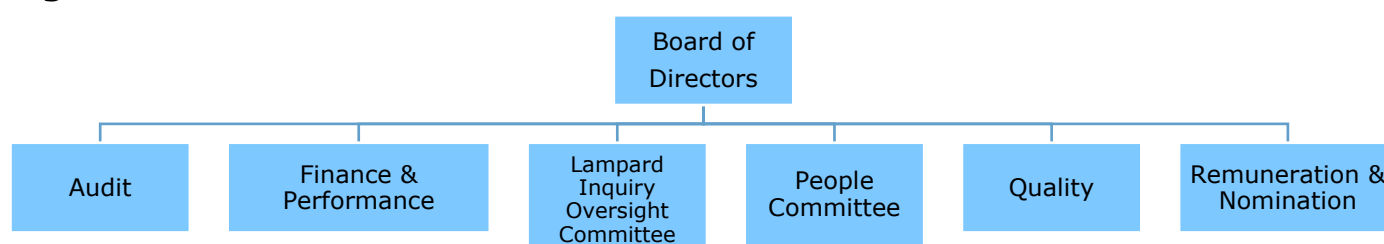
Table 33: Non-compulsory departure payments 2024/25

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

Board of Directors

In 2025/26, the Board of Directors operated with the structure below:

Figure 16



In addition to the above standing committees, the Trust has a Charitable Funds Committee which reports into the Board of Trustees. In December 2025, the Lampard Inquiry Oversight Committee was dissolved, and its remit reverted to the direct oversight of the Board of Directors.

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

All the powers of the Trust shall be exercised by the Board of Directors on behalf of the organisation. The rules and regulations within which the Board is expected to operate are captured in the Trust's corporate governance documents, which includes the constitution, the standing orders for the Board of Directors, its schedule of matters reserved for Board decision, standing financial instructions and scheme of delegation. These documents explain the respective roles and responsibilities of the Board of Directors and the Council of Governors, the matters which require Board and / or Council approval and matters that are delegated to committees or executive management.

Collectively the Board of Directors have responsibility for:

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

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

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

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

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

The Board has a Vice-Chair and a Senior Independent Director. All non-executive directors are assessed as independent taking into account character, judgement and length of tenure, in accordance with the Code of Governance. Details of the Board's composition, including directors' roles, dates of appointments and committee memberships, are set out on pages 69 – 76.

During the course of the year, the Board met nine times. Six of these meetings were held in public.

The attendance record of all meetings for the Board of Directors for the year ended 31 March 2026 is as follows:

Table 34: Attendance at the Board of Directors 2025/26

Name	Role	Meetings Attended (actual/possible)	Of which were meetings in public (actual/possible)
Hattie Llewelyn-Davies	Chair	9/10	5/6
Paul Scott	Chief Executive Officer	9/10	5/6
Doug Field	Associate Non-Executive Director	2/2	2/2
Alex Green	Executive Chief Operating Officer / Deputy Chief Executive Officer	9/10	6/6
Denver Greenhalgh	Executive Director of Governance	7/10	4/6
Dr Ruth Jackson	Non-Executive Director	8/10	4/6
Dr Mateen Jiwani	Non-Executive Director / Senior Independent Director	9/10	6/6
Dr Milind Karale	Executive Chief Medical Officer	5/7	3/4
Diane Leacock	Non-Executive Director	9/10	5/6
Nigel Leonard	Executive Director of Major Projects and Programmes	4/5	2/2
Loy Lobo	Non-Executive Director / Vice Chair	10/10	6/6
Elena Lokteva	Non-Executive Director / Chair of the Audit Committee	8/10	6/6
Andrew McMenemy	Executive Chief People Officer	10/10	6/6
Ann Sheridan	Executive Chief Nurse	10/10	6/6
Trevor Smith	Executive Chief Finance Officer / Deputy Chief Executive Officer	8/10	5/6
Richard Spencer	Non-Executive Director	9/9	5/5
Dr Kallur Suresh	Executive Medical Director	2/3	1/2
Sarah Teather	Non-Executive Director	9/9	5/5
Zephan Trent	Executive Director of Strategy, Transformation & Digital	8/10	5/6

Board of Directors appointments

The Trust has a formal, rigorous and transparent procedure for the appointment of both executive and non-executive directors. Appointments are made on merit and based on objective criteria.

The Trust has applied the principles of the Code of Governance for NHS Provider Trusts during the year.

Executive directors are permanent appointments, while non-executive directors are appointed to a maximum three-year term of office.

The reappointment of a non-executive director after their first term of office will be subject to a satisfactory performance appraisal. Any term beyond six years is only supported in exceptional circumstances and with the support of NHS England and takes into account the need for progressive refreshing of the Board.

Both the Chair and non-executive directors are appointed by the Council of Governors who may also terminate their appointment as set out the Trust's constitution.

Appointment of executive directors

The Board of Directors Remuneration and Nominations Committee has delegated responsibility to oversee the appointment of executive directors to the Board of Directors, including approving successful candidates and establishing remuneration for new appointments.

The recruitment of executive directors is completed using a robust selection process, including stakeholder panels and a formal interview panel. Candidates are interviewed by a range of individuals, including ensuring diversity at both stakeholder and interview panel level.

During 2025/26, the Trust appointed Dr Kallur Suresh as Interim Medical Director and subsequently as the substantive Executive Medical Director. The Trust completed a rigorous recruitment and selection process, utilising the services of Executive Search Company Hunter Healthcare, to identify candidates that had the skills, knowledge and experience to support the Trust.

Appointment of non-executive directors

The appointment of non-executive directors to the Board of Directors is undertaken by the Council of Governors Nomination Committee on behalf of the Council of Governors. Non-executive directors are appointed for three-year terms. The non-executive director may be appointed for a further three-year term following a re-appointment process. Any term beyond six years will be subject to rigorous review and satisfactory annual performance appraisal, taking into account the need for progressive refreshing of the Board.

The Trust constitution sets-out the circumstances that disqualify an individual from holding a Directorship. Should any of those circumstances become applicable to a non-executive director, their appointment will be terminated. In addition, either party shall be entitled to terminate that agreement by giving at least one month's notice in writing to the other. The appointment may be terminated with immediate effect if the non-executive director becomes disqualified for appointment or membership. This is set out in the Terms and Conditions signed by the non-executive director on appointment.

The non-executive director will leave their post at the completion of their term of office unless re-appointed by the Council of Governors for a further term.

There were two non-executive directors re-appointed in 2025/26:

- Diane Leacock (until December 2026)
- Elena Lokteva (until May 2028)

The Council of Governors appointed the following non-executive directors during 2024/25 following who commenced in post in 2025/26:

- Richard Spencer (28 April 2025)
- Sarah Teather (12 May 2025)
- Doug Field (Associate Non-Executive Director – 11 August 2025)

Jenny Raine (May 2025) and Doug Field (January 2026) stepped down as Associate Non-Executive Directors during 2025/26.

Chair's significant commitments

Hattie Llewelyn-Davies has no other significant commitments outside the Trust. However, she has declared interests for the following:

- Chair, Eastlight Community Housing
- Chair, Norwich City Services Ltd.
- Senior Independent Director, Adsure PLC
- Chair, The NHS Disabled Directors Network
- Director, Crescent Amenities Ltd

The Board is satisfied that these commitments do not materially affect the Chair's ability to discharge her responsibilities to the Trust.

Independence of the non-executive Directors

Following consideration of the Code of Governance, the Board takes the view that all non-executive directors are independent. All non-executive directors declare their interest and, in the rare likelihood that such interest conflicts with those of the Trust, then the individual would be excluded from any discussion and decision relating to that specific matter.

Balance, completeness and appropriateness of the membership of the Board of Directors

The current Board of Directors comprises eight non-executive directors (including the Trust Chair) and eight executive directors (including the Chief Executive Officer, seven voting).

Taking into account the wide experience of the whole Board as well as the balance and completeness of membership, and the use of associate non-executive directors the composition of the Board is considered to be appropriate for the requirements of the business and future direction of the Trust.

Board of Directors performance evaluation

The Trust has put in place processes for an annual performance evaluation of the Board and its Directors in relation to their performance. During 2025/26, the Board's evaluation drew on structured reviews of the effectiveness of its standing committees. These reviews considered the extent to which committees met their terms of reference, the quality of assurance provided to the Board, effectiveness of reporting and scrutiny, and the operation of governance processes including alignment to the Board Assurance Framework and risk management systems. The evaluation process was informed by committee self-assessment, facilitated by the Trust Secretary's Office, with outputs used to develop forward improvement priorities and work plans for each committee.

The most recent programme of effectiveness reviews concluded that the Board committees continue to operate effectively, providing robust oversight across the Trust's strategic objectives, principal risks and systems of internal control. Improvements were evidenced in the alignment of committee business with the Board Assurance Framework, the quality and clarity of reporting to support effective scrutiny, and strengthened arrangements for triangulating assurance through audit, risk and performance information.

The review identified opportunities for further development in strengthening the use of benchmarking and comparative data, enhancing the conciseness and consistency of reporting, and ensuring effective coordination between committees in managing cross-cutting risks and interdependencies. In response, the Board has agreed a programme of actions for 2026/27, including the introduction of enhanced action tracking and assurance processes, further development of report formats to support focused discussion, and continued review of committee membership and succession arrangements.

The annual Board effectiveness review for 2025/26 is scheduled to report to the Board in July 2026. The review builds on and will assess board dynamics, strategic oversight, and the effectiveness of assurance processes. Any further actions arising from the review or the CQC well-led inspection will be incorporated into the Board development plan and monitored to ensure sustained improvement.

The Board is satisfied that it has operated effectively during the year, maintaining clear oversight of the Trust's strategic objectives, risk profile and performance.

The Board has also considered its role in ensuring the efficient and economic use of resources. This is evidenced through delivery of £30.1m of efficiency savings alongside maintaining quality and safety standards, oversight and prioritisation of the capital programme based on risk and clinical need and strengthened system-wide collaboration to improve productivity and reduce unwarranted variation. The Board has maintained focus on financial sustainability while ensuring that decisions support delivery of high-quality patient care.

Effective governance is fundamental to organisational performance and continuous improvement. During 2025/26, governance arrangements have contributed to strengthened oversight of quality and safety through improved triangulation of risk, assurance and performance information; enhanced visibility of services through Quality Assurance Visits involving Board members; and strengthened workforce and culture oversight through the People Committee, including Freedom to Speak Up and staff survey reporting. These

governance processes have enabled the Board to challenge performance, identify emerging risks and monitor delivery of improvement actions.

All members of the Board receive a full and tailored induction on joining the Trust and undertake a personal induction programme during the first 12 months of appointment. All directors will undergo an annual performance review against agreed objectives, skills and competences and agree personal development plans for the forthcoming year. The performance evaluation of the executive directors is undertaken by the Chief Executive Officer whose performance is appraised by the Chair.

The Chair conducts the annual performance evaluation and appraisal of each non-executive director. The Senior Independent Director conducts the annual performance evaluation and appraisal of the Chair, having met with all other non-executive directors and received feedback from governors.

Detailed consideration of the results of the performance evaluation of the Chair and non-executive directors for 2024/25 was undertaken by the Council of Governors Remuneration Committee in line with the process agreed by the Council and a report from the Committee made to the Council of Governors. All submissions for the outcome of the Chair's performance evaluation were submitted to NHS England, as required.

Board performance is also evaluated through focused discussions at Board Development / Seminar sessions and ongoing in-year review of the Board Assurance Framework. The Framework provides clear information and enables a continuous and comprehensive review of the performance of the Trust against agreed plans and objectives, linked to the Strategic Objectives.

All Directors meet the criteria for being a fit and proper person as prescribed by the Trust's Provider Licence and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Trust is following the Fit and Proper Persons Tests framework published in 2024.

No external evaluator was engaged to support the Board effectiveness review in 2025/26; the evaluation was undertaken internally, drawing on committee effectiveness reviews and director appraisal processes.

Nominations Committees

The Trust has two Nominations Committees: The Board of Directors Remuneration and Nominations Committee and the Council of Governors Remuneration and Nominations Committee. The Council of Governors agreed at its meeting in October 2025 to merge the Council of Governors Remuneration Committee and Nominations Committee. These arrangements are consistent with the Code of Governance for NHS Provider Trusts and the Trust's Constitution.

Board of Directors Remuneration and Nominations Committee

The Board of Directors Remuneration and Nominations Committee is constituted as a standing committee of the Board. It has the statutory responsibility for identifying and appointing suitable candidates to fill executive director positions on the Board of Directors, ensuring compliance with any mandatory guidance and relevant statutory requirements.

This Committee is also responsible for succession planning and reviewing Board structure, size,

composition and diversity, taking into account future challenges, risks and opportunities facing the Trust and the skills and expertise required on the Board to meet them.

The Committee is chaired by the Trust's Chair with membership comprising all non-executive directors. The Chief Executive Officer will attend when the Committee is considering appointments to executive director positions other than the post of Chief Executive Officer. At the invitation of the Committee the Executive Chief People Officer (or their deputy) will normally attend (depending on the agenda items to be discussed) in an advisory capacity. The Executive Director of Corporate Governance (or their deputy) is the Committee Secretary.

The Committee's terms of reference are reviewed annually in line with good practice. The Committee meets at least annually and as required to undertake its roles and responsibilities.

The Committee met five times during the year.

Council of Governors Remuneration and Nominations Committee

The Council of Governors Remuneration and Nominations Committee is responsible for establishing a clear and transparent process for the identification and nomination of suitable candidates that fit the criteria set out by the Board of Directors Remuneration and Nominations Committee for the appointment of the Trust Chair and non-executive directors, for approval by the Council.

The Committee is chaired by the Trust's Chair and Lead Governor with membership comprising elected and appointed governors. If the Chair is being appointed or not available, the Vice-Chair, Senior Independent Director, one of the other non-executive directors who is not standing for appointment or the Lead Governor will be the Chair. When the Trust Chair is being appointed, the Committee comprises only governors who will elect a Chair of the Committee from amongst its members. The Assistant Trust Secretary is the Committee Secretary.

The Committee's terms of reference are reviewed annually in line with good practice. The Committee meets at least annually or as and when required to undertake its roles and responsibilities.

Details of the membership and meeting attendance for the Board of Directors Remuneration and Nominations Committee and the Council of Governors Remuneration and Nominations Committee are set out in Tables 8 and 9 in the report.

Both Committees operate a structured and transparent process for Board appointments. This includes the use of open recruitment processes, independent executive search where appropriate, stakeholder engagement and formal interview and assessment arrangements.

The Committee undertakes regular review of the Board's size, structure, skills, experience and composition, informed by Board evaluation outcomes and organisational priorities.

Succession planning is undertaken on an ongoing basis to ensure continuity of leadership and capability, with consideration given to anticipated vacancies, tenure and development needs.

In fulfilling its responsibilities, the Committee considers the development of a diverse pipeline of candidates, including diversity of gender, ethnicity, professional background and lived experience, to support an appropriately balanced and effective board. For example, in 2025/26 a decision was taken to appoint an associate non-executive director with lived experience to enhance the patient voice and co-production.

Audit Committee

The Audit Committee comprises solely of independent non-executive directors who have a broad set of financial, legal and commercial expertise to fulfil the Committee's duties. The Committee is constituted in accordance with the Code of Governance for NHS Provider Trusts. Members of the Committee and the number of meetings attended by each member during the year are set out below:

Table 35: Membership and attendance at Audit Committee meetings

Name	Role	Meetings attended
Elena Lokteva	Chair of Committee	6/6
Doug Field	Associate Non-Executive Director	2/2
Dr Mateen Jiwani	Non-Executive Director	5/6
Loy Lobo	Non-Executive Director	1/1
Jenny Raine	Associate Non-Executive Director	1/1

At the request of the Committee Chair, each meeting is attended by the Executive Chief Finance and Resources Officer, Director of Finance, Executive Director of Corporate Governance, Head of Financial Accounts, an External Audit representative, an Internal Audit representative, and the Local Counter Fraud Specialist. In addition, the Chief Executive Officer presents the Annual Governance Statement on an annual basis.

Internal audit

The Trust has an internal audit function which forms an important part of the organisation's internal control environment. During the year, this function was provided by TIAA. The functions of the internal audit service are to provide an '*independent, objective assurance and consulting activity designed to add value to an organisation's activities*'. This means that the role embraces two key areas:

- 1 The provision of an independent and objective opinion to the Accounting Officer, the governing body and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives
- 2 The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

Anti-Crime Specialist

During 2025/26, TIAA also provided the Trust with a dedicated counter fraud service. TIAA agrees a detailed counter fraud work plan with the Trust, based on guidance received from the NHS Counter Fraud Authority. The Trust also has a counter fraud policy and response plan which has been approved by the Board of Directors. Anyone suspecting fraudulent activities within the Trust's services should report their suspicions to the Executive Chief Finance and Resources Officer or telephone the NHS Counter Fraud Authority confidential hotline on 0800 028 4060.

All NHS funded services are required to provide assurance against the NHS Counter Fraud Authority (NHSCFA) Requirements of Government Functional Standards 013: Counter fraud. In May 2025, the Trust submitted its assurance return for 2025/26 with an overall rating of GREEN.

External audit

The Audit Committee has considered the independence of the external auditors throughout the year. Independence is supported through the use of a formal procurement and appointment process, clear contractual arrangements, and review of any potential conflicts of interest.

The 2024/25 audit reflected the third year of a three-year contract for the Trust External Auditors. Following agreement by the Audit Committee and Council of Governors, the Trust undertook a market testing process via the East of England procurement hub, which returned bids from three audit providers.

The bids were assessed by an Evaluation Panel, which included a member of the Council of Governors, which scored the technical aspects of the bids with the Head of Sustainability scoring the social value elements. Following the evaluation panel agreeing the combined scores, the bidders were asked to present to the Trust and a combined score was agreed thereafter. These scores were taken along with commercial scores (assessed independently by procurement) to identify the preferred bidder.

During the procurement process, bidders were required to declare any relationships with the Trust and demonstrate how conflicts would be managed. The Committee is satisfied that appropriate safeguards are in place to maintain auditor independence.

Following a recommendation from the Audit Committee, the Council of Governors agreed to appoint Grant Thornton as the Trust External Auditors for a three-year period, with the option to extend by a further two-years and subject to annual re-appointment. This tender included non-audit services in respect of the independent examination of the EPUT Charity Accounts.

The value of the external audit contract for the Trusts accounts for 2025/26 was £222,250 (excluding VAT). There was no non-audit work undertaken during the year.

The Committee reports to the Board of Directors and Council of Governors on external audit independence, effectiveness and performance, ensuring oversight and accountability.

Work of the Audit Committee

During the year, the Committee considered a number of significant issues including the impact of the current inquiry and the planning regime.

Further matters relating to the 2025/26 annual accounts, which were discussed by the Committee, were as follows:

- Accounting for ongoing costs of servicing the inquiry in the 2025/26 accounts
- Revaluation and impairment of property, plant and equipment, and action taken to address asset componentisation and derecognition during the year;
- Changes to classifications of investment properties and assets held for sale in line with approved Estates Strategy;
- Restatement in annual leave accrual;
- Accounting treatment for the Local Government Pension Scheme; and
- Losses and special payments.

Following discussion by the Audit Committee, the treatment of the significant issues and the accounting policies for the year were approved by the Committee.

Council of Governors

Our Council of Governors is an integral part of the Trust. Our governors bring the views and interests of the public, service users and patients, carers, our staff and other stakeholders into the heart of our governance. This group of committed individuals has an essential involvement with the Trust and contributes to its work and future developments to help improve the quality of services and care for all our service users and patients. These arrangements are consistent with the Code of Governance for NHS Provider Trusts and the Trust's Constitution.

Role of the Council of Governors

The roles and responsibilities of the Council of Governors are set out in our Constitution. The Council of Governors' statutory responsibilities include:

- To hold the non-executive directors, individually and collectively, to account for the performance of the Board of Directors
- To represent the interests of the members of the Trust as a whole and the interests of the public
- To amend/approve amendments to the Trust's constitution
- To appoint/remove the Chair and other non-executive directors
- To approve the appointment of the Chief Executive
- To determine the remuneration, allowances and other terms and conditions of office of the Chair and non-executive directors
- To appoint/remove the Trust's external auditor
- To provide views to the Board of Directors in the preparation of the Trust's Annual Plan
- To receive the Trust's Annual Report and Accounts and any report of the auditor on them
- To take decisions on significant transactions and on non-NHS income.

The Council of Governors is required to meet a minimum of four times a year.

The Health and Social Care Act 2012 require the Board of Directors to empower Governors by:

- Holding open Board meetings
- Sending a copy of the agendas to the Council before holding a Board meeting
- Sending copies of the approved minutes to the Council as soon as practicable after holding a Board meeting
- Ensuring that governors are equipped with the skills and knowledge they need to undertake their role.

Composition of the Council of Governors

The Council is led by the Chair of the Trust. The composition of the Council of Governors is in accordance with the Trust's constitution as below.

Table 36: Council of Governors Composition

Constituency		Number of Governors
Public	Essex Mid & South	9
	North East Essex & Suffolk	3
	West Essex, Hertfordshire and the Rest of England	7
Staff	Clinical	4
	Non-Clinical	2
Appointed	Essex County Council	1
	Southend Borough Council	1
	Thurrock Council	1
	Anglia Ruskin & Essex Universities*	1
	Voluntary/Third Sector	1

*joint appointment

Strengthening Council of Governors effectiveness and systematic review

During 2025/26, the Trust strengthened its approach to ensuring the Council of Governors operates with an effective structure, clearly defined roles, and a demonstrable framework for continuous improvement.

A formal review of the Council's effectiveness, structure and supporting governance arrangements was undertaken as part of the Trust's annual governance cycle. This review considered the Council's composition, committee arrangements, role clarity, and alignment with the Trust's strategic priorities and stakeholder representation.

As part of this process, the Trust completed a comprehensive review of the Standing Orders for the Council of Governors and the Trust Constitution, to ensure they remained fit for purpose, compliant with statutory and regulatory requirements, and reflective of evolving expectations of public, staff and partner representation.

Following this review, amendments were approved and implemented during 2025/26, including:

- Changes to governor constituencies, to ensure representation remains aligned to the populations and communities served by the Trust.
- Revision of the third sector/voluntary governor role, to widen eligibility and explicitly include the opportunity for appointment of a Lived Experience Ambassador, strengthening the Council's ability to incorporate lived experience insight into its deliberations and statutory duties.

The review also identified opportunities to strengthen member engagement and the integrity of the membership base, by adding a process for public members to be removed from the register of members where there is a lack of engagement, ensuring the membership remained truly representative.

Board relationship with the Council of Governors

The Trust has continued to strengthen the way in which feedback from the Council of Governors informs Board decision-making. During 2025/26, governors engaged in a range of activities including Quality Assurance Visits, attendance at Board and committee meetings, and both structured and informal engagement sessions with Executive and Non-Executive Directors.

Feedback from governors is formally captured through meetings, visit reports and engagement sessions. This information is reported through established governance routes and, where relevant, considered by the Board of Directors as part of its decision-making process.

During the year, governor input has directly influenced decision-making in a number of areas, including:

- Service quality and environment: Feedback from Quality Assurance Visits highlighting variability in ward environments contributed to the prioritisation of estates and safety improvements within the Trust's capital and quality improvement programmes.
- Patient and carer experience: Governor insights regarding communication and involvement in care planning informed approaches to patient communication.
- Strategic development: Engagement with governors as part of the mid-point review of the Strategic Plan informed the Board's consideration of future priorities, including focus on becoming a trauma-informed organisation.

Joint seminar meetings between the Board of Directors and Council of Governors are held to support effective engagement and information sharing. These provide an opportunity for governors to bring forward the views they have gathered through their engagement activities and to contribute to Board discussions on strategic priorities, performance and governance matters. Topics discussed through joint sessions during 2025/26 included: Community First Mental Health Strategy; Cultural Review; Community Health Services - with a focus on neighbourhood place-based care.

The Trust Chair is responsible for the leadership of both the Council of Governors and the Board of Directors. The Chair has overall responsibility for ensuring that the views of the Council and Trust members are communicated to the Board as a whole and considered as part of decision-making processes and that the two bodies work effectively together.

The Chair works closely with the Lead Governor and meets with them prior to Council meetings to set the agenda and review key issues.

The non-executive directors attend each meeting of the Council, presenting agenda items and taking part in open discussions that form part of each meeting. The executive directors attend meetings to present specific items or provide support for any presentations on a theme related to their portfolios. Standing agenda items include reports from the Chief Executive Officer and executive directors on Trust performance, finance and quality matters, a report from the Chair and national and local systems updates.

The Senior Independent Director pursues an effective relationship between the Council and the Board. Governors can contact the Senior Independent Director if they have concerns regarding any issues which have not been addressed by the Chair, Chief Executive Officer or Executive Chief Finance and Resources Officer. There are a number of procedures in place to guide key processes for the involvement of the Council of Governors, including in situations where the Council disagrees with or rejects a proposal made by the Board of Directors. This includes

criteria by which the Council may reject or disagree with a recommendation from the Board and action that should be taken. A formal policy and procedure are in place which sets-out the relationship between the Board and Council, including how any disagreement or dispute will be resolved.

Board of Directors' meetings are held in public, and governors can and do attend, having the opportunity to ask questions of the Board on matters relating to agenda items. In addition, the Trust establishes working groups of Board and Council representatives to take forward specific work.

The Board values the relationship it has with the Council and recognises that its work promotes the strategic aims and assists in shaping the culture of the Trust. Both the Board of Directors and the Council of Governors are committed to continuing to promote enhanced joint working so that they can deliver their respective statutory roles and responsibilities in the most effective way possible. The Board considers that the Council of Governors has been effective in fulfilling its statutory role during the year.

Awareness of governors' and members' views

The Council of Governors actively seek to understand, represent and reflect the views of the Trust's members, patients and staff and the wider community in the discharge of its duties.

Governors canvass these views through a range of engagement mechanisms, including participation in local community groups, participation in quality assurance visits, and stakeholder events, engagement with members through the Trust's membership programme, and ongoing communication activity to ensure member views are represented within the Trust.

The Trust's Membership Strategy continues to strengthen these arrangements, supporting improved diversity of the membership and enhancing communication with members, with Governors encouraged to engage directly with local communities and events to gather views. The Council of Governors Membership Sub-Committee meets quarterly to provide oversight and review of activities in association with the Membership Strategy.

During the year, the Board was kept informed of the views of governors and members through a variety of means, including:

- Attendance and agenda item presentations by executive directors and non-executive directors at all quarterly Council meetings, where governors can ask questions and provide feedback
- Council meetings held in public
- Quarterly informal non-executive directors and governors' meetings
- Quarterly Chief Executive Officer briefing sessions with governors
- Regular Lead and Deputy Lead Governors meetings with the Trust Chair and Trust Secretary's Office
- Attendance by governors at Board of Director meetings
- Public "Your Voice" member meetings across Trust constituencies, enabling members and the public to meet with the Chair, Chief Executive Officer, directors, senior managers and governors
- Annual Members Meeting
- The Trust's website

- The Trust fosters an 'open door' policy where issues, queries and feedback can be raised with the Chair, the Chief Executive and any Board member as appropriate, either on a face-to-face basis or via email.

Table 37: Council of Governors Meeting Attendance 2025/26

Name	Term	Attendance at Council of Governor Meetings (actual/possible)	
		Elected Public: Milton Keynes, Bedfordshire and Luton	
Paula Grayson	3 term: 3 years	Jun 2022 – Jun 2025	1/1
John Jones	3 term: 3 years	Jun 2022 – Jun 2025	1/1
(Lead Governor)			
Elected Public: Essex Mid and South			
Simon Cross	1 term: 3 years	Jun 2025 – Jun 2028	4/4
Gwyn Davies	1 term: 3 years	Sep 2023 - Sep 2026	5/5
Kingsley Edore	1 term: 3 years	Sep 2023 - Sep 2026	0/5
David Finn	1 term: 3 years	Sep 2023 - Sep 2026	5/5
Richard Gregory	1 term: 3 years	Jun 2025 – Jun 2028	3/4
Megan Leach	2 term: 3 years	Jun 2025 – Jun 2028	2/5
Pamela Madison	3 term: 1 year, 11 months	Sep 2023 - Aug 2025	1/1
David Norman	1 term: 1 year, 8 months	Sep 2023 - May 2025	0/1
Stuart Scrivener	3 term: 3 years	Jun 2025 – Jun 2028	5/5
(Lead Governor)			
Ekoh West	1 term: 3 years	Jun 2025 – Jun 2028	2/4
Elected Public: North East Essex and Suffolk			
Ashley John	1 term: 3 years	Jun 2025 – Jun 2028	2/4
James McCarthy	1 term: 3 years	Jun 2025 – Jun 2028	3/4
Cort Williamson	2 term: 3 years	Jun 2025 – Jun 2028	5/5
Elected Public: West Essex, Hertfordshire and Rest of England			
Voke Aghoghovbia	1 term: 3 years	Jun 2025 – Jun 2028	2/4
Nat Ehigie-Obano	1 term: 3 years	Jun 2024 – Jun 2027	5/5
Jason Gunn	2 term: 3 years	Jun 2025 – Jun 2028	3/5
Olivia Houlihan	1 term: 3 years	Jun 2025 – Jun 2028	1/4
Bilaminu Yesufu	1 term: 3 years	Sep 2023 - Sep 2026	0/5
Elected Staff: Clinical			
Spencer Dinnage	1 term: 2 years, 2 months	Apr 2025 – Jun 2027	4/5
Ibraheem Lateef	1 term: 3 years	Sep 2023 - Sep 2026	1/5

Name	Term		Attendance at Council of Governor Meetings (actual/possible)
Oladipo Ogedengbe	1 term: 1 year, 9 months	Dec 2024 – Sep 2026	3/5
Edwin Ugoh	1 term: 3 years	Jun 2022 – Jun 2025	1/2
Elected Staff: Non-Clinical			
Zisan Abedin	1 term: 2 years, 4 months	Sep 2023 - Jan 2026	2/4
Helen Semoh	1 term: 1 year, 7 months	Jun 2024 – Jan 2026	2/4
Appointed: Essex County Council			
Andrew Johnson	1 term: 2 years	Jun 2025 – Jun 2027	0/4
Holly Whitbread	1 term: 10 months	Aug 2024 – Jun 2025	0/1
Appointed: Southend on Sea Council			
Maxine Sadza	2 term: 3 years	Jul 2024 – Jul 2027	3/5
Appointed: Thurrock Council			
Elizabeth Rigby	1 term: 2 years	Jun 2025 – Jun 2027	3/4
Neil Speight	1 term: 10 months	May 2024 – Jun 2025	1/1
Appointed: Anglia Ruskin and Essex Universities			
Nicky Milner	1 term: 2 years, 10 months	Aug 2022 – Jun 2025	1/1

The Trust is committed to ensuring that elections and re-elections to the Council of Governors are conducted in a transparent and informed manner, enabling members to make well-informed decisions.

As part of the election process, all candidates are required to submit a supporting statement, outlining their experience, skills and motivations for seeking election. These submissions are subject to review by the Trust Secretary's Office to ensure accuracy and appropriateness.

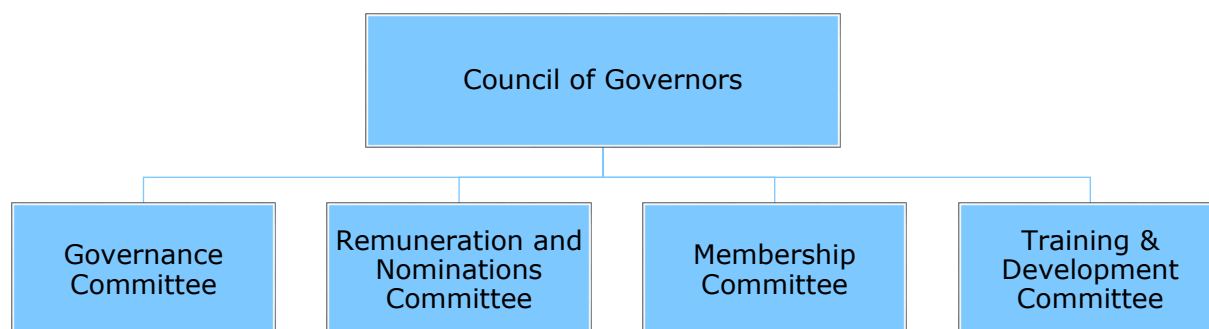
Candidate statements are made available to members as part of the election materials, providing information on the skills, experience and perspectives that individuals would bring to the Council of Governors.

In respect of re-election, the Trust recognises the importance of transparency in relation to a Governor's contribution and ongoing suitability for the role. Where the Trust is aware of any relevant performance-related matters, including concerns relating to attendance, engagement or conduct, these would be appropriately reflected within the candidate's statement, in line with the Trust's governance processes and regulatory requirements.

Council of Governors Committees

The Council's committee governance framework is designed to ensure it robustly supports and enables the Council to fulfil its duties, roles and responsibilities effectively. The Committees do not have any delegated authority. All responsibilities are undertaken in support of the Council, as it is the Council of Governors that holds the responsibility for decisions relating to all issues covered by the Committees.

Figure 17: Committee structure underpinning Council of Governors



In line with good governance practice, an effectiveness review of the Council of Governors and its sub-committee structure is currently being completed and will be reported to the Council of Governors meeting in August 2026. The sub-committees present an annual report to the Committee, providing details of its activity over the previous year and confirming the Committee met its Terms of Reference.

The Council of Governors Training and Development Committee is a subcommittee of the Council which ensures effective and robust training and development arrangements are in place to develop Governors' skills, knowledge and capabilities.

The Trust has an established structured and systematic approach to assessing and developing the capability of Governors, ensuring that the Council of Governors collectively maintains the skills and knowledge required to effectively discharge its statutory duties (for example all Governors as invited to attend induction programmes following each election period as a refresher of core skills and experience).

A Governor Learning and Development Plan is in place and reviewed annually, informed by an assessment of the core competencies required of Governors and aligned to relevant NHS guidance. The Council of Governors Training and Development Sub-Committee reviews new guidance (e.g. Fit for the Future: 10 Year Health Plan for England); Trust strategic objectives, financial and quality oversight to identify new training needs and agree amendments to the plan.

The programme of development opportunities includes a combination of:

- structured induction for new Governors (refresher for existing Governors)
- targeted development sessions aligned to key areas such as strategy, quality, finance and governance; and
- access to external learning resources and guidance relevant to NHS Foundation Trust Governors.

This approach ensures that development activity is planned and responsive to identified capability requirements, rather than solely reactive or ad hoc.

The development plan is kept under review as part of the Council of Governors arrangements to ensure the Council continues to operate with the necessary skills, knowledge and confidence to fulfil its responsibilities. The Council Governors made the annual self-assessment of training provided to Governors to inform the Board self-certification of discharging this duty.

During the year, the Trust has hosted or provided governors with access to a range of training and development opportunities with the purpose of enhancing their knowledge and understanding of the organisation.

All governors have undertaken a comprehensive induction programme, which is regularly reviewed and updated, taking account of best practice from the national and local sources. This includes a Governor Induction Handbook based on handbooks developed by NHS Providers, which provides new Governors with information about the Trust and their role as governors.

Governors are kept regularly informed through direct emails. Knowledge is kept up to date through the sharing of best practice and centrally published information. In addition, the Chief Executive Officer provides a briefing in private prior to each Council meeting.

The Trust has established procedures to support high standards of conduct, behaviour and participation by Governors. This is underpinned by the Code of Conduct for the Council of Governors Procedure and the Governor Meeting Attendance Monitoring Procedure, which together set out the expected standards of behaviour, engagement and attendance to effectively discharge their statutory duties.

These arrangements operate collectively to provide a transparent and proportionate framework for identifying and addressing concerns relating to Governor conduct or participation. Where Governors fall short of the required standards, the Trust's procedures support a graduated response, including early engagement, clarification of expectations and, where appropriate, escalation.

In circumstances where concerns cannot be resolved through these processes, the Trust's Constitution sets out the formal provisions for the removal of a Governor.

During 2025/26, no Governors required formal removal under these provisions and five cases were managed through the monitoring of Governor attendance procedure.

Council of Governors Register of Interests

All members of the Council of Governors have a responsibility to declare relevant interests as defined in the Trust's Constitution. Declarations made are entered into a register which is retained by the Trust Secretary's Office.

Governor expenses

Whilst governors do not receive remuneration, they are entitled to claim travel and other expenses in line with Trust policy. Eight governors in place during the year claimed expenses, with all claims totalling £1,314.72.

Contacting our governors

Our governors can be contacted through our Membership Office:

Email: epunft.membership@nhs.net

Freephone: 01268 739739

Post: Freepost RTRG-UCEC-CYXU

Trust Secretary's Office

The Lodge, Lodge Approach

Wickford

SS11 7XX

Annual Report of the Council of Governors

Over the past year, we have continued to embrace our role as Governors as constructive and supportive partners to the Trust. We provide constructive challenge, ask thoughtful questions and ensure robust processes are followed. Most importantly, we've kept the wellbeing of patients and carers at the heart of every decision.

We welcomed Hattie Llewelyn-Davies to the Trust in April following her appointment as our new Trust chair. Hattie brings a wealth of experience, having chaired several NHS organisations over the years. Before joining the NHS, she held several Chief Executive and senior leadership roles in the housing and homelessness sector. Although she has only been with us for a short time, Hattie has already brought fresh thinking, new ideas and, most importantly, a genuine passion for making things better for everyone who uses and works in our services.

We also welcomed two new Non-Executive Directors in April / May, Richard Spencer and Sarah Teather, following a recruitment process undertaken in the previous financial year. Both Richard and Sarah bring a great deal of senior leadership experience to the Trust, built up across the public, voluntary and private sectors. Their combined backgrounds help the Council of Governors ask the right questions, offer constructive challenge and keep the needs of patients, families and local communities at the heart of discussions. Together, they have strengthened our ability to support the Trust and carry out our role effectively over the past year.

As Governors, we have the opportunity to visit Trust services. I have personally visited a number of sites and know that many of my fellow Governors have also undertaken Quality Assurance Visits during the past year. These visits give us valuable insight into how service is experienced by both patients and staff.

We also actively engage with our membership and members of the public. This includes public meetings (such as Board Meetings, Your Voice Sessions), local visits (Anglia Ruskin University, Chelmsford College) and attendance at key events such as EPUT Forums, and the Co-Production conference. This engagement ensures that the views of members and the public are shared with the Board when key decisions are made. By attending public Board meetings, Governors can see how the Board works and raise questions on your behalf, keeping patients and carers at the heart of decisions.

We want to assure you, our members, that EPUT follows the Code of Governance. Put simply, this means the Trust works to clear standards that help ensure it is well run, open, and accountable. Good governance supports strong performance and, most importantly, helps make sure decisions are made in the best interests of patients and those who use our services. When we visit Trust sites and spend time meeting staff, we see first-hand the dedication they

bring to their roles every day. Their compassion for the people they support, and their determination to provide the best possible care, is clear. We are truly grateful for their hard work and the difference they make to patients, families and communities.

As I come to the end of this year's report, we would like to thank you for your continued support, interest and commitment to the Trust. Your membership really does matter. It strengthens our collective voice and helps ensure that the services we provide reflect the needs of the communities we serve.

If you have any questions about this report, ideas you would like to share, or issues you would like us to explore on your behalf, please do get in touch. We are here to represent you and always welcome hearing your views.



Stuart Scrivener
Lead Governor

Membership

Foundation trust membership aims to give local people, service users, patients and staff a greater influence in how the Trust's services are provided and developed. The benefits to the Trust in developing an effective membership and providing active engagement include:

- Wider engagement with and improved access to the views of the populations and communities we serve.
- Improved and more representative feedback from the local population as a whole.
- A better understanding of service user/patients' views in identifying particular service needs/gaps in services and feedback on how well services are meeting the requirements of local communities, improving the quality of care.
- Continuing to build good and trusting relationships.
- The ability to inform/consult with local communities on the work of the Trust, including service developments.

Membership is important in helping to make the Trust more accountable to the people we serve, to raise awareness of mental health, community health and learning disabilities and helps the Trust to work in partnership with our local communities.

The membership structure for the Trust is made up of two categories of membership:

- **Public Members** - Anyone aged 12 and over living in England can become a member. Public membership is sub-divided into four constituencies which reflect the areas within which the Trust delivers services, one of which - Bedford, Luton, Milton Keynes - also includes the rest of England.
- **Staff Members** - All staff who are on permanent or fixed term contracts that run for 12 months or longer automatically become members, unless they opt out. Staff who are seconded from our partnership organisations and are working in the Trust on permanent or fixed term contracts that run for 12 months or longer are also automatically eligible to become members. Staff are members of one of two sub-groups which are linked to their different fields of work – clinical or non-clinical.

These arrangements support the Trust's accountability to its members and are consistent with the Code of Governance for NHS Provider Trusts.

Membership size and breakdown

Our aim is to establish and maintain a broad and engaged membership that is evenly spread geographically across the areas we serve and reflects the ages and diversity of our local population.

Table 38: Membership Breakdown

Membership size and movements	
Public constituency	Last Year (2025/26)
At year start (April 1)	4,065
New members	69
Members leaving	195
At year end (March 31)	3,939
Staff constituency	Last Year (2024/25)
At year start (April 1)	4,832
New members	27
Members leaving	794
At year end (March 31)	4,065
Analysis of current membership	
Analysis of current membership	Last Year (2023/24)
Public constituency	Number of members
Age (years):	
0-16	2
17-21	6
22+	3,485
Ethnicity:	
White	2,899
Mixed	78
Asian or Asian British	350
Black or Black British	267
Other	13
Socio-economic groupings*:	
AB	1,017
C1	1,152
C2	835
DE	889
Analysis of current membership	
Gender Analysis	Last Year (2023/24)
Male	1,551
Female	2,282

The analysis section of this report excludes:

- 446 public members with no dates of birth, 330 members with no stated ethnicity and 106 members with no stated gender.

Membership strategy

During the year, the Trust continued to implement its Membership strategy. The strategy was approved by the Board in November 2023 and by the Council of Governors in December 2023. It runs for three years until 2026 and includes the following priorities:

- Establish a membership that is representative of the population served by EPUT
- Communicate effectively with members and ensure their views are represented within EPUT
- Develop a process to ensure membership engagement operates across the system and with Integrated Care Boards.

The Council of Governors agreed to adjust the final priority for the third year of the strategy to incorporate the proposed changes to the role of the Council of Governors and Membership.

Each priority has key milestones to be achieved for each year of the strategy, and a series of sub-actions have been identified to achieve each milestone. The sub-actions are detailed in an implementation plan which is overseen by the Council of Governors' Membership Committee.

The strategy completed its first year of implementation in March 2025, with the following key achievements:

- The use of census data established that the Trust Membership was underrepresented amongst young people (under the age of 30). As a result, the focus has been on establishing links with local colleges and universities with the attendance at fresher's week as the first achievement.
- More work is underway, including the delivery of talks, where membership can be promoted alongside.
- Regular communication with members has now been established again and will continue throughout the year.
- Governors attending local groups and events is still an ongoing issue and Governors are encouraged to research groups and events in their own areas to attend as an EPUT Governor.

The third year of the strategy is now underway.

Engagement and recruitment of members

The Membership strategy includes a priority to establishment a membership that is reflective of the population served. This includes comparing membership demographics with national data to identify areas of under-representation for targeted attention.

During 2025/26, the Trust held a Your Voice meetings online and attended other Trust events to engage with members, such as attending colleges, universities and the EPUT Co-Production conference.

Members are also kept up to date with developments at the Trust by:

- Direct communication
- The Trust's website
- Following the Trust on social media
- Attending public meetings of the Board of Directors and Council of Governors
- Attending locality-based patient/carers events
- Attending the Annual Members' Meeting
- Attending Patient Forums.



Paul Scott
Chief Executive Officer
24 June 2026

Glossary

BMS	Building Management Systems	MSEFT	Mid and South Essex Foundation Trust
BWC	Body Work Cameras	NED	Non-Executive Director
CAMHS	Child and Adolescent Mental Health Service	NHSCFA	NHS Counter Fraud Authority
CBI	Confederation of British Industry	NOF	NHS Oversight Framework
CQC	Care Quality Commission	NQPS	National Quarterly Pulse Survey
CRR	Corporate Risk Register	PAH	Princess Alexandra Hospital
DHSC	Department of Health and Social Care	PALS	Patient Advice and Liaison Service
DDQI	Data Quality Maturity Index	PCREF	Patient and Carer Race Equality Framework
EDI	Equality, Diversity and Inclusion	PFI	Private Finance Initiative
EDS	Equality Delivery System	PLACE	Patient-Led Assessment of the Care Environment
EPR	Electronic Patient Record	PSED	Public Sector Equality Duty
EQUIA	Equality and Health Inequality Impact Assessment	QAV	Quality Assurance Visit
FFT	Friends and Family Test	SR	Strategic Risk
GAM	General Accounting Manual	STaRS	Specialist Treatment and Recovery Service
GDPR	General Data Protection Regulations	SUN	Service User Network
ICB	Integrated Care Board	TCFD	Taskforce on Climate-Related Financial Disclosures
ICS	Integrated Care System	UCL	University College London
IFRS	International Financial Reporting Standard	VSM	Very Senior Manager
IWGC	I Want Great Care	WDES	Workforce Disability Equality Standards
KPI	Key Performance Indicator	WECHS	West Essex Health and Care Partnership
LGPS	Local Government Pension Scheme	WRES	Workforce Race Equality Standards
MARS	Mutually-Agreed Resignation Scheme	WTE	Whole Time Equivalent
MSECC	Mid and South Essex Community Collaborative		



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Statement of the Chief Executive's Responsibilities as the Accounting Officer of Essex Partnership University NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS England.

NHS England has given Accounts Directions which require Essex Partnership University NHS Foundation Trust (the Trust) to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy; and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information. To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.



Paul Scott,
Chief Executive Officer
24 June 2026

Annual governance statement for the year ended 31 March 2026

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Essex Partnership University NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently and economically. The system of internal control has been in place in Essex Partnership University NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

Capacity to handle risks

The overall responsibility for risk management within the Trust rests with me and the Executive Management team, along with the requirements to meet all statutory requirements and adhere to the guidance issued by NHS England and the Department of Health and Social Care in respect of governance. As the Accounting Officer, I am accountable for ensuring that the Trust can discharge its legal duty for all aspects of risk. I have overall responsibility for the management of risk and for maintaining a sound system of internal control.

Leadership arrangements for risk management are detailed in the Trust's Risk Management Framework, supported by the Board Assurance Framework and individual job descriptions. The Risk Management Framework outlines our approach to risk and the accountability arrangements including the responsibilities of the Board and its committees, Executive Directors and all staff.

Active leadership from all managers at all levels to ensure effective risk management is a fundamental part of an integrated approach to quality, corporate and clinical governance, performance management and assurance.

The Executive Director of Governance has delegated responsibility for the Trust's Board Assurance Framework and for ensuring the implementation of the risk management framework within services. All Executive Directors have responsibility to identify and manage risk within their specific areas of control in line with the management and accountability arrangements in the Trust. Directorates and Care Units have identified leads for risk management. Risks and mitigations are considered at all Accountability Framework meetings.

The Board and its committees receive and scrutinise the risks to achieving our strategic objectives through the Board Assurance Framework. The Audit Committee has delegated responsibility for developing, maintaining and monitoring the risk management and assurance systems within the Trust and specifically the Board Assurance Framework. Care Units and corporate directorate team meetings review their Risk Registers the Trust's Executive Operational Group regularly reviews the Corporate Risk Register. All members of staff have an important role to play in identifying, assessing and managing risk.

The Trust engenders a fair, open environment and does not seek to apportion blame. Where staff feel that raising issues or concerns may compromise them or may not be effective, they are encouraged to follow alternative feedback mechanisms, including through the Freedom to Speak-Up Guardian and / or the Trust's Freedom to Speak-Up / Whistleblowing policy.

The Trust ensures that staff are equipped to manage risk in a variety of ways and at different levels of strategic and operational function. Staff are trained in various aspects of risk management, including as part of the on-boarding process for new staff. The training is designed to provide an awareness and understanding of the risk management framework, the risk management process and to give practical experience of completing risk assessments. Additional training is made available to all levels of staff covering areas such as fire safety, health and safety, moving and handling, resuscitation and first aid. The Trust regularly shares information and with all staff to support learning from good practice, experience and lessons learnt from incidents or near misses. The Trust uses Quality Improvement (QI) methodology to encourage staff to learn from good practice. Local improvement data is shared and visible to teams so that they can learn from, scale-up and spread what works well.

The Risk and Control Framework

Key elements of the risk management framework

The Trust considers risk management to be an intrinsic part of our governance and quality frameworks and an essential element of the entire management process and not a separate entity. The management of risk underpins the achievement of the Trust's strategic objectives, and effective risk management is imperative to provide a safe environment and improved quality of care for service users and staff.

Risk management including clinical, non-clinical, corporate, business and financial risks is intrinsic in the operational and strategic thinking of every part of service delivery within the organisation and applies to all staff. Risk management processes involve the identification, evaluation and treatment of risk as part of a continuous process aimed at helping the Trust and individuals to reduce the incidence and impact of the risks they face.

The Trust Risk Management Framework details our risk management arrangements. Potential risks are identified from a variety of sources, including risk assessments, risk registers, incidents, safety alerts, management, complaints, claims, internal / external reviews and staffing trends. The framework overarches both clinical and non-clinical risk management and defines risk and identifies individual collective responsibility for risk management within the organisation. It also sets-out the Trust's approach to the identification, assessment, scoring, management and monitoring of risk. The framework also includes the Trust's risk appetite statement for the levels and types of risk the Trust is prepared to accept in pursuance of its strategic priorities by

considering the Trust's position against a range of factors including national policy, system requirements, local plans and pressures.

The Trust manages its most significant current and future potential risks to the achievement of our strategic objectives through the Board Assurance Framework that provides a structure for the effective and focused management of principal risks. Risks are assessed by using a 5 x 5 (Likelihood x Consequence) risk matrix where the total score is an indicator as to seriousness of the risk. Each risk is allocated an Executive Director lead and a lead committee of the Board, and these risks are reviewed at committee meetings. The Board reviews the complete Board Assurance Framework at its meetings in public.

Quality Governance

The Trust has an accountability framework in place as an executive management system to oversee performance and gain assurance in an integrated, consistent and transparent way, including through care units and corporate directorates. The framework covers five domains:

- Quality and Safety
- Operational Performance
- Workforce and Culture
- Finance
- Strategy, Transformation and External Relations

Maintaining an effective quality governance system supports our compliance with national standards and we are committed to continuous improvement of our systems. The Trust has a risk on the Board Assurance Framework relating to quality governance (SR13) to ensure there are effective quality governance processes in place to provide thorough insight into quality risks. The risk noted the importance of the development and embedding of governance and reporting (including triangulating a range of quality and performance information) to ensure there is consistent understanding of key risks and mitigating actions, leading to the consistency of standards across the Trust.

The Quality Committee is the key governance committee, which is a standing committee of the Board that is chaired by a Non-Executive Director. The Committee seeks assurance that high standards of care are provided, that quality improvement and learning is embedded in the Trust, and ensures that adequate and appropriate governance structures, processes and controls are in place across the organisation. The Committee receives regular assurance reports focused on safer staffing, learning from deaths. NICE compliance safeguarding, medicines management, infection control and health & safety.

Performance matters are overseen by the Trust's Finance and Performance Committee.

The Board receives regular quality and performance reports at its meetings in public. The quality report provides the Board with assurance related to quality across the Trust, incorporating two domains of quality assurance and quality improvement. Quality control is covered in the quality and performance scorecard report that contains quality measures at an organisation level and provides an oversight of strategic performance and risk issues. The quality of performance information is assessed through the Data Security Protection Toolkit.

The Trust aspires to provide care of the highest quality, working with people who use our services. The aspiration is supported by our quality management system, which includes quality planning, quality control, quality assurance and quality improvement. We embrace continuous improvement and learning through our established quality improvement programme. We provide training for all staff to help them develop the skills they need to lead change and deliver improvements to patient experience and outcomes, focusing on what matters most to our service users and staff.

The Trust is registered with the Care Quality Commission (CQC) and is fully compliant with the CQC's registration requirements. Additional conditions of registration are placed on the Trust's services for accommodation for persons who require nursing or personal care at both Clifton Lodge and Rawreth Court Nursing Homes, specifically,

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

The CQC published three reports pertaining to the Trust's services in 2025/26:

- April 2025 – Forensic Inpatient or Secure Wards – Brockfield House (from an inspection completed in March / April 2024) receiving an overall rating of 'Good', with a 'Good' rating in all domains.
- July 2025 – Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units – Peter Bruff Ward, Ardleigh Ward and Chelmer Ward (from an inspection completed in November / December 2024) receiving an overall rating of 'Requires Improvement'
- November 2025 - Wards for People with Learning Disabilities or Autism – Byron Court (from an inspection completed in July 2025) receiving an overall rating of "Requires Improvement".

In year, the CQC undertook an unannounced focused inspection of Long Stay Rehabilitation (November 2025), following which a section 29A warning notice was issued for improvements to be made by 30 April 2026. The CQC completed an unannounced focused inspection of Ardleigh Ward, in January 2026.

The CQC also completed an announced inspection of Community Health Inpatients (Avocet Ward and Cumberlege Intermediate Care Centre) in December 2025. The final reports for all these inspections are awaited.

The CQC completed a Well-Led Inspection of the Trust in March 2026 and feedback is awaited.

The Trust is overall rated as 'Requires Improvement' by the CQC, with the rating for the caring domain being 'Good'.

The Trust continues to progress the improvement plan, in response to inspections. The plan is implemented by local operational CQC Care Unit meetings with oversight reporting to the Quality of Care Group and Quality Committee and this year our internal auditors provided a substantial assurance opinion for our improvement plan governance.

As of July 2025, 100% of actions of the 2022 CQC Improvement Plan were reported as closed, with 97% closed through the evidence assurance process. Therefore, a new plan was developed for inspections completed from 2025, with the 3% of actions awaiting evidence assurance transferred to the new plan. This brought the CQC Improvement Plan 2022 to a close.

As at the end of 2025/26:

- There were 73 actions addressing 16 'must do' / 'should do' recommendations made by the CQC.
- 76% of actions in response to the CQC recommendations have been reported as complete by action owners.
- 1% have been through the evidence assurance process and closed.

As of 31 March 2026, there are fourteen sub-actions past the original stated timelines, and action is being taken to recover the position.

Oversight is through the Quality of Care Group, Quality Committee, Board of Directors and System Partners. The Trust internal auditors completed an audit of the Management and Implementation of CQC Actions in October 2025, which received Substantial Assurance.

Embedding risk management in the activity of the organisation

Risk management is embedded throughout the Trust's operational structures, with emphasis on ownership of risk within the care units and directorates support by the Risk and Compliance Team. Directorates are responsible for maintaining their own risk registers that feed into the Trust's Corporate Risk Register. Local Risk Registers are reviewed at monthly care unit meetings and shared with the assurance team. Directorate representatives attend key committees of the healthcare governance framework ensuring formal channels of reporting, wide staff involvement and sharing of learning. The implementation of incident management and other risk-related policies and procedures throughout the Trust ensures the involvement of all staff in risk management activity.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to guidance) within the past twelve months as required by the *Managing Conflicts of Interest in the NHS* guidance.

The Trust maintains arrangements to prevent fraud, bribery and corruption, including policies on standards of business conduct, gifts and hospitality, and conflicts of interest, supported by counter-fraud services in line with NHS Counter Fraud Authority standards.

Trust major risks

The Board Assurance Framework includes eleven risks that align with the Trust's strategic objectives. Some risks and target scores reflect multi-year programmes. The standing committees of the Board review and discuss the controls and assurance for each of their assigned risks, including the actions identified to address gaps and whether there should be any changes to the current and / or target scores. The Audit Committee has responsibility for ensuring the Trust has good risk management processes in place, which operate effectively. To avoid duplication, the Audit Committee does not discuss in detail any risks that are the responsibility of other committees.

As of 31 March 2026, the Trust identified the most significant risks to the achievement of its strategic objectives as being:

- SR3: If EPUT does not adapt its infrastructure to support service delivery then it may not have the right estate and facilities to deliver safe, high-quality care resulting in not attaining our safety, quality and compliance ambitions. The Trust continued its strategy towards the ambition of being the leading health and wellbeing service in the provision of mental health and community services by continuing the implementation of the Estates Strategy developed in 2024. The Trust undertook a Premises Assurance Model (PAM) self-assessment during the year and is now in the process of implementing actions from this assessment. PAM reporting evidence strong and sustained improvements. In addition, the Trust has submitted expressions of interest for NHS Property Services properties. (Risk Score 15)
- SR4: If EPUT does not effectively address demands, then its resources may be over stretched, resulting in an inability to deliver high quality safe care, transform, innovate and meet partnership ambitions. The Trust completed the implementation of the new target operating model within inpatient mental health services. The Trust is moving to a Community First Transformation Programme to shift the focus to care provided in the community to improve flow and capacity across the system. The Trust continues to collaborate with system partners to improve patient flow and capacity. (Risk Score 15)
- SR5: If EPUT is not open and transparent, with the correct governance arrangements in place then it will not serve the Inquiry effectively or embed learning from past failings resulting in the undermining of the Quality of Care Strategy. The Trust has continued to fully cooperate with the Inquiry team and has strengthened the project team, including the appointment of a dedicated project director to ensure timely and effective responses are provided. There has been a significant increase in the number of Rule 9 requests, creating significant pressure on the project team, and the Trust has worked with the inquiry team to clarify requests for information and expected deadlines for the submission of information. These processes were overseen by a committee reporting directly to the Board to provide assurance the Inquiry is served appropriately and highlight any potential risks directly to the Board. This Committee was discontinued in December 2025, with direct oversight reverted to the Board. The Trust has continued to take action to ensure the systematic and sustained embedding of learning. (Risk Score 16)
- SR6: If EPUT experiences a cyber-attack, then it may encounter system failures and downtime, resulting in a failure to achieve safety ambitions, compliance and consequential financial and reputational damage. The Trust continues to hold cyber essentials plus accreditation and has implemented enhancements to the cyber assurance framework, which now reports regularly to the Finance and Performance Committee. The Trust has business continuity plans in place for IT disruption. (Risk Score 15)
- SR7: If EPUT does not have sufficient capital resource, e.g. digital and electronic patient records (EPR), then it will be unable to undertake essential works or capital dependent transformation programmes, resulting in non-achievement of some of its strategic and safety ambitions. The Trust faces an increasing backlog maintenance requirement across its large and aging Estate (c£114m) as well as EPR investment requirements. The Trust has therefore prioritised its capital plan and tracks key strategic investments to monitor the impact on the plan. The Trust actively horizon scans to maximise opportunities for both regional and national

investment and is engaged within system finance meetings where accountability for capital resources are held. A range of applications for additional capital have been submitted, and a planned set of site disposals is being progressed for the coming years. (Risk Score 20)

- SR8: If EPUT (as part of Mid and South Essex Integrated Care System) does not effectively and efficiently manage its use of resources, then it may not meet its financial control total, resulting in potential failure to sustain and improve services. The Trust has internal policies and processes to manage and monitor effective and efficient management of resources, including standing financial instructions, scheme of delegation and accountability framework meetings. The Trust has continued additional oversight and support for areas of highest spend, such as use of temporary staffing, which has seen significant improvements in this area. The Executive Chief Finance Officer and deputies continue to be actively involved and engaged with the system finance meetings and delivering financial sustainability. The Trust recognises the challenging and associated risks that exist at both local, ICS and national levels and has enhanced pay and non-pay controls measures in place. (Risk Score 20)
- SR9: If EPUT does not have the required capability and expert knowledge to deliver the digital and data strategy, then the trust may fail to achieve strategic ambitions. Specifically, embedding a digital mid-set and culture, which may result in limitations in its ability to procure and implement the appropriate technology to support the integration of care close to where service users live, and support staff to undertake their duties effectively; threaten the development of patient facing technologies to support service users, families and carers; and stall its capability and agility to use data to inform both direct care and insight driven decision making. The Trust is currently in the process of implementing phase two of its digital target operating model, which is impacted by the progress of the Nova Unified Electronic Patient Record (UEPR) programme. The UEPR programme has continued to progress, with new risks identified and managed during the year, which has included the raising of a specific risk to the corporate risk register. (Risk Score 15)
- SR10: If EPUT does not have workforce plans that support recruitment and development; then staff may not choose to remain at EPUT, resulting in associated skills deficit, reliance on temporary staffing, staff morale and its ability to provide high quality of care to service users. The Trust has continued to deliver the People and Education Strategy Implementation Plan for 2025/26 and has ensured effective workforce and recruitment planning takes place. This has resulted in continued improvement in turnover and vacancies. Staff sickness has increased in year, and a comprehensive review is underway to identify services and areas where sickness exceeds 5% to identify proposals to improve the position. (Risk Score 12)
- SR11: If EPUT does not effectively and efficiently manage a coherent staff retention strategy, then it will continue to effect staff and skills shortages in certain professions resulting in associated skills deficit, impact on staff morale and the ability to provide high quality of care to service users. The continued implementation of the People and Education Strategy has ensured a greater focus on staff retention. The Trust is demonstrating a positive trend in staff turnover and vacancy rates alongside a continued improvement in temporary staff use. (Risk Score 12)
- SR12: If EPUT does not have in place effective organisational development support to address cultural development and management of change, then it may not achieve a positive impact, resulting in suboptimal outcomes for staff and patient care. The Trust completed a restructure

of the Organisational Development and Culture structure to meet aims and objectives identified through the previous years gap analysis. The Trust has undertaken a cultural and leadership review with external support, with a view to reporting outcomes in the early part of 2026/27. (Risk Score 16)

- SR13: If EPUT does not have in place effective floor to Board quality governance and is not able to provide thorough insights into quality risks caused by the need to further develop and embed governance and reporting (including triangulating a range of quality and performance information), the this may result in inconsistent understanding of key risks and mitigating actions, leading to variance in standards. The Trust has a Quality of Care Strategy, which is supported by a range of other policies and processes, such as a Quality Assurance Framework, quality visits programme and information driven oversight arrangements. The Trust Internal Auditors are currently undertaking a review of Quality forums from Care Unit to Board and reporting to strengthen quality governance. (Risk Score 15)

The Trust has processes whereby risks are identified such as, risk assessments, clinical benchmarking, audit data, clinical and non-clinical incident reporting, complaints, claims, patient and public feedback, stakeholder and partnership feedback, national and regional risk registers held by NHS England / local Integrated Care Systems and internal / external assessment, including Care Quality Commission inspection reports.

At Essex Partnership University NHS Foundation Trust, we believe that every incident offers an opportunity to learn. The reporting of incidents is a fundamental building block in achieving an open, transparent and fear-free way of fulfilling this aim. Our structures and frameworks promote learning, escalation, treatment and mitigation of, or from, risk.

We recognise the rapidly changing health and social care landscape – both nationally and locally – combined with wider system pressure poses potential risks to the sustainability of high-quality service provision for the populations we serve and our financial sustainability, as well as providing opportunities for further improvement.

The Board continuously reviews the risks that may affect the Trust's achievement of its strategic priorities.

NHS Foundation Trust licence condition compliance.

The Trust's risk and governance frameworks as described in this statement ensures that the organisation can confirm validity of its governance arrangement as required under NHS provider licence section 4 (NHS2 Governance arrangements). The Trust Executive team undertakes an annual review of its compliance with these principles, systems and standards of good corporate governance and flags for the Board's attention those areas where action is required. The Board of Directors reviews the Corporate Governance Statement itself, with a summary of evidence supporting it.

During the year, the Board used a number of mechanisms to gain positive assurance that the Trust continued to comply with those requirements, in preparation for the making of the statement. These included regular reporting from Board Committees regarding the level of assurance in respect of the matters that they were delegated to oversee, receiving patient and staff stories to hear directly about the quality of care provided to patients; regular reviews of the

Board Assurance Framework and reviewing the risks recorded within it; and regular consideration of key business plans, and updates on progress for the various projects within the Trust's strategic and transformation programme.

A self-assessment of compliance against the Trust's licence is undertaken by the Executive Director of Corporate Governance and reviewed by the Finance and Performance Committee. The Trust also has a programme of internal audit in place aligned to key areas of potential financial and operational risk. The Board has not identified any principle risks to compliance with provider licence section.

Involvement of stakeholders

The interests of our patients, carers, staff, members and local partner organisations are embedded in our values and demonstrated in our ways of working. Our Working in Partnership with People and Communities Strategy continues to be implemented and sets-out our ambition for involving stakeholders across all functions.

The Trust has a continuing positive relationship with stakeholders and staff through the delivery of strategic plans and delivering performance against contracts.

Risks to public stakeholders are managed through formal review processes with NHS England and local commissioners through joint actions on specific issues, such as emergency planning and learning from incidents, and through scrutiny meetings with upper tier local authorities' Health and Overview Scrutiny Committees. We work across the local health economy, including integrated care systems, particularly on the delivery of integrated care pathways. This way of working has been particularly effective in our collaborative working arrangements for specialist mental health services and community services.

The interests of our patients are overseen by the Director of Patient Experience through various forums and by including representatives in the coproduction of services, quality improvement initiatives, peer support workers and other patient-led programmes. The Council of Governors represents the interests of members (both public and staff) as well as appointing organisations and has a role in holding the Non-Executive Directors both individually and collectively to account for the performance of the Board.

The Trust workforce

Staffing

During the year, the Trust's workforce planning has continued to focus on ensuring our operational care units are able to recruit and retain the staff required to ensure high quality, safe care can be provided. The Time To Care programme was fully implemented during the year, which focused on inpatient services, to increase staffing levels for critical clinical roles.

The Time To Care programme will continue as part of Trust business, with the benefits reported to the relevant standing committees of the Board and contractual oversight meetings.

The Trust introduced a new programme, Community First, which will focus on community services to improve flow and capacity as part of the wider system, and this will continue to be implemented

during 2026/27.

The work undertaken during 2025/26 has led to the successful appointment of 1,107 staff split across the following staffing groups:

- 316 registered Nurses
- 41 Allied Health Professionals
- 312 Additional Clinical Services of which 147 Healthcare Assistants
- 7 Substantive Medical staff and 5 NHS Locum medics (47 Trainee Medics)
- 109 Additional Professional, Scientific and Technical
- 270 Infrastructure support roles

The Trust-wide vacancy rate is 8.8 percent and a turnover rate of 8.8 percent in March 2026, which is below the Trust target of 10 percent.

The Trust has collaborated closely with Care Unit management teams and clinical leaders to establish safe staffing levels for each ward and unit. The governance arrangements enables us to review staffing levels to ensure the delivery of high quality, safe care for our patients while operating efficiently. These efforts will help us continue to drive improvements in care and services across the Trust. The Trust has effective systems and processes in place to assure the Board that staffing is safe, sustainable, effective and supports provision of a quality service. The Trust regularly reviews staffing establishments, ensuring the right number and skill mix of staff are available to meet the needs of people using our services. These reviews include use of evidence-based tools where available, national guidance, reviews of quality measures, quality outcomes and professional judgement.

The Trust has continued to reduce its reliance on temporary staffing, with lower levels of usage sustained into 2025/26. Continued enhanced and focused oversight has resulted in a corresponding reduction in temporary staffing costs of 23 percent.

On a daily basis, professional teams undertake daily staffing reviews in line with standard operating procedures, considering staff numbers, skill mix and competencies, patient acuity, dependency and activity. Where indicated, staff are used flexibly to provide cover and risks are formally escalated for action.

The Trust completed an annual safer Staffing establishment review in February 2026, providing the Board with assurance that safer staffing standards were being met. The Trust electronic roster system for nursing staff details the type and number of staff required to meet patient care and treatment needs. Rotas for trainee doctors are monitored for compliance with oversight from the Guardian of Safe Working and the People Committee. All changes to skill mix and new roles undergo a quality impact assessment which is signed off by the Executive Nurse and Executive Medical Director. The People Committee also oversees the Trust's wider talent management, leadership development and training initiatives, which are all designed to create resilience and capacity within the workforce.

During 2025/26, the Trust responded to industrial action by resident doctors, using emergency planning protocols to establish cover rotas and agree pay and escalation procedures.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules and that member Pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Equality, diversity and human rights legislation

Control measures are in place to ensure that all the Trust's obligations under equality, diversity and human rights legislation are complied with. In addition, strategies are in place to further equality, diversity and inclusion.

Financially viable programmes are subject to Quality Impact Assessment and Equality Impact Assessment as necessary, ongoing monitoring to ensure that efficiencies do not adversely impact on the quality of service delivery.

Climate change obligations

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has published an updated Green Plan 2026-29 in February 2026, which looks to build on the improvements and investments made over the past five-years. The Trust ensures that obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

Review of the economy, efficiency and effectiveness of the use of resources

As Accounting Officer, I have responsibility for ensuring economy, efficiency and effectiveness of the use of resources and am supported by my Executive team who are responsible for overseeing the day-to-day operations of the Trust. Performance in this area is monitored by the Board on a regular basis and through assurance reports from its standing committees. The Board discusses and approves the Trust's strategic and annual plans and budgets, taking into account the views of the Council of Governors.

The Board receives regular finance, financial viability, quality and performance reports which enable it to monitor progress in implementing the annual plan, and strategic objectives. The quality and performance scorecard presented to Board provides assurance on the delivery of Trust-wide performance, finance and compliance matters and seeks to demonstrate how the Trust is improving quality of life for the communities it serves.

The key processes embedded within the Trust to ensure that resources are used economically, efficiently and effectively centre on a robust budget-setting and control system which includes activity related budgets and periodic reviews during the year. These are considered by the Executive Directors, the Finance and Performance Committee and the Board.

The budgetary control system is complemented by Standing Financial Instructions, a Scheme of Delegation and financial approval limits. Due to the challenged financial environment in which the

Trust operates, the enhanced internal systems of control introduced in 2024/25 have continued, including reviewing non-pay spend to ensure the budgets are being utilised economically and the Trust is getting best value-for-money for any non-pay spend. Furthermore, Vacancy Control Panels operate across the Trust, and the Trust has been working to Triple Lock Control arrangements with System and Regional colleagues.

The Trust's Audit Committee supports the Board and me as the Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management and control environment. The scope of the Audit Committee's work is defined in its Terms of Reference and encompasses all the assurance needs of the Board and the Accounting Officer. The Audit Committee is involved with the work of internal and external audit and is chaired by a Non-Executive Director.

Information Governance

The Trust recognises the vital importance of data security and protection, as we hold sensitive personal data related to a large number of individuals, both patients and staff. The Trust has appropriate data security arrangements in place, including password restricted access to systems and information, and systems to record all access to records. Staff receive regular update training on information governance and security measures, and the Trust takes appropriate disciplinary action against staff who have improperly accessed information.

The Executive Director of Strategy, Transformation and Digital is the Executive-lead for information governance and is supported by staff within the Data Protection Officer Office, Information Governance Team and directorate leads.

The Trust nominated Caldicott Guarding is the Executive Medical Director and the Executive Director of Strategy, Transformation and Digital is the Senior Information Risk Owner (SIRO).

The Trust has policies in place which are compliant with NHS guidelines, and incident-reporting procedures are in place and utilised by staff. An Information Governance Steering Committee forms part of the Trust's healthcare governance framework and the Board receives reports on compliance with the Data Security and Protection Toolkit (DPST), The arrangements are in place to manage and control risks to information and data security and the Board has been assured by the SIRO, in the annual DSPT assessment that these are effective.

The Trust regularly reviews and updates its cyber assurance approach to align with the NCSC Cyber Assurance Framework (CAF).

There were two reportable incidents via the Data Security Incident Reporting Tool in 2025/26 that met the threshold for notification to the Information Commissioner's Office:

- **July 2025:** During a disciplinary hearing held via Microsoft Teams, a transcript of the hearing was automatically generated and subsequently made accessible via the Teams meeting chat to individuals who should not have retained access post-meeting. The meeting involved confidential witness testimony and HR-sensitive content. The ICO reviewed the incident and confirmed no further regulatory action, advising the Trust to check policies and procedures were fit for purpose, ensuring all staff received data protection training and investigate the incident, including the root cause. The Trust undertook the actions as advised by the ICO.

- **December 2025:** In June 2024, a provider of pathology services including blood, urine and specimen testing for a number of NHS organisations, was the victim of a cyberattack. During the night of 20 June 2024, NHS England was made aware that a cyber-criminal group published data it claimed to have stolen from the provider as part of this attack. On 24 June 2024, the provider confirmed that initial analysis indicated that the data published had been stolen from some of their systems. The Provider took urgent steps to limit the impact, including obtaining an injunction to prevent further publication of the data. A response from the ICO is awaited.

Ongoing training and awareness programmes are undertaken with individuals, teams and Trust-wide to reiterate the Trust's commitment to maintain the confidentiality of personal information.

Data Quality and Governance

A fundamental requirement for the Trust to deliver safe, high-quality care is the provision of timely and effective monitoring reports, using complete data. Key performance indicators are reported regularly to the Board as part of performance monitoring arrangements. Scrutiny of the information contained within the indicators and its implications for clinical outcomes, patient safety and patient experience takes place at the Board committees.

Reviews of data quality and the accuracy, validity and completeness of Trust information fall within the remit of the Audit Committee, which is informed by the review of internal and external audit management assurances.

The Trust achieved an average Data Quality Maturity Index (DQMI) score of 90.5% for Q1 and 90.6% for Q2 and achieved an average DQMI score of 90.9% for the most recent reporting period (Q3 2025/26) which is 3.8% above / below the national average. (noting that Q4 is yet to be published).

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Essex Partnership University NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on performance information available to me. My review is also informed by the comments made by the external auditors in their Audit Findings Report and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and other committees of the board and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Progress against actions are monitored by the Executive Team and the Audit and Quality Assurance Committees. The following processes have been applied in maintaining and review the effectiveness of the system of internal control:

- The Board met six times in public during 2025/26 and received a report at each meeting relating to finance, performance and quality, inviting scrutiny and challenge.
- A structure of standing committees beneath the Board provides a layered approach to monitoring, scrutiny and challenge of systems of internal control.
- A comprehensive quality, assurance and risk structure is in place.
- The Board has identified strategic risks facing the Trust that are included in the Board Assurance Framework, has monitored the controls in place and the assurance available to ensure that these risks are being appropriately managed. The Board received the Board Assurance Framework at each meeting as well as assurance reports from all standing committees.
- Executive Directors ensure that key risks have been identified and monitored within their directorates and the necessary action taken to address them. They are also directly involved in monitoring and reviewing the Board Assurance Framework and attend the assigned lead committees to report on risk with their areas of control.
- The Audit Committee provides the Board with an independent and objective view of arrangements for internal control and risk management within the Trust and ensures the internal audit service complies with mandatory audit standards. It approves the annual audit plans for internal and external audit activities, receives regular progress reports and individual audit reports, and ensures that recommendations arising from audits are actioned by Executive management.
- The Quality Committee receives internal audit reports at each of its meetings pertaining to quality related updates. A Non-Executive Director member of the Quality Committee is also a member of the Audit Committee.
- A clinical audit programme is in place to drive-up quality standards. The Quality Committee considers the clinical audit plan, and management ensures that appropriate action is being taken to address any areas of under-performance. An annual report of results is produced.
- The Trust has a local anti-crime and investigation service in place. The Audit Committee receives regular reports from the local anti-crime specialist.
- Internal audit services are outsourced to an organisation called TiAA who provide an objective and independent opinion on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives. Individual audit reports include a management response and action plan. Internal audit routinely follow-up actions with the management to establish the level of compliance, and the results are reported to the Audit Committee.
- The comprehensive programme of internal audit is aligned to key areas of potential financial and operational risk. My review is also informed by the work through the year of the Board of Directors and of Board standing committees, as described in the risk and control framework section above. I have also been informed by the work of the internal auditors during the year, working to a risk-based plan agreed by the Audit Committee and the action plans resulting to address areas for improvement.

Head of internal audit's annual opinion

In accordance with the Public Sector Internal Audit Standards (PSIAS), internal audit provides the Trust with an independent and objective opinion to the Accounting Officer, the Board of Directors and the Audit Committee on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

Internal Audit issued 13 reports in 2025/26 – see table below:

	Audit	Opinion	Status
1.	Compliance with Policies – Site Visits (2024/25)	Reasonable	Final
2.	Data Security and Protection Toolkit (2024/25)	Reasonable	Final
3.	Ann McIntyre Review (c/f from 2024/25)	Reasonable	Final
4.	Consent*	Limited	Final
5.	Management and Implementation of CQC Actions	Substantial	Final
6.	Apprenticeship Levy	Reasonable	Final
7.	Clinical Governance Arrangements	Reasonable	Final
8.	Fit and Proper Persons Test	Reasonable	Final
9.	Safety Plans	Reasonable	Final
10.	Employee Relations	Reasonable	Final
11.	Financial Assurance	Substantial	Final
12.	Follow Up of Limited Assurance E-rostering Report	Reasonable	Final
13.	Follow Up of Limited Assurance Consultant Job Planning Report	Reasonable	Final
14.	Payroll including Salary Overpayments	Reasonable	Final
15.	Board Assurance and Risk Management	Reasonable	Final
16.	Data Security and Protection Toolkit	Substantial	Final

***Consent** – The internal audit review focused on the effectiveness of the consent processes in place, focusing on the newly implemented arrangements for consent for remote monitoring. The auditors concluded that the Trust had a Standard Operating Procedure (SOP) in place which clearly outlined the processes in place for obtaining consent, training requirements and roles and

responsibilities. Audit testing identified gaps in documented evidence at service level, hence limited assurance was provided. Management action is being taken to address the recommendations, and a follow-up audit has been scheduled to take place in Q4 2025/26.

The framework for monitoring and review of action in response to internal audit reports is established and status for each reported at each Audit Committee meeting.

The annual report 2025/26 will note that: TIAA is satisfied that, for the areas reviewed during the year, the Trust has reasonable and effective risk management, control and governance processes in place.

The following matters have been identified by the Board as significant issues in relation to the Trust's system of internal control during the year. These issues have been subject to enhanced oversight and continue to be actively managed.

Lampard Inquiry: During the year, the Trust continued to be the subject of the Lampard Inquiry examining the deaths of mental health inpatients in Essex between 2000 and 2023. Its scope includes deaths occurring during inpatient care and within three months of discharge, and covers safety and quality of care, staff actions, organisational culture and governance, the adequacy of investigations, and the interaction between the NHS trusts and other public bodies. The inquiry represents a significant external examination of aspects of the Trust's governance and operational arrangements.

The Board established dedicated governance arrangements to oversee the Trust's engagement with the inquiry, including clear executive accountability, legal and professional support, and regular reporting to the Board. At the year end, the inquiry remained ongoing and therefore outcomes and recommendations were not yet known.

Looking forward the Trust has arrangements in place to identify and track emerging themes arising from the Inquiry. These themes will be triangulated with other sources of current organisational learning, including incidents, complaints, Prevention of Future Death reports, our safety improvement plans and regulatory feedback, to ensure a comprehensive understanding or underlying risks and areas requiring improvement. Governance arrangements will be kept under regular review to ensure they remain proportionate and effective as the Inquiry progresses.

The Trust is also establishing a readiness framework to respond to the Inquiry's final recommendations, which will include a structured assessment of the recommendations, prioritisation of actions, and clear reporting mechanisms to the Board, regulators and stakeholders.

The Board recognises the importance of openness, cooperation and learning, and is committed to implementing any recommendations arising from the inquiry and embedding learning across the organisation.

Resource Implications of Supporting the Lampard Inquiry: During the year, the Trust was required to support a statutory public inquiry. While the Inquiry is external in nature, the scale and duration of engagement required have had a material impact on organisational capacity, particularly at senior leadership, clinical leadership and corporate levels.

Supporting the Inquiry has necessitated the diversion of significant management and professional resource to activities including document identification and disclosure, witness preparation, governance coordination and engagement with legal advisers and the Lampard Inquiry team. This has created pressure on the Trust's ability to maintain business-as-usual activity alongside delivery of improvement programmes and operational priorities.

The Board assessed the cumulative impact of these capacity pressures as a significant issue for the system of internal control, given the risk of reduced organisational resilience and the potential for delay or strain in assurance, oversight and improvement activity.

In response, the Board established enhanced governance and oversight arrangements, including clear executive accountability for Inquiry support, regular reporting on resource impact, and active monitoring through the Board. Mitigating actions have included the temporary reconfiguration of responsibilities, prioritisation of critical activity, and the deployment of additional or specialist capacity to support both Inquiry activity and core operational functions.

The Board continues to monitor the impact of Inquiry-related demands on organisational capacity and is satisfied that appropriate arrangements are in place to manage the risks arising, while ensuring continued delivery of safe patient care and fulfilment of statutory duties. The Board recognises that these pressures are ongoing while the Inquiry remains active and will continue to keep the adequacy of mitigation and resourcing under regular review.

CQC Section 29A Warning Notice: During the year, the CQC issued the Trust with a Section 29A Warning Notice in relation to the Trust's Long Stay Rehabilitation Service (439 Ipswich Road). The Notice required the Trust to take immediate action to address areas of non-compliance with regulatory requirements.

The Trust responded promptly, approving an improvement plan and oversight arrangements, including addition service level assurance via non-executive directors. The Trust has continued to engage constructively with the CQC to demonstrate improvement and sustain compliance. At the year end, the Trust was in the process of writing to the regulator with evidence addressing the areas of non-compliance with regulatory requirements. In 2025/26 all other services subject to CQC inspections have maintained or improved in rating.

Conclusion

Whilst these matters represent significant challenges for the Trust and reflect areas where the system of internal control has required strengthening, the Board is assured that appropriate governance, risk management and oversight arrangements are in place to address these issues and that the system of internal control continues to evolve in response to risks identified.

Taking account of the work described above, I am satisfied that, subject to the significant issues outlined, the Trust has maintained an effective system of internal control throughout the period and up to the date of approval of the annual report and accounts.



Paul Scott
Chief Executive Officer
24 June 2026

Independent auditor's report to the Council of Governors of Essex Partnership University NHS Foundation Trust

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of Essex Partnership University NHS Foundation Trust (the 'Trust') for the year ended 31 March 2026, which comprise the statement of comprehensive income, the statement of financial position, the statement of changes in taxpayers equity, the statement of cash flows and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2026 and its expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion.

Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2025-26 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report and accounts, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report and accounts. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2025/26 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2025/26; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of the Chief Executive's responsibilities as the Accounting Officer, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS Foundation Trust Annual Reporting Manual 2025/26, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26).
- We enquired of management and the audit committee, concerning the Trust's policies and procedures relating to:
 - the identification, evaluation and compliance with laws and regulations;
 - the detection and response to the risks of fraud; and
 - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the audit committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of control, the risk of fraud in revenue and expenditure recognition. We determined that the principal risks were in relation to:
 - journal entries and other adjustments reflecting management override of controls, including unusual journals, estimates, transactions outside the normal course of business and manual journal entries that impact the control total through decreasing the level of expenditure;

- the occurrence and timing of revenue recognition in respect of other operating income streams (including research, education, non-patient services and grant income), which are more susceptible to manipulation as variable streams of income;
- the completeness of non-pay operating expenditure and associated liabilities, including the risk that expenditure is omitted or deferred to achieve financial targets; and
- the accuracy, completeness and existence of year-end accruals, including the risk of inappropriate estimation or inclusion of balances not representing genuine liabilities.

Our audit procedures involved:

- evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
 - evaluation of journal entries and other adjustments reflecting the risk of management override, including testing of journals across the full population to identify unusual or higher-risk entries, review of estimates and judgements for indicators of potential bias, and a focus on manual journals posted at year-end, transactions outside the normal course of business, and entries impacting the control total through reductions in expenditure;
 - testing of the occurrence of revenue recognition for other operating income streams, including research, education, non-patient services and grant income, through substantive sample testing;
 - testing of the completeness of non-pay operating expenditure and associated liabilities by sample testing invoices received post period end and payments made post period end;
 - sample testing year end accruals to confirm the existence and accuracy of transactions; and
 - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
 - We communicated relevant laws and regulations and potential fraud risks to all engagement team members. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
 - The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:

- understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
- knowledge of the health sector and economy in which the Trust operates
- understanding of the legal and regulatory requirements specific to the Trust including:
 - the provisions of the applicable legislation
 - NHS England’s rules and related guidance
 - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
 - The Trust’s operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
 - The Trust’s control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council’s website at:

www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor’s report.

Report on other legal and regulatory requirements – the Trust’s arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust’s arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

We have nothing to report in respect of the above matter.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust’s resources.

Auditor’s responsibilities for the review of the Trust’s arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust’s arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in March 2026. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for Essex Partnership University NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of Chapter 10 of the National Health Service Act 2006 and the Code of Audit Practice until we have completed the work necessary in relation to the Trust's consolidation schedules and we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2026. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2026.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

Parris Williams

**Parris Williams, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor**

**London
24 June 2026**

Foreword to the accounts

Essex Partnership University NHS Foundation Trust

These accounts, for the year ended 31 March 2026, have been prepared by Essex Partnership University NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

If you require any further information on these accounts, please contact:

The Executive Chief Finance Officer
Essex Partnership University NHS Foundation Trust
Trust Head Office
The Lodge
Lodge Approach
Runwell
Wickford
Essex SS11 7XX

Telephone: 01268 366000



Paul Scott
Chief Executive Officer
24 June 2026

Statement of Comprehensive Income

		2025/26	2024/25
	Note	£000	£000
Operating income from patient care activities	2	657,292	581,711
Other operating income	3	30,440	26,972
Operating expenses	6,7	(677,234)	(637,044)
Operating surplus / (deficit) from continuing operations		10,498	(28,361)
Finance income	8.1	3,263	3,137
Finance expenses	8.2	(6,940)	(7,618)
PDC dividends payable		(4,828)	(5,011)
Net finance costs		(8,505)	(9,492)
Other gains / (losses)	9	112	(688)
Surplus / (deficit) for the year from continuing operations		2,105	(38,541)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	11.5	(6,612)	(44,557)
Revaluations	11.5	12,993	50,175
Remeasurements of the net defined benefit pension scheme asset	7.4.8	523	(6)
Other reserve movements		57	146
Total comprehensive income / (expense) for the year		9,066	(32,783)

The notes on pages 168 – 221 form part of these accounts. All income and expenditure derive from continuing operations.

Adjusted financial performance (unaudited)

	2025/26	2024/25
	£000	£000
Surplus / (deficit) for the year	2,105	(38,541)
Remove net impairments not scoring to the Departmental Expenditure Limit	148	27,515
Remove capital donations / peppercorn lease I&E impact	(1,961)	(1,293)
Prior period adjustments	-	8,651
Remove impact of technical PFI adjustment	(268)	(239)
Remove non-cash element of on-SOFP pension costs	69	86
Adjusted financial performance surplus / (deficit)	93	(3,821)

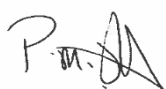
The Trust is monitored by NHS England on the basis of adjusted financial performance. This is based on the reported surplus/(deficit) for the year and is adjusted for a number of agreed items. For the financial year 2025/26 the Trust adjusted financial performance was a surplus of £93k.

Statement of financial position

		31 March 2026	31 March 2025
	Note	£000	£000
Non-current assets			
Intangible assets	10	16,930	14,184
Property, plant and equipment	11	224,233	209,992
Right of use assets	12.1	50,701	44,378
Investment property	13	11,045	12,585
Receivables	15	152	176
Other assets	7.4.3	475	21
Total non-current assets		303,536	281,336
Current assets			
Inventories	14	429	411
Receivables	15	22,788	23,310
Non-current assets for sale and assets in disposal groups	16	3,100	500
Cash and cash equivalents	17	45,263	28,077
Total current assets		71,580	52,298
Current liabilities			
Trade and other payables	19	(64,723)	(51,227)
Borrowings	21	(8,898)	(12,781)
Provisions	23	(11,766)	(9,199)
Other liabilities	20	(2,501)	(1,825)
Total current liabilities		(87,888)	(75,032)
Total assets less current liabilities		287,228	258,601
Non-current liabilities			
Borrowings	21	(75,556)	(72,887)
Provisions	23	(5,507)	(7,334)
Total non-current liabilities		(81,063)	(80,221)
Total assets employed		206,165	178,380
Financed by			
Public dividend capital		167,048	148,329
Revaluation reserve		104,351	98,853
Other reserves		475	21
Income and expenditure reserve		(65,709)	(68,823)
Total taxpayers' equity		206,165	178,380

The notes on pages 168 – 221 form part of these accounts.

The financial statements on pages 163 to 167 were approved by the Board on 24 June 2026 and signed on its behalf by:



Paul Scott
Chief Executive Officer
24 June 2026

Statement of changes in taxpayers equity for year ended 31 March 2026

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2025 - brought forward	148,329	98,853	21	(68,823)	178,380
Surplus for the year	-	-	-	2,105	2,105
Other transfers between reserves	-	-	(69)	69	-
Impairments	-	(6,612)	-	-	(6,612)
Revaluations	-	12,993	-	-	12,993
Remeasurements of the defined net benefit pension scheme asset	-	-	523	-	523
Public dividend capital received	18,719	-	-	-	18,719
Other reserve movements	-	(883)	-	940	57
Taxpayers' equity at 31 March 2026	167,048	104,351	475	(65,709)	206,165

Statement of changes in taxpayers equity for year ending 31 March 2025

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2024 - brought forward	144,861	78,104	113	(15,383)	207,695
(Deficit) for the year	-	-	-	(38,541)	(38,541)
Adjustment to revaluation reserve	-	15,012	-	(15,012)	-
Other transfers between reserves	-	-	(86)	86	-
Impairments	-	(44,557)	-	-	(44,557)
Revaluations	-	50,175	-	-	50,175
Remeasurements of the defined net benefit pension scheme asset	-	-	(6)	-	(6)
Public dividend capital received	3,468	-	-	-	3,468
Other reserve movements	-	119	-	27	146
Taxpayers' equity at 31 March 2025	148,329	98,853	21	(68,823)	178,380

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care (DHSC). A charge, reflecting the cost of capital utilised by the Trust, is payable to the DHSC as the public dividend capital dividend.

Revaluation reserve

Increase in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in operational capacity.

Other reserves

Other reserves are the Local Government Pension Scheme reserves, as disclosed in note 7.4.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of cash flows

	Note	2025/26 £000	2024/25 £000
Cash flows from operating activities			
Operating surplus / (deficit)		10,498	(28,361)
Non-cash income and expense:			
Depreciation and amortisation	6	20,819	15,556
Net impairments	11.5	148	27,515
Income recognised in respect of capital donations	3	(2,480)	(1,380)
Non-cash movements in on-SoFP pension liability		69	86
(Increase) / decrease in receivables and other assets		127	(3,106)
(Increase) / decrease in inventories		(18)	78
Increase / (decrease) in payables and other liabilities		9,025	1,728
Increase / (decrease) in provisions		(545)	(3,354)
Net cash flows from / (used in) operating activities		37,643	8,762
Cash flows from investing activities			
Interest received		1,905	2,035
Purchase of intangible assets		(5,447)	(4,657)
Purchase of PPE and investment property		(17,117)	(10,885)
Sales of PPE and investment property		-	2
Net cash flows from / (used in) investing activities		(20,659)	(13,505)
Cash flows from financing activities			
Public dividend capital received		18,719	3,468
Movement on loans from DHSC		(400)	(400)
Capital element of lease rental payments		(7,538)	(2,926)
Capital element of PFI, LIFT and other service concession payments		(3,134)	(2,611)
Interest on loans		(41)	(51)
Interest paid on lease liability repayments		(553)	(421)
Interest paid on PFI, LIFT and other service concession obligations		(2,438)	(2,537)
PDC dividend (paid) / refunded		(4,413)	(5,080)
Net cash flows from / (used in) financing activities		202	(10,558)
Increase / (decrease) in cash and cash equivalents		17,186	(15,301)
Cash and cash equivalents at 1 April - brought forward		28,077	43,378
Cash and cash equivalents at 31 March	17	45,263	28,077

Notes to the accounts

Note 1 Summary of Accounting Policies and Other Information

Note 1.1 General Information

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.2 Presentation of Financial Statements

When preparing the financial statements, the Trust will in normal circumstances follow the standard format. However, where it is determined that the standard format is not representative in reflecting the true performance of the Trust, the presentation of the primary statements may be amended accordingly. There are no departures from the standard format in these financial statements.

Note 1.2.1 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.3 Going Concern

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

The Directors of the Trust have considered whether there are any local or national policy decisions that are likely to affect the Trust's continued funding and provision of services. The Trust submitted a three-year revenue plan and five-year capital plan to NHSE on 18 March 2026, which included an adjusted breakeven position for 2026/27. The plan includes the continued provision of services by the Trust and/or within the WGA boundary. No circumstances were identified which caused the Directors to doubt the continued provision of NHS services.

Against the adjusted financial performance measure for 2025/26, the Trust has reported a surplus of £93k for the current financial year (2024/25: £3,821k deficit).

Our going concern assessment is made up to the end of June 2027. The Trust has prepared a cash forecast modelled on the above expectations for funding during the going concern period which shows sufficient liquidity for the Trust to continue to operate during that period.

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

Note 1.4 Income

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's income is earned from NHS commissioners in the form of fixed payments to fund an agreed level of activity.

In 2025/26, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements termed Aligned Payment and Incentive (API) contracts. These payments are accompanied by a variable element to adjust income for actual activity delivered.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred, and other income top-ups to support the delivery of services.

Mental health and community provider collaboratives

NHS led provider collaboratives for specialised mental health, learning disability and autism services, and community services involve a lead NHS provider taking responsibility for managing services, care pathways and specialised commissioning budgets for a population. The Trust has been the lead provider for the East of England Adult Secure Provider

Collaborative and the lead provider for the Mid & South Essex Community Collaborative during the year. As lead provider for both of these Collaboratives, the Trust is accountable to NHS England and Mid & South Essex ICB respectively, and as such recognises the income and expenditure associated with the commissioning of services from other providers in these accounts. Where the Trust is the provider of commissioned services, this element of income is recognised in respect of the provision of services, after eliminating internal transactions. The Trust accounts for these transactions as a principal, in accordance with IFRS 15.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases, it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

Note 1.4.2 Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Note 1.4.3 Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional cost is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from

1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

NEST Pension Scheme

A small number of employees are members of the NEST (National Employment Savings Trust) Scheme. NEST is a defined contribution scheme. This means that the contributions paid in by the employer, the employee, and anyone else are invested and used to build up the employee's own pension pot in accordance with the Scheme's policies.

The contributions are managed by the NEST Corporation, who are a Trustee body representing the employees. The employer shares no gain or loss on those funds. The employer is responsible only for its pension cost contributions and nothing else and does not bear the risks related to the plan rather those risks are borne by employees.

Employer's pension cost contributions are charged to operating expenses as and when they become due. The current year's contributions are in note 7.

Local Government Pension Scheme

Some employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme, i.e. the Essex Pension Fund, which is administered by Essex County Council. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the Trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

To assess the value of the Employer's liabilities at 31 March 2026, the liabilities have been recalculated from the latest full funding valuation carried out at 31 March 2025, using financial assumptions compliant with IAS19.

To calculate the Employer's asset share, the actuaries have rolled forward the assets allocated to the Employer at the latest valuation date allowing for investment returns (estimated where necessary), contributions paid into, and estimated benefits paid from the Fund by and in respect of the employer and its employees.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Re-measurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Note 1.6 Expenditure on Other Goods and Services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, Plant & Equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- future economic benefits will flow to the Trust as assets are in use and held for their operational capacity
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Tenant Improvements

Property, plant and equipment are capitalised where they are tenant improvements made on leased properties that cost at least £5,000 and add value to the leased property such that it is probable that future economic benefits will flow to the Trust for more than one year over the remaining lease term.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or operational capacity deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or operational capacity, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Note 1.7.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their operational capacity and are in use (i.e. operational assets used to deliver either front-line services or back-office functions) are measured at their current value in existing use. Assets that were most recently held for their operational capacity but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use as the present value of the asset's remaining operational capacity, which is assumed to be at least equal to the cost of replacing that operational capacity. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity, meeting the location requirements of the services being provided.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the Trust's Private Finance Initiative (PFI) schemes where the construction is completed by a special purpose vehicle, and the costs have recoverable VAT for the Trust.

The Trust uses Montagu Evans LLP, who are professionally qualified valuers and work in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The Trust instructed Montagu Evans LLP to undertake an annual assessment of the asset carrying amount at the end of the financial year and reflected these in the financial statements.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

The Trust applies the following useful lives to property, plant and equipment assets. The lives applied to building assets from the year ending 31 March 2026 are based on the latest valuations received from Montagu Evans LLP where assets have been revalued.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

Main Asset Category	Sub Category	Minimum Useful Life (in years)	Maximum Useful Life (in years)
Buildings		1	60
Plant, machinery and equipment	Medical and surgical equipment	5	15
	Office equipment	5	5
	IT Hardware	5	10
	Other engineering works	5	30
Furniture and fitting	Furniture	5	10
	Soft furnishings	5	7
Motor vehicles		7	7

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of operational capacity in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of operational capacity is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition / Assets Held for Sale

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.8 Private Finance Initiative (PFI)

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the Trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial Recognition

In accordance with HM Treasury's *FReM*, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent Measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Note 1.9 Intangible Assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or operational capacity be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Software

Software, which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software, which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown in the table below:

Main Asset Category	Sub Category	Useful Economic Life	
		Minimum (in years)	Maximum (in years)
Intangible assets - purchased	Software	2	15
Intangible assets – internally generated	IT	5	10

Note 1.10 Inventories

Inventories are stated at the lower of cost or net realisable value. The cost of inventories is measured using the weighted average cost method.

Note 1.11 Investment Properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

The Trust currently has properties which are leased to housing associations, other NHS organisations and private tenants, following the decommissioning of the services that were previously rendered from these properties.

The Trust instructed Montagu Evans LLP, who are professionally qualified valuers and work in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual, to undertake a valuation on the Trust's investment properties as at the end of the financial year.

Note 1.12 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial Assets and Financial Liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables and contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses at an amount equal to lifetime expected losses.

At the Statement of Financial Position date, the Trust assesses whether any financial assets, are impaired. Financial assets are impaired, and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows from the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly, or through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the Statement of Comprehensive Income to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Provision for debtor impairment

A provision will be provided against the recovery of debts, where such a recovery is considered doubtful. Where the recovery of a debt is considered unlikely, the debt will either be written down directly to the Statement of Comprehensive Income or charged against a provision to the extent that there is a balance available for the debt concerned and thereafter charged to operating expenses.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

Note 1.14.1 The Trust as lessee

Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments include fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

Note 1.14.2 The Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal Rate	Prior Year Rate
Short Term	Up to 5 years	3.64%	4.03%
Medium Term	After 5 years and up to 10 years	4.22%	4.07%
Long Term	After 10 years and up to 40 years	5.32%	4.81%
Very Long Term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis.

Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation Rate	Prior Year Rate
Year 1	2.50%	2.60%
Year 2	2.00%	2.30%
Into Perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 23 but is not recognised in the Trust's accounts.

Non clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets but are disclosed in note 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised but are disclosed in note 26. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at

<https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Taxation

The Trust is a Health Service body within the meaning of s519A of the Income and Corporation Taxes Act (ICTA) 1988 and accordingly is exempt from taxation in respect of income and capital gains within the categories covered by this. There is a power for the Treasury to dis-apply the exemption in relation to specified activities of a Foundation Trust (s519 A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits there from exceed £50,000 per annum. There is no corporation tax liability arising in the current financial year.

Note 1.19 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.20 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.21 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.22 Capital commitments

For ongoing capital projects at the balance sheet date, the value of capital commitments will be based on the value of contracted work not yet completed at the balance sheet date. The value of the capital commitment is disclosed at note 24.

Note 1.23 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses. The value of losses and special payments is disclosed in note 29.

Note 1.24 Critical Accounting Judgements and Key Sources of Estimation Uncertainty

Critical judgements in applying accounting policies: Provisions

A key critical judgement made in the preparation accounts relates to the recognition of costs associated with the Lampard Inquiry as a provision under IAS 37. The Trust exercised judgement in determining whether the Trust has a present obligation as a result of past events and whether a reliable estimate of the outflow of resources to settle the obligation can be made in accordance with IAS 37.

The judgement was informed by the following factors:

- The Inquiry has been granted Statutory status under the Inquiries Act 2005, conferring legal powers to compel evidence and attendance.
- The Trust was formally designated as a Core Participant, creating enforceable duties to co-operate with the Inquiry noting that failure to comply can result in legal sanctions and regulatory consequences.
- The Trust has publicly committed to supporting the Inquiry and affected staff, giving rise to a constructive obligation in addition to the legal obligation.
- External legal advice confirmed that the Trust has a legal and constructive obligation to participate fully in the Inquiry.

Senior management have concluded that these factors represent a critical judgement in applying the accounting policy for provisions, as it involves determining whether an obligation meeting the definition of a provision exists, rather than estimating the quantum of costs. This judgement has informed the recognition of liabilities and expenses within the financial statements.

Key sources of estimation uncertainty Provisions

Whilst the Trust exercised critical judgement in concluding that a present obligation exists and that recognition of a provision is required, the measurement of the provision involves estimation uncertainty due to the nature, scale and duration of the Inquiry.

In estimating the value of the provision, management has made assumptions in relation to:

- The duration of the Inquiry.
- The volume and complexity of statutory information requests received from the Inquiry.
- Legal and counsel costs, including the level of legal support required for current and former staff.
- Staffing resources required to respond to the Inquiry outside of normal business-as-usual operations.
- Information technology and data management costs resulting from a legal obligation to retain documents.

These estimates are inherently uncertain and are influenced by factors outside the Trust's control, including decisions taken by the Inquiry Chair, changes to the Inquiry's scope or

approach, and external legal and procedural requirements.

At the reporting date, the provision represents reasonable estimate of the unavoidable costs required to meet the Trust's obligations to the Inquiry. Actual costs incurred may differ from estimates as the Inquiry progresses and annual cost reassessments will be undertaken which may result in an adjustment to the carrying amount of the provision within the next financial year as the Inquiry concludes.

The provision excludes potential costs associated with remediation or implementation of recommendations arising from the Inquiry, which cannot be reliably estimated at this stage.

Valuation of Land and Buildings

The most significant estimate within the accounts is the value of land and buildings, including those held as a right of use peppercorn asset. In accordance with International Accounting Standards, a full property valuation is carried out on the Trust's land and buildings every five years, with a review of the market indices undertaken each year to assess for material changes; and interim desktop valuations initiated as required. The Trust has as at the 31 March 2026 initiated a desktop valuation and engaged Montagu Evans LLP to provide the valuation. Montagu Evans LLP has applied suitable indices to reflect changes in the building costs and local land price movements since the date of the last valuation.

The source of estimation uncertainty relates to the selection of the valuation techniques applied and the input factors used therein; primarily build costs, the asset's remaining economic life and the floor area of the modern equivalent asset, based on efficient use of space, for specialised assets valued on a Depreciated Replacement Cost basis, and market or income input factors for non-specialised assets valued on a fair value basis, i.e. Existing Use Value. The next full revaluation is due March 2030. Valuations do not take into account future potential changes in market value which cannot be predicted with any certainty therefore, between valuations, management reviews the values for any material changes and makes judgements about market changes and assesses whether the carrying amount does not differ materially from that which would be expected using fair value at the end of the reporting period.

The review of the estate values carried out in 2025/26 resulted in an overall net gain in the value of assets of £6,233k of which, a net gain of £6,381k has been recognised against the revaluation reserve and the remaining £(148)k charged to the Statement of Comprehensive Income. The carrying amount of the revalued assets at the end of the reporting period is £256.0m (£244.8m 2024/25). The valuation exercise was carried out in March 2026 with a valuation date of 31 March 2026. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has not declared any 'material valuation uncertainty' in the valuation report. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements.

Pension liability

Estimation of the net liability to pay pensions depends on a number of complex judgements relating to the discount rate used, the rate at which salaries are projected to increase, changes in retirement ages, mortality rates and expected returns on pension fund assets. A firm of consulting actuaries is engaged to provide the Trust with expert advice about the assumptions to be applied.

The effects of the net pension liability of changes in individual assumptions can be measured. For instance, a 0.5% increase in the discount rate assumption would result in a decrease in the pension liability of £724k. Further sensitivity analysis of factors affecting the pensions fund is set out in note 7.4.10.

Note 1.25 Consolidation of the EPUT Charity Accounts with the Trust Accounts

The accounting standards require consolidation of a group of entities under the control of a parent where there exists the power to govern the financial and operational policies of an entity so as to obtain benefits from its activities. The Trust is a corporate trustee of the Essex Partnership NHS Foundation Trust General Charitable Fund, and the purpose of the Charity is to assist Trust NHS patients, hence the Trust has control over and benefits from the Charity's activities, so the requirements of the relevant accounting standards would be applicable in the preparation of the Trust Accounts.

However, in line with IAS 1, Presentation of Financial Statements, specific disclosure requirements set out in individual accounting standards or interpretations need not be satisfied if the information is not material. The net asset of the Charity is approximately 0.5% of the Trust's total assets employed and are therefore not considered to be material in the context of the Trust's wider accounts. As such, the Board of Directors have noted and approved that the Charity's Accounts will not be consolidated into the main Trust Accounts for 2025/26. This is subject to an annual materiality review each financial year.

Note 1.26 Operating Segments

Under International Financial Reporting Standards, operating segments are components of an entity that engage in separate revenue earning activities, have discrete financial information available, and whose results are reviewed separately by the entity's Chief Operating Decision Maker. Activities or departments of an organisation that earn no or incidental revenues would not be operating segments.

Operating segments are reported in a manner consistent with the internal reporting to the Chief Operating Decision Maker of the Trust. The Chief Operating Decision Maker of the Trust is the Trust Board.

The Trust's activities constitute a single segment of healthcare activity provided wholly in the UK, subject to similar risks and rewards, and all assets are managed as one central pool. This is consistent with the monthly financial report to the Trust Board.

Note 1.27 Limitation of auditors' liability

In line with guidance from the Financial Reporting Council, the Trust's external auditor, Grant Thornton UK LLP, have limited their liability in respect of their external audit work. The limitation on auditors' liability for external audit work is £3m.

Note 1.28 Accounting standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:
IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets - The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £212,102k as at 31 March 2026.

Note 1.29 Prior Period Adjustment

Prior period adjustments may arise from a change in accounting policy or in correcting a material error.

Changes in accounting policies are only made when required by proper accounting practices or when the effect of the changes will provide more reliable or relevant information regarding the impact of transactions, other events and conditions on the Trust's financial position or financial performance.

Where a change is made, it is applied retrospectively (unless stated otherwise), by adjusting opening balances and comparative amounts for the prior period as though the new policy had always been applied.

Material errors identified in prior period amounts are corrected retrospectively by amending opening balances and comparative amounts for the prior period.

New or updated information may give rise to reclassifications between balances in the Statement of Financial Position, thereby leading to the restating of their opening balances under the new classifications.

During 2025/26, the Trust has not accounted for any prior period adjustments.

Note 2 Operating Income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.

Note 2.1 Income from patient care activities (by nature)

	2025/26 £000	2024/25 £000
Mental health services		
Income from commissioners under API contracts*	294,923	264,185
Services delivered under a mental health collaborative	34,924	30,083
Income for commissioning services in a mental health collaborative	66,602	63,958
Clinical partnerships providing mandatory services (including S75 agreements)	3,478	3,749
Other clinical income from mandatory services	15,334	20,875
Community services		
Income from commissioners under API contracts*	170,246	134,202
Income from other sources (e.g. local authorities)	21,560	23,158
All services		
Private patient income	365	7
National pay award central funding**	-	406
Additional pension contribution central funding***	24,140	23,114
Other clinical income****	25,720	17,974
Total income from activities	657,292	581,711

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

**Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

***Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

****Other clinical income includes £12,139k relating to pay awards, inflationary uplifts and capital charge support. The remaining £13,581k relates to other clinical income within block contracts.

Note 2.2 Income from patient care activities (by source)

	2025/26	2024/25
Income from patient care activities received from:	£000	£000
NHS England *	29,184	118,411
Integrated care boards	576,694	408,146
Other NHS providers	34,406	30,438
Local authorities	13,547	19,335
Non-NHS: private patients	365	7
Injury cost recovery scheme	2	17
Non NHS: other	3,094	5,357
Total income from activities	657,292	581,711

*From April 2025, specialised commissioning of adult secure services was devolved from NHS England to Integrated Care Boards.

Note 3 Other operating income

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	672	-	672	593	-	593
Education and training	18,893	-	18,893	18,370	-	18,370
Income in respect of employee benefits accounted on a gross basis	1,423	-	1,423	1,231	-	1,231
Receipt of capital grants and donations and peppercorn leases	-	2,480	2,480	-	1,380	1,380
Charitable and other contributions to expenditure	-	31	31	-	37	37
Revenue from operating leases	-	1,818	1,818	-	2,570	2,570
Other income	4,823	288	5,123	2,791	-	2,791
Total other operating income	25,823	4,617	30,440	22,985	3,987	26,972

Note 4 Additional information on income

Note 4.1 Additional information on contract revenue (IFRS 15) recognised in the year

	2025/26 £000	2024/25 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	<u>1,108</u>	<u>1,513</u>

Note 4.2 Income from activities arising from commissioner requested services

The Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2025/26 £000	2024/25 £000
Income from services designated as commissioner requested services	<u>657,292</u>	<u>581,711</u>
Total	<u>657,292</u>	<u>581,711</u>

Note 5 Operating leases - Trust as lessor

This note discloses income generated in operating lease agreements where the Trust is the lessor.

Note 5.1 Operating lease income

	2025/26 £000	2024/25 £000
Lease receipts recognised as income in year:		
Minimum lease receipts	1,818	2,570
Total in-year operating lease income	1,818	2,570

Note 5.2 Future lease receipts

	31 March 2026 £000	31 March 2025 £000
Future minimum lease receipts due in:		
- not later than one year	1,648	2,151
- later than one year and not later than two years	442	431
- later than two years and not later than three years	134	232
- later than three years and not later than four years	131	127
- later than four years and not later than five years	131	112
- later than five years	77	415
Total	2,563	3,468

Note 6 Operating expenses

	2025/26 £000	2024/25 £000
Purchase of healthcare from NHS and DHSC bodies	83,519	60,794
Purchase of healthcare from non-NHS and non-DHSC bodies	69,179	56,298
Staff and executive directors costs	431,542	410,855
Remuneration of non-executive directors	187	163
Supplies and services - clinical (excluding drugs costs)	8,094	7,002
Supplies and services - general	6,612	6,582
Drug costs (drugs inventory consumed and purchase of non- inventory drugs)	5,460	4,697
Inventories written down	24	-
Consultancy costs	237	210
Establishment	3,193	2,456
Premises	24,400	21,470
Transport (including patient travel)	4,932	5,195
Depreciation on property, plant and equipment	17,557	13,236
Amortisation on intangible assets	3,262	2,320
Net impairments *	148	27,515
Movement in credit loss allowance: contract receivables / contract assets	4	3
Increase / (decrease) in other provisions	(2,598)	66
Change in provisions discount rate(s)	(1,101)	(1,169)
Fees payable to the external auditor audit services- statutory audit **	236	321
Internal audit costs	141	121
Clinical negligence	3,236	3,023
Legal fees	1,664	903
Insurance (as a policy holder)	423	634
Research and development	668	567
Education and training	5,286	5,734
Expenditure on short term leases	886	1,175
Expenditure on low value leases	162	140
Redundancy	1,297	420
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (PFI)	1,290	1,318
Car parking & security	600	611
Hospitality	4	32
Losses, ex gratia & special payments	502	70
Other services, e.g. external payroll	6,111	4,207
Other	77	75
Total	677,234	637,044

*Net impairments relate to changes in market value on land and buildings and right of use peppercorn assets. Further information can be found in note 11.5.

** Statutory audit costs include irrecoverable VAT. The 2025/26 cost includes the reversal of a £30k prior year accrual.

Note 7 Employee benefits

	2025/26	2024/25
	Total	Total
	£000	£000
Salaries and wages	324,698	307,559
Social security costs	41,964	32,417
Apprenticeship levy	1,576	1,512
Employer's contributions to NHS pensions	60,964	58,470
Termination benefits	1,071	93
Temporary staff (agency)	8,607	16,524
Total staff costs *	438,880	416,575
Of which		
Costs capitalised as part of assets	2,551	2,066

*Total staff costs include costs shown within Research and Development, and Education and Training in note 6.

Note 7.1 Retirements due to ill-health

During 2025/26 there were 7 early retirements from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £288k (£496k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 7.2 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027

Note 7.3 National Employment Savings Scheme

Staff may opt to join the National Employment Savings Scheme (NEST), which is a defined contribution scheme. The Trust accounts for the contributions to the scheme in the period which they are payable.

Note 7.4 Employee retirement benefit obligation – Local Government Pension Scheme

Some employees are members of the Local Government Pension Scheme, a defined benefit pension scheme, i.e. the Essex Pension Fund, which is administered by Essex County Council.

Note 7.4.1 Amounts recognised in the SoCI

	2025/26 £000	2024/25 £000
Current service cost	(56)	(75)
Interest expense / income	2	5
Administration expenses	(15)	(16)
Total net (charge) recognised in SOCI	(69)	(86)

Note 7.4.2 Principal actuarial assumptions

	2025/26 %	2024/25 %
Discount rate	6.05	5.75
Pension increases (CPI)	2.90	2.90
RPI inflation	3.30	3.20
Rate of increase in salaries	3.90	3.90

Note 7.4.3 Amounts recognised in the Statement of Financial Position

	31 March 2026 £000	31 March 2025 £000
Present value of the defined benefit obligation	(12,443)	(11,651)
Plan assets at fair value	25,447	23,956
Impact of asset ceiling	(12,529)	(12,284)
Net defined benefit asset recognised in the SoFP	475	21

Note 7.4.4 Reconciliation of asset ceiling

	31 March 2026 £000	31 March 2025 £000
Opening impact of asset ceiling	(12,284)	(10,544)
Interest on asset ceiling	(706)	(517)
Actuarial (gains) / losses	461	(1,223)
Closing impact of asset ceiling	(12,529)	(12,284)

Note 7.4.5 Change in benefit obligation

	2025/26 £000	2024/25 £000
Present value of the defined benefit obligation at 1 April	(11,651)	(13,017)
Current service cost	(56)	(75)
Interest cost	(654)	(625)
Contribution by plan participants	(21)	(23)
Remeasurement of the net defined benefit asset:		
- Actuarial gains / (losses)	(631)	1,535
Benefits paid	570	554
Present value of the defined benefit obligation at 31 March	(12,443)	(11,651)

Note 7.4.6 Change in fair value of plan assets

	2025/26 £000	2024/25 £000
Plan assets at fair value at 1 April	23,956	23,674
Administrative expenses	(15)	(16)
Interest income	1,362	1,147
Other Actuarial (Losses)	(192)	-
Remeasurement of the net defined benefit (liability) / asset:		
- Return on plan assets	885	(318)
Contributions by the plan participants	21	23
Benefits paid	(570)	(554)
Plan assets at fair value at 31 March	25,447	23,956

Note 7.4.7 Analysis of fair value of plan assets

	2025/26 £000	2025/26 %	2024/25 £000	2024/25 %
Equities	14,176	56%	13,630	57%
Gilts	367	1%	359	2%
Property	2,234	9%	1,767	7%
Cash / Temporary investments	456	2%	452	2%
Alternative investments	3,845	15%	3,482	15%
Other managed funds	4,368	17%	4,266	18%
Plan assets at fair value at 31 March	25,446	100%	23,956	100%

Note 7.4.8 Remeasurement in other comprehensive income

	2025/26 £000	2024/25 £000
Returns on funds in excess of interest	885	(318)
Other actuarial (losses) on assets	(192)	-
Change in financial assumption	468	1,494
Change in demographic assumptions	(332)	29
Experience (loss) / gain on defined benefit obligation	(767)	12
Change in impact of asset ceiling	461	(1,223)
Remeasurement of the net asset / (defined liability)	523	(6)

Note 7.4.9 Projected pension expenses

	Year to 31 March 2027 £000
Service costs	54
Net interest on defined asset	(29)
Administration expenses	15
	40
Employer contributions	-
Total	40

Note 7.4.10 Sensitivity Analysis

Adjustment to discount rate	+0.5%	+0.1%	0.0%	-0.1%	-0.5%
Present value total obligation	11,719	12,293	12,443	12,596	13,242
Projected service cost	47	52	54	55	61
Adjustment to long term salary increase	+0.5%	+0.1%	0.0%	-0.1%	-0.5%
Present value total obligation	12,479	12,450	12,443	12,436	12,408
Projected service cost	54	54	54	54	54
Adjustment to pension increases and deferred revaluation	+0.5%	+0.1%	0.0%	-0.1%	-0.5%
Present value total obligation	13,193	12,599	12,443	12,319	11,791
Projected service cost	61	55	54	52	47
Adjustment to life expectancy assumptions	+1 year		None	-1 year	
Present value total obligation	12,890		12,443	12,013	
Projected service cost	55		52	52	

Note 7.5 Director Remunerations and Staff Costs

The analysis of directors' remunerations and pension benefits for the year ended 31 March 2026 are in the Remuneration Report section of the Annual Report.

The analysis of staff costs, average staff numbers and staff exit packages for the year ended 31 March 2026 are in the staff report section of the Annual Report.

Note 8 Finance income, expenditure and late payment of commercial debt

Note 8.1 Finance income

Finance income represents interest received on assets and investments in the period.

	2025/26 £000	2024/25 £000
Interest on bank accounts	1,901	1,990
Other finance income	1,362	1,147
Total finance income	3,263	3,137

Note 8.2 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2025/26 £000	2024/25 £000
Interest expense:		
Interest on loans from the Department of Health and Social Care	39	47
Interest on lease obligations	553	421
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	2,438	2,537
Remeasurement of the liability resulting from change in index or rate	1,324	1,804
Total interest expense	4,354	4,809
Unwinding of discount on provisions	1,214	1,639
Other finance costs	1,372	1,170
Total finance costs	6,940	7,618

Note 8.3 The late payment of commercial debts (interest) Act 1998

There was a total interest payment (including administration charges) of £343 relating to the late payment of commercial debts in the year ended 31 March 2026 (2024/25: £140).

Note 9 Other gains / (losses)

	2025/26 £000	2024/25 £000
Gains on disposal of right of use assets	118	108
Losses on disposal of property, plant and equipment	(6)	(16)
Total gains / (losses) on disposal of assets	112	92
Fair value gains / (losses) on investment properties	-	(780)
Total other gains / (losses)	112	(688)

Note 10 Intangible assets

Note 10.1 Intangible assets - 2025/26

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Cost at 1 April 2025 - brought forward *	24,347	947	6,803	32,097
Additions	1,696	143	3,608	5,447
Reclassifications	2,217	2,279	(3,934)	562
Disposals / derecognition	(4,519)	-	(1)	(4,520)
Cost at 31 March 2026	23,741	3,369	6,476	33,586
Amortisation at 1 April 2025 - brought forward	17,681	232	-	17,913
Provided during the year	2,724	538	-	3,262
Disposals / derecognition	(4,519)	-	-	(4,519)
Amortisation at 31 March 2026	15,886	770	-	16,656
Net book value at 31 March 2026	7,855	2,599	6,476	16,930
Net book value at 1 April 2025	6,666	715	6,803	14,184

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 10.2 Intangible assets - 2024/25

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2024 - as previously stated	22,681	579	4,089	27,349
Additions	1,525	368	2,764	4,657
Reclassifications	141	-	(50)	91
Valuation / gross cost at 31 March 2025	24,347	947	6,803	32,097
Amortisation at 1 April 2024 - as previously stated	15,477	116	-	15,593
Provided during the year	2,204	116	-	2,320
Amortisation at 31 March 2025	17,681	232	-	17,913
Net book value at 31 March 2025	6,666	715	6,803	14,184
Net book value at 1 April 2024	7,204	463	4,089	11,756

Note 11 Property, plant and equipment

Note 11.1 Property, plant and equipment – 2025/26

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025 - brought forward	35,654	164,590	923	1,213	6,489	264	12,621	1,455	223,209
Additions	-	10,483	-	8,570	2,248	-	991	28	22,320
Impairments	(1,134)	(8,505)	(158)	-	-	-	-	-	(9,797)
Reversals of impairments	121	4,381	-	-	-	-	-	-	4,502
Revaluations	440	588	-	-	-	-	-	-	1,028
Reclassifications	462	1,206	-	(828)	-	-	138	-	978
Transfers to / from assets held for sale	(780)	(1,820)	-	-	-	-	-	-	(2,600)
Disposals / derecognition	-	-	-	(5)	(1,055)	(122)	(57)	(50)	(1,289)
Valuation/gross cost at 31 March 2026	34,763	170,923	765	8,950	7,682	142	13,693	1,433	238,351
Accumulated depreciation at 1 April 2025 - brought forward	-	-	-	-	4,922	264	7,437	594	13,216
Provided during the year	-	9,785	26	-	342	-	1,571	237	11,961
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	-	(9,785)	-	-	-	-	-	-	(9,785)
Disposals / derecognition	-	-	-	-	(1,046)	(122)	(57)	(50)	(1,275)
Accumulated depreciation at 31 March 2026	-	-	26	-	4,218	142	8,951	781	14,118
Net book value at 31 March 2026	34,763	170,923	739	8,950	3,464	-	4,742	652	224,233
Net book value at 1 April 2025	35,654	164,590	923	1,213	1,567	-	5,184	861	209,993

Note 11.2 Property, plant and equipment – 2024/25

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	48,903	166,263	739	4,110	6,249	296	10,707	934	238,201
Additions	-	7,838	-	128	232	-	1,153	419	9,770
Impairments	(21,234)	(53,324)	(233)	-	-	-	-	-	(74,791)
Reversals of impairments	209	2,555	-	-	-	-	-	-	2,764
Revaluations	6,202	36,050	417	-	-	-	-	-	42,669
Reclassifications	1,575	5,208	-	(3,025)	8	-	761	102	4,629
Disposals / derecognition	-	-	-	-	-	(33)	-	-	(33)
Valuation/gross cost at 31 March 2025	35,654	164,590	923	1,213	6,489	264	12,621	1,455	223,208
Accumulated depreciation at 1 April 2024 - as previously stated	-	-	-	-	4,519	275	5,862	447	11,103
Provided during the year	-	5,776	44	-	403	4	1,575	147	7,949
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	-	(5,776)	(44)	-	-	-	-	-	(5,820)
Disposals / derecognition	-	-	-	-	-	(15)	-	-	(15)
Accumulated depreciation at 31 March 2025	-	-	-	-	4,922	264	7,437	594	13,216
Net book value at 31 March 2025	35,654	164,590	923	1,213	1,567	-	5,184	861	209,993
Net book value at 1 April 2024	48,903	166,263	739	4,110	1,730	21	4,845	487	227,098

Note 11.3 Property, plant and equipment financing – 2025/26

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	34,763	132,626	739	8,950	3,464	-	4,742	652	185,936
On-SoFP PFI contracts and other service concession arrangements	-	38,011	-	-	-	-	-	-	38,011
Owned - donated/granted	-	286	-	-	-	-	-	-	286
Total net book value at 31 March 2026	34,763	170,923	739	8,950	3,464	-	4,742	652	224,233

Note 11.4 Property, plant and equipment financing – 2024/25

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	35,654	126,069	924	1,213	1,567	-	5,184	861	171,472
On-SoFP PFI contracts and other service concession arrangements	-	38,230	-	-	-	-	-	-	38,230
Owned - donated/granted	-	291	-	-	-	-	-	-	291
Total net book value at 31 March 2025	35,654	164,590	924	1,213	1,567	-	5,184	861	209,993

Note 11.5 Revaluation and impairments

In line with accounting policy and International Accounting Standard (IAS16) the Trust is required to undertake periodic revaluations of Estate. This is to ensure the value of assets do not differ materially from their fair value at the Statement of Financial Position date. As such, the Trust instructed Montagu Evans LLP to conduct a revaluation of its land and buildings including assets held as a right of use peppercorn asset (note 12.1) and assets held for sale (note 16) in 2025/26.

The impact of the revaluation was a net gain in the value of assets of £6,233k. This consists of a £5,518k increase in land and buildings, an increase of £715k in right of use assets and a £nil movement in assets held for sale.

Of the £6,233k, a net gain of £6,381k has been recognised against the Revaluation Reserve in the Statement of Financial Position with the remaining £148k charged to the Statement of Comprehensive Income (note 6).

	Revaluation Reserve Surplus	Revaluation Reserve Impairment	Net Impairment in Operating Expenditure	Total
	£000	£000	£000	£000
Land and Buildings	10,813	(5,723)	428	5,518
Right of Use Peppercorn Asset	2,180	(889)	(576)	715
Asset Held for Sale	-	-	-	-
Total 2025/26	12,993	(6,612)	(148)	6,233

	Revaluation Reserve Surplus	Revaluation Reserve Impairment	Net Impairment in Operating Expenditure	Total
	£000	£000	£000	£000
Land and Buildings	48,489	(44,557)	(27,470)	(23,538)
Right of Use Peppercorn Asset	1,686	-	-	1,686
Asset Held for Sale	-	-	(45)	(45)
Total 2024/25	50,175	(44,557)	(27,515)	(21,897)

Note 11.6 Assets under PFI contract

	2025/26 £000	2024/25 £000
Valuation/gross cost		
Valuation/gross cost at 1 April	38,230	34,933
Additions	65	2,013
Revaluations	(284)	7,995
Impairment	-	(7,393)
Reclassifications	-	682
Valuation/gross cost at 31 March	38,011	38,230
Accumulated depreciation		
Accumulated depreciation at 1 April	-	-
Provided during the year	1,492	843
Revaluations	(1,492)	(843)
Accumulated depreciation at 31 March	-	-
Net book value at 31 March	38,011	38,230
Net book value at 1 April	38,230	34,933

Assets held under PFI contract are included within Property, plant and equipment in notes 11.1 and 11.2.

Elderly Mentally Ill (EMI) Homes – PFI

In 2004, two homes were opened for the provision of care for the EMI, one in Rawreth and one in Westcliff-on-Sea. These homes have since been re-designated under CQC registration as Nursing Homes. The construction has been financed by a private finance initiative, between the Trust, legacy South Essex Partnership Trust (the grantor) and Ryhurst (the operator), under a public private service concession arrangement.

The term of the arrangement is 30 years, over which the grantor will repay the financing received from the operator, ending in 2033. At the end of the financing period legal ownership will pass from Ryhurst to the Trust.

During the period of the arrangement the grantor will have full and sole use of the properties to provide the health care services as described above.

The operator is contracted to provide maintenance services of a capital and revenue nature over the period of the contract. No material capital expenditure is included in the contract arrangement.

Maintenance costs payable to the operator are subject to annual increases based on the Retail Price Index (RPI).

There are no changes in the arrangement over the contract period.

Forensic Unit - PFI

In November 2009 a new forensic unit was opened to provide low and medium secure services. The construction of the new facility has been financed by a private finance initiative between the Trust, legacy South Essex Partnership Trust (the grantor) and Grosvenor House (the operator), under a public private service concession arrangement.

The term of the arrangement, over which the grantor will repay financing received to the operator, is 29 years ending in 2037. At the end of the financing period legal ownership will pass from Grosvenor House to the Trust.

During the period of the arrangement the grantor will have full and sole use of the unit to provide health care services as described above.

The operator is contracted to provide maintenance services of a capital and revenue nature over the period of the contract.

Maintenance costs payable to the operator are subject to annual increases based on the Retail Price Index (RPI).

There are no changes in the arrangement over the contract period.

Note 12 Leases – the Trust as a lessee

This note details information about leases for which the Trust is a lessee. The Trust applied IFRS 16 to account for lease arrangements from 1 April 2022.

Note 12.1 Right of use assets - 2025/26

	Property (land and buildings) £000	Transport equipment £000	Furniture & fittings £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2025 - brought forward	57,694	466	492	58,652	52,139
Additions	17,850	520	-	18,370	10,907
Remeasurements of the lease liability	27	89	-	116	(63)
Movements in provisions for restoration / removal costs	70	-	-	70	26
Impairments	(1,465)	-	-	(1,465)	(1,465)
Revaluations	2,180	-	-	2,180	2,180
Disposals / derecognition	(7,352)	-	-	(7,352)	(7,158)
Valuation/gross cost at 31 March 2026	69,004	1,075	492	70,571	56,566
Accumulated depreciation at 1 April 2025 - brought forward	14,065	197	12	14,274	12,349
Provided during the year	5,351	195	50	5,596	4,681
Impairments	-	-	-	-	-
Revaluations	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-
Accumulated depreciation at 31 March 2026	19,416	392	62	19,870	17,030
Net book value at 31 March 2026	49,588	683	430	50,701	39,536
Net book value at 1 April 2025	43,629	269	480	44,378	39,790

Net book value of right of use assets leased from other NHS providers	5,950
Net book value of right of use assets leased from other DHSC group bodies	33,586

Note 12.2 Right of use assets - 2024/25

	Property (land and buildings)	Transport equipment	Furniture & fittings	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	52,775	278	-	53,053	48,244
Additions	2,186	188	492	2,866	1,380
Remeasurements of the lease liability	1,707	-	-	1,707	1,547
Movements in provisions for restoration / removal costs	58	-	-	58	-
Revaluations	1,605	-	-	1,605	1,605
Disposals / derecognition	(637)	-	-	(637)	(637)
Valuation/gross cost at 31 March 2025	57,694	466	492	58,652	52,139
Accumulated depreciation at 1 April 2024 - brought forward	8,955	113	-	9,068	7,911
Provided during the year	5,191	84	12	5,287	4,519
Revaluations	(81)	-	-	(81)	(81)
Disposals / derecognition	-	-	-	-	-
Accumulated depreciation at 31 March 2025	14,065	197	12	14,274	12,349
Net book value at 31 March 2025	43,629	269	480	44,378	39,790
Net book value at 1 April 2024	43,820	165	-	43,985	40,333

Net book value of right of use assets leased from other NHS providers 9,184

Net book value of right of use assets leased from other DHSC group bodies 30,606

Note 12.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 21.1.

	2025/26 £000	2024/25 £000
Carrying value at 1 April	44,600	45,078
Lease additions	15,890	1,486
Lease liability remeasurements	116	1,707
Interest charge arising in year	553	421
Early terminations	(7,470)	(745)
Lease payments (cash outflows)	(8,091)	(3,347)
Carrying value at 31 March	45,598	44,600

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 12.4 Maturity analysis of future lease payments

	Of which leased from DHSC group bodies:		Of which leased from DHSC group bodies:	
	Total		Total	
	31 March	31 March	31 March	31 March
	2026	2026	2025	2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	7,367	5,751	8,962	8,089
- later than one year and not later than five years;	26,244	20,218	21,497	18,640
- later than five years.	20,558	11,919	16,461	15,258
Total gross future lease payments	54,169	37,888	46,920	41,987
Finance charges allocated to future periods	(8,571)	(3,320)	(2,320)	(1,894)
Net lease liabilities at 31 March 2026	45,598	34,568	44,600	40,093
Of which:				
Leased from other NHS providers		2,484		9,286
Leased from other DHSC group bodies		32,084		30,807

Note 13 Investment property

	2025/26	2024/25
	£000	£000
Carrying value at 1 April - brought forward	12,585	18,085
Movement in fair value	-	(780)
Reclassifications (to) / from PPE or right of use assets *	(1,540)	(4,720)
Carrying value at 31 March	11,045	12,585

*During 2025/26, properties at Weymarks, Laindon, were reclassified from Investment Property to Property, Plant and Equipment. They are no longer held for income generation or capital appreciation purposes and have been repurposed for clinical use.

Investment properties have been valued on the basis of market value where the Valuer has considered the comparative method in applying either a capitalised rent model or a capital value comparison and applying the most suitable approach in valuing each investment property.

Note 14 Inventories

	31 March	31 March
	2026	2025
	£000	£000
Drugs	135	114
Wheelchairs	294	297
Total inventories	429	411

Inventories recognised in expenses for the year were £4,225k. Write-down of inventories recognised as expenses for the year were £24k.

Note 15 Trade and other receivables

Note 15.1 Receivables

	31 March 2026 £000	31 March 2025 £000
Current		
Contract receivables	18,017	18,507
Allowance for impaired contract receivables / assets	(31)	(27)
Prepayments (non-PFI)	2,035	2,378
Interest receivable	167	171
PDC dividend receivable	311	726
VAT receivable	1,654	861
Other receivables	635	694
Total current receivables	22,788	23,310
Non-current		
Other receivables	152	176
Total non-current receivables	152	176
Of which receivable from NHS and DHSC group bodies:		
Current	15,727	13,519
Non-current	152	176

Note 15.2 Allowances for credit losses

	2025/26 Contract receivables and contract assets £000	2024/25 Contract receivables and contract assets £000
Allowances as at 1 April - brought forward	27	24
New allowances arising	4	3
Allowances as at 31 March 2026	31	27

Note 16 Non-current assets held for sale and assets in disposal groups

	2025/26 £000	2024/25 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	500	545
Assets classified as available for sale in the year	2,600	-
Impairment of assets held for sale	-	(45)
NBV of non-current assets for sale and assets in disposal groups at 31 March	3,100	500

As at 31 March 2026, the Trust held four properties for sale.

Note 17 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2025/26 £000	2024/25 £000
At 1 April	28,077	43,378
Net change in year	17,186	(15,301)
At 31 March	45,263	28,077
Broken down into:		
Cash at commercial banks and in hand	449	270
Cash with the Government Banking Service	44,814	27,807
Total cash and cash equivalents as in SoFP and SoCF	45,263	28,077

Note 18 Third party assets held by the Trust

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the Trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2026 £000	31 March 2025 £000
Bank balances	407	381
Total third party assets	407	381

Note 19 Trade and other payables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables	25,521	11,805
Capital payables	7,090	1,943
Accruals	17,375	24,421
Social security costs	5,035	4,034
Other taxes payable	4,497	4,034
Pension contributions payable	5,205	4,990
Total current trade and other payables	64,723	51,227
Of which payables from NHS and DHSC group bodies:		
Current	15,552	15,172
Non-current	-	-

Note 20 Other liabilities

	31 March 2026 £000	31 March 2025 £000
Current		
Deferred income: contract liabilities	2,501	1,825
Total other current liabilities	2,501	1,825

Note 21 Borrowings and liabilities arising from financing activities

Note 21.1 Borrowings

	31 March 2026 £000	31 March 2025 £000
Current		
Loans from DHSC	409	411
Lease liabilities	6,047	8,962
Obligations under PFI, LIFT or other service concession contracts	2,442	3,408
Total current borrowings	8,898	12,781
Non-current		
Loans from DHSC	1,204	1,604
Lease liabilities	39,551	35,638
Obligations under PFI, LIFT or other service concession contracts	34,801	35,645
Total non-current borrowings	75,556	72,887

Note 21.2 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Lease Liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2025	2,015	44,600	39,053	85,668
Cash movements:				
Financing cash flows - payments and receipts of principal	(400)	(7,538)	(3,134)	(11,072)
Financing cash flows - payments of interest	(41)	(553)	(2,438)	(3,032)
Non-cash movements:				
Additions	-	15,890	-	15,890
Lease liability remeasurements	-	116	-	116
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	1,324	1,324
Application of effective interest rate	39	553	2,438	3,030
Early terminations	-	(7,470)	-	(7,470)
Carrying value at 31 March 2026	1,613	45,598	37,243	84,454

	Loans from DHSC £000	Lease Liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2024	2,419	45,078	39,860	87,357
Cash movements:				
Financing cash flows - payments and receipts of principal	(400)	(2,926)	(2,611)	(5,937)
Financing cash flows - payments of interest	(51)	(421)	(2,537)	(3,009)
Non-cash movements:				
Additions	-	1,486	-	1,486
Lease liability remeasurements	-	1,707	-	1,707
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	1,804	1,804
Application of effective interest rate	47	421	2,537	3,005
Early terminations	-	(745)	-	(745)
Carrying value at 31 March 2025	2,015	44,600	39,053	85,668

Note 22 On-SoFP PFI arrangements

Note 22.1 On-SoFP PFI obligations

The following obligations in respect of the PFI are recognised in the Statement of Financial position:

	31 March 2026 £000	31 March 2025 £000
Gross PFI, LIFT or other service concession liabilities	51,545	55,241
Of which liabilities are due		
- not later than one year;	4,700	5,656
- later than one year and not later than five years;	20,514	18,709
- later than five years.	26,331	30,876
Finance charges allocated to future periods	(14,302)	(16,188)
Net PFI, LIFT or other service concession arrangement obligation	37,243	39,053
- not later than one year;	2,442	3,408
- later than one year and not later than five years;	13,181	10,808
- later than five years.	21,620	24,837

Note 22.2 Total on-SoFP PFI obligations

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2026 £000	31 March 2025 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	72,818	77,737
Of which payments are due:		
- not later than one year;	7,187	6,998
- later than one year and not later than five years;	27,769	27,026
- later than five years.	37,862	43,713

Note 22.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operation:

	2025/26 £000	2024/25 £000
Unitary payment payable to service concession operator	6,927	6,757
Consisting of:		
- Interest charge	2,438	2,537
- Repayment of balance sheet obligation	3,160	2,854
- Service element and other charges to operating expenditure	1,251	1,270
- Capital lifecycle maintenance	39	48
- Revenue lifecycle maintenance	39	48
Total amount paid to service concession operator	6,927	6,757

Note 23 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Pensions: injury benefits £000	Legal claims £000	Redundancy £000	Other * £000	Total £000
At 1 April 2025	3,368	1,680	131	109	11,246	16,534
Change in the discount rate	(447)	(404)	-	-	(262)	(1,113)
Arising during the year	554	161	26	143	6,013	6,897
Utilised during the year	(483)	(169)	(48)	-	(1,972)	(2,672)
Reversed unused	(375)	-	-	(109)	(3,113)	(3,597)
Unwinding of discount	411	339	-	-	474	1,224
At 31 March 2026	3,028	1,607	109	143	12,386	17,273
Expected timing of cash flows:						
- not later than one year;	449	165	109	143	10,900	11,766
- later than one year and not later than five years;	1,661	613	-	-	1,364	3,638
- later than five years.	918	829	-	-	122	1,869
Total	3,028	1,607	109	143	12,386	17,273

* Other provisions includes a closing provision of £8,823k (2024/25: £8,600k) in respect of the Lampard Inquiry.

The total value of clinical negligence provisions carried by NHS Resolution on the Trust's behalf as at 31 March 2026 was £21,208k (2024/25: £18,915k). This figure is not included in the above table and does not form part of the Trust's financial position.

Note 24 Capital commitments

The value of the capital commitments under expenditure contracts at 31 March 2026 was £1,968k (2024/25: £nil) on Property, Plant and Equipment, and £8,873k (2024/25: £9,100k) on Intangible Assets, giving a total capital commitment of £10,841k (2024/25: £9,100k).

Note 25 Events after the Reporting Period

There are no events after the reporting period to report.

Note 26 Contingent Liabilities

As at 31 March 2026, the Trust had contingent liabilities in respect of the Liabilities to Third Parties Scheme and Property Expenses Scheme totalling £53k (2024/25: £65k).

Note 27 Related Party Transactions

The Trust is a body corporate established by the Secretary of State. NHS England and other Foundation Trusts are considered related parties. The Department of Health and Social Care is regarded as a related party as it exerts influence over a number of transactions and operating policies of the Trust. During the year ended 31 March 2026 the Trust had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department of those entities.

During the year and at the period end, the Trust had material transactions with other NHS bodies, namely NHS Mid & South Essex ICB, NHS Suffolk & North East Essex ICB, NHS Hertfordshire & West Essex ICB, Hertfordshire Partnership University NHS Foundation Trust, Norfolk & Suffolk NHS Foundation Trust, North East London NHS Foundation Trust, and NHS England.

During the year and at the period end, the Trust had material transactions with other public sector bodies namely Essex County Council, His Majesty's Revenue and Customs and NHS Pensions.

During the year none of the Board Members, Governors or members of the key management staff or parties related to them and Department of Health and Social Care (DHSC) related parties (i.e. DHSC Ministers, senior officials and entities controlled or influenced by them) has undertaken any material transactions with the Trust.

The Governors appointed to the Council of Governors may also be members of Boards and Committees of local stakeholder organisations. Local stakeholder organisations can nominate an individual as a Governor on the Council under the following arrangements.

Three Local Authority Governors, one each appointed by:

- Essex County Council;
- Southend-on-Sea City Council;
- Thurrock Council.

Two Partnership Governors appointed by partnership organisations, one each appointed by:

- Essex University and Anglia Ruskin University (joint appointment);
- Third Party / Voluntary Sector

The Trust is the Corporate Trustee of the Essex Partnership NHS Foundation Trust General Charitable Fund. During the year ended 31 March 2026, the Trust received income of £31k from the Charity for administrative services provided by the Trust on behalf of the Charity. The Trust did not receive any capital payments. All the members of the Corporate Trustee are also members of the Trust Board.

Note 28 Financial Instruments

IFRS 7, Financial Instruments: Disclosures, requires disclosure of information that enables users of the accounts to evaluate the nature and extent of risks arising from financial instruments to which the entity is exposed at the end of the reporting period. Due to the continuing service provider relationship that the Trust has with the local Integrated Care Board and the way those Integrated Care Boards are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of the limited companies to which IFRS 7 mainly applies. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Credit risk

Over 90% of the Trust's income is from contracted arrangements with commissioners. As such any material credit risk is limited to administrative and contractual disputes.

Where a dispute arises, provision will be made on the basis of the age of the debt and the likelihood of a resolution being achieved.

Liquidity risk

The Trust's net operating costs are incurred under annual service agreements with local Integrated Care Boards, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from cash made available from prior year surpluses; and Public Dividend Capital funding that may be available from the Department of Health and Social Care to fund particular projects. The Trust has also funded two of its buildings through Private Finance Initiative scheme. The Trust is not, therefore, exposed to significant liquidity risks.

Interest-rate risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest, it is not, therefore, exposed to significant interest rate risk.

Foreign currency risk

The Trust has nil foreign currency income and expenditure.

Note 28.1 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2026	Held at amortised cost £000
Trade and other receivables excluding non financial assets	18,940
Cash and cash equivalents	45,263
Total at 31 March 2026	64,203

Carrying values of financial assets as at 31 March 2025	Held at amortised cost £000
Trade and other receivables excluding non financial assets	19,521
Cash and cash equivalents	28,077
Total at 31 March 2025	47,598

Note 28.2 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost £000
Loans from the Department of Health and Social Care	1,613
Obligations under leases	45,598
Obligations under PFI, LIFT and other service concession contracts	37,243
Trade and other payables excluding non financial liabilities	48,133
Provisions under contract	-
Total at 31 March 2026	132,587

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost £000
Loans from the Department of Health and Social Care	2,015
Obligations under leases	44,600
Obligations under PFI, LIFT and other service concession contracts	39,053
Trade and other payables excluding non financial liabilities	35,833
Provisions under contract	11,486
Total at 31 March 2025	132,987

Note 28.3 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the Statement of Financial Position which are discounted to present value.

	31 March 2026 £000	31 March 2025 £000
In one year or less	60,609	59,422
In more than one year but not more than five years	47,962	44,591
In more than five years	46,889	47,482
Total	155,460	151,495

Note 28.4 Fair value of financial assets and liabilities

The Trust reviews the fair value of assets and liabilities annually and considers the book value of all assets and liabilities to be a reasonable approximation of fair value.

Note 29 Losses and special payments

	2025/26		2024/25	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	55	110	26	12
Fruitless payments and constructive losses	2	1	-	-
Bad debts and claims abandoned	4	3	5	7
Stores losses and damage to property	1	24	1	0
Total losses	62	139	32	20
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	13	12	14	51
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	13	12	14	51
Total losses and special payments	75	151	46	70

Essex Partnership University NHS Foundation Trust

Trust Head Office

The Lodge

Lodge Approach

Runwell

Wickford

Essex

SS11 7XX

Tel: 0300 123 0808

Email: epunft.marketing@nhs.net

Online: www.EPUT.nhs.uk