



Essex Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS MEETING PART 1



BOARD OF DIRECTORS MEETING PART 1



7 October 2026



10:00 GMT+1 Europe/London



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



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REFERENCES

Only PDFs are attached



#0 Part 1 BoD agenda Oct 2026 FINAL.pdf

**Meeting of the Board of Directors held in Public
Wednesday 7 October at 10:00**

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

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

AGENDA

1	APOLOGIES FOR ABSENCE	Chair	Verbal	Noting
2	DECLARATIONS OF INTEREST	Chair	Verbal	Noting
PRESENTATION Patient Story Mrs. Helen Mackenzie				
3	MINUTES OF THE PREVIOUS MEETING HELD ON: 5 August 2026	Chair	Attached	Decision
4	ACTION LOG AND MATTERS ARISING	Chair	Attached	Decision
5	Chair's Report	Chair	Attached	Noting
6	Chief Executive Officer Report	Chief Executive	Attached	Noting
7	Board Assurance Framework	Executive Director Governance	Attached	Noting
8	STRATEGIC INITIATIVES			
8.1	EPUT Cultural Review Findings and Next Steps	Chief People Officer	Attached	Discussion
9	QUALITY AND OPERATIONAL PERFORMANCE			
9.1	Integrated Performance Scorecard	Chief Executive	Attached	Assurance
9.2	Patient Experience & Complaints Annual Report	Chief Medical Officer	Attached	Assurance
9.3	Winter Plan	Chief Operating Officer	Attached	Noting

9.4	Public Sector Equality Duty (PSED) 2025-2026	Chief People Officer	Attached	Decision
9.5	Equality and Inclusion Annual Report (WRES / WDES)	Chief People Officer	Attached	Decision
9.6	Gender, Ethnicity and Disability Pay Gap Report	Chief People Officer	Attached	Decision
9.7	CQC Well Led Report and Response Plan	Chief Executive	Attached	Noting
10	ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL			
10.1	Committee Chairs Report	Chairs	Attached	Noting
10.2	Infection, Prevention and Control (IPC) Annual Report	Chief Nurse	Attached	Assurance
10.3	Mental Health Act Annual Report	Chief Nurse	Attached	Assurance
11	OTHER			
11.1	Correspondence circulated to Board members since the last meeting.	Chair	Verbal	Noting
11.2	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Decision
12	ANY OTHER BUSINESS	ALL	Verbal	Noting
13	QUESTION THE DIRECTORS SESSION A session for members of the public to ask questions of the Board of Directors			
	EXCLUSION OF THE PUBLIC AND PRESS Notice of Motion: Those members of the public and press be excluded from the remainder of the meeting by reason of the confidential nature of the business to be transacted.			
	DATE AND TIME OF NEXT MEETING Wednesday 2 December 2026 at 10:00, The Lodge Training Room 1			
	DATE AND TIME OF FUTURE MEETINGS Wednesday 3 February 2027 at 10.00, The Lodge Training room 1			

Dr Jackie Craissati
Interim Chair

1. APOLOGIES FOR ABSENCE

● Standing item

👤 Chair

2. DECLARATIONS OF INTEREST

● Standing item

👤 Chair

PRESENTATION: PATIENT STORY

- Information Item

3. MINUTES OF THE PREVIOUS MEETING HELD ON: 5 AUGUST 2026

● Decision Item

● Chair

REFERENCES

Only PDFs are attached



Board of Director Part 1 Minutes 05.08.2026.pdf

Minutes of the Board of Directors Meeting held in Public

Held on Wednesday 5 August 2026

Held in person at Trust Headquarters

MEMBERS PRESENT:

Loy Lobo	LL	Acting Chair (Chair)
Trevor Smith	TS	Interim Joint Chief Executive Officer
Jenny Davis	JD	Interim Executive Chief Finance Officer
Ruth Jackson	RJ	Non-Executive Director
Nicola Jones	NJ	Director of Risk and Compliance (for Denver Greenhalgh)
Diane Leacock	DL	Non-Executive Director
Andrew McMenemy	AM	Executive Chief People Officer / Interim Deputy CEO
Ann Sheridan	AS	Executive Chief Nurse
Richard Spencer	RS	Non-Executive Director
Dr Kallur Suresh	KS	Executive Medical Director
Zephan Trent	ZT	Executive Director Chief Digital and Information Officer
Lizzy Wells	LW	Interim Executive Chief Operating Officer

IN ATTENDANCE:

Angela Laverick	AL	Executive Assistant to Chief Executive, Chair and NEDs (minutes)
Chris Jennings	CJ	Assistant Trust Secretary
Georgina Beadon Ekers	GBE	Senior Physiotherapist, South Essex Trauma Alliance
Sonam Verma	SV	Assistant Psychologist, South Essex Trauma Alliance
Madeleine Bean	MB	Assistant Psychologist for Southend in South Essex Adult Community

There were eight members of the Public / Staff Members present. LL welcomed Board members, Governors, members of the public and staff joining this in public Board meeting.

081/26 APOLOGIES FOR ABSENCE

Apologies were received from Alex Green, Denver Greenhalgh and Sarah Teather.

082/26 DECLARATIONS OF INTEREST

There were no declarations of interest.

083/26 PRESENTATION: SOUTH ESSEX TRAUMA ALLIANCE WORK

Georgina Beadon Ekers (Senior Psychotherapist), Sonam Verma (Assistant Psychologist) and Madeleine Bean (Assistant Psychologist) delivered a presentation on the South Essex Trauma Alliance, highlighting:

- The Alliance had been established in 2020 to promote trauma-informed practice across South East Essex through partnership working with statutory, voluntary and community organisations.
- The Alliance supported organisations to assess practice against a validated trauma-informed framework and develop tailored improvement plans, with annual reviews used to measure progress and drive cultural change.

- The Alliance had expanded significantly, with 34 active teams and organisations participating. Over 90 training sessions had been delivered to almost 1,600 attendees, alongside more than 50 reviews and extensive engagement with staff and service users.
- Review findings demonstrated a strong commitment to trauma-informed care across the system, while identifying challenges including inconsistent practice, limited opportunities for reflective practice, difficulties accessing specialist interventions and the need for further support for staff wellbeing.

Questions and Discussion

- KS asked what a trauma-informed organisation would look like in practice. GBE advised that this would be reflected in a calmer, more inclusive culture, with fewer trauma responses and greater involvement of staff and service users in co-production.
- RJ asked about the sustainability of reflective practice once Alliance support concluded. GBE explained that reflective practice could initially be challenging for teams and required trust and psychological safety. The Alliance encouraged organisations to embed these approaches locally, with positive feedback received, although sustaining protected time remained a challenge.
- AS asked how the Alliance influenced cultural change. GBE noted that culture change was achieved through a gradual shift in mindset and increased awareness across teams and organisations.
- AM asked what additional support might be required for staff wellbeing. GBE acknowledged the significant work already underway within EPUT and emphasised the importance of investing in reflective practice, facilitation and protected time for staff.
- LL suggested that learning from the Alliance should inform the Trust's wider cultural transformation programme and be monitored through the People Committee. AM advised that related work was already underway through the Trust's leadership development programme and agreed to align this with the trauma-informed agenda.

LL thanked GBE, SV and MB for their presentation.

084/26 MINUTES OF THE PREVIOUS MEETING HELD ON 3 JUNE 2026

The Board of Directors reviewed the minutes of the meeting held on the 3 June 2026, noting the following amendments:

- Page 5 (Questions and Discussions, Bullet Point 1): Update to clarify the industrial action related to resident doctors.
- Page 6 (People and Culture, Bullet Point 3): Update to clarify the trajectories related to absence management, trend analysis and trajectories around sickness absence.

With the above amendments, the minutes were agreed as an accurate record.

085/26 ACTION LOG AND MATTERS ARISING

The action log was reviewed noting there were no open actions. LL advised that he had identified some areas for follow-up from the previous minutes. CJ had discussed these with Executive Directors and would ensure these items are followed-up.

086/26 CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

LL presented a report, which provided the Board of Directors with a summary of key governance developments since the previous meeting, highlighting:

- The Trust's continued commitment to supporting the Lampard Inquiry. LL noted the importance of ensuring that learning from the Inquiry supported improvements in mental health services nationally and helped secure the resources required to deliver effective services.

- LL provided an update on the proposed legislation relating to Foundation Trusts and the role of Governors. Pending confirmation of any legislative changes, existing arrangements would continue. A campaign to elect new Governors had been launched, and LL reaffirmed the Trust's commitment to working closely with Governors in their current role and under any future arrangements.

The Board of Directors received and noted the content of the report.

087/26 CEO REPORT

TS presented the report, providing a summary of key activities and developments since the previous meeting, highlighting:

- Director portfolios had been updated and shared with staff. These would be further promoted across the organisation to help colleagues better understand leadership responsibilities and roles.
- An assurance statement had been submitted to NHS England under delegated authority in relation to the findings of the Fuller Inquiry and Ockenden Review.
- TS thanked colleagues for the achievement of the Child and Adolescent Mental Health Services (CAMHS) inpatient wards receiving a Good rating from the Care Quality Commission (CQC).
- AM provided an update on the recently published NHS Staff Standards, noting that assurance arrangements had been considered by the People Committee.
- AM updated the Board on work arising from the Lord Mann Review, including partnership work with the King's Fund and BRAP to support the Trust's anti-racism programme and engagement with staff networks.
- AS provided an update on the Fundamentals of Care programme, noting that the current priority was embedding the framework into sustainable practice and workforce development.

Questions and Discussion

- RS welcomed the improvement in CAMHS CQC rating and asked whether learning from the team's approach could be shared more widely across inpatient services. TS acknowledged the importance of addressing variation across services and advised that this had been discussed at a recent Board seminar, which had focused on how learning could be embedded more consistently and sustainably across the Trust.

The Board of Directors received and noted the content of the report.

088/26 QUALITY AND PERFORMANCE SCORECARD

TS introduced the report, alongside the summary included within the Chief Executive's report. The report provided an overview of operational performance, quality indicators, safer staffing levels, financial performance and key NHS England metrics, highlighting:

Operational Performance

- LW reported that Mental Health Services remained fifth nationally for average length of stay, reflecting positive patient flow through inpatient wards, although demand continued to exceed available capacity.
- Adult inpatient occupancy remained above target, whilst PICU occupancy remained below target. LW noted that sustained demand was being supported through transformation initiatives, including the Time to Care programme.
- Due to continued service pressures, out of area placements remained in use. LW advised that placements were now classified in line with revised NHS England criteria and that a dedicated discharge co-ordination team worked closely with patients, families and providers to support timely discharge.
- Virtual ward occupancy remained below target in both Mid and South Essex and West Essex. An audit had identified five key recommendations to support improvement.

Quality and Nursing

- AS and KS reported continued improvement in cardiometabolic monitoring, particularly within Mid and South Essex. Work continued between medical, nursing and primary care colleagues to improve monitoring of patients against key cardiometabolic indicators, particularly those who did not regularly access GP services.
- RS asked whether greater collaboration with voluntary sector organisations could support access to assessments for vulnerable groups, including people experiencing homelessness or addiction. AS agreed that further partnership working opportunities existed and that this remained an area for development.

People and Culture

- AM advised that sickness absence remained a key workforce risk. A range of interventions were in place with executive oversight; however, absence levels continued to trend upwards.
- Vacancy rates and staff turnover continued to improve, placing the Trust in a stronger workforce position.
- AM reported that temporary staffing levels had reduced significantly since Month 3, reflecting lower bank and agency usage and a positive trajectory towards workforce plan targets.

Finance

- JD reported a £1 million deficit for Month 3, resulting in a year-to-date deficit of £5.6 million, which was £1.5 million behind plan.
- Delivery of the extended efficiency programme remained a key focus, supported by strengthened oversight arrangements through the Transformation and Efficiency Group and local accountability structures.

Questions and Discussion

- RS noted that Board reports contained limited information regarding performance and risks within Community Services, including emerging pressures relating to neurodiversity pathways. TS agreed that future reports should provide greater visibility of these areas.
- DL asked when improvements in virtual ward occupancy were expected. LL asked how the Trust was working with acute partners to address the issue. LW advised that close partnership working was taking place with both West Essex and Mid and South Essex acute trusts to improve pathways and support occupancy levels.
- RJ asked whether delayed roster publication could be contributing to sickness absence levels. AM reported that improvements had been seen across inpatient and urgent care services, although some inconsistency remained. Action was being taken to ensure greater compliance and consistency across the Trust. AM emphasised that timely publication of rosters was important for staff wellbeing and remained an area of focus.
- LL asked whether management remained confident in delivering the financial plan. JD acknowledged the challenges but reiterated that work continued to deliver the required improvements. RS requested further scrutiny of delivery against the efficiency programme to be taken through the Finance and Performance Committee.

The Board of Director received and noted the content of the report.

Actions:

1. **Ensure the report provides more information regarding performance and risks within Community Services, including emerging pressures relating to neurodiversity. (TS / LW)**
2. **Undertake further scrutiny of delivery against the efficiency programme through the Finance and Performance Committee. (JD)**

089/26 COMMITTEE CHAIRS' REPORT

LL introduced the report, which provided a summary of key assurances and issues identified through the Board's Standing Committees.

Finance and Performance Committee

- DL reported that the Committee had reviewed new risks added to the Corporate Risk Register relating to backlog maintenance and estates workforce capacity.

People Committee

- RJ advised that the Committee's primary focus had been on delivery of the People Plan, Equality, Diversity and Inclusion priorities, and the Trust's response to the Mann Review, with work continuing in these areas.

Quality Committee

- MJ reported that the Committee had focused on learning arising from recent CQC inspections. Feedback had been received following the inspection at Ardleigh, and the Committee would undertake further review of thematic learning from regulators and the Lampard Inquiry.
- The Committee had also considered the governance arrangements for Contactless Patient Monitoring Technology, seeking assurance regarding both its benefits and the concerns that may be experienced by patients and families.
- MJ advised that the Committee had received assurance regarding work to reduce ligature risks and incidents of violence and aggression, including how learning was being shared across services.
- The Committee had received assurance following the results of the Patient-Led Assessment of the Care Environment (PLACE) for 2025 and this had been included in the Board papers.

The Board of Directors received, noted the content of the report and noted the outcome of the PLACE assessments 2025.

090/26 CQC ASSURANCE REPORT

AS presented the report, which provided an update on CQC-related activities, progress against the Trust's CQC improvement plan, internal assurance of compliance against CQC Quality Statements, and recent CQC guidance and developments. AS highlighted:

- The Trust's Well-Led Inspection had taken place and the draft report had been received for factual accuracy review. The report related to Strategic Risks 8, 10 and 13 within the Board Assurance Framework.
- Recent unannounced inspections had informed a review of the Trust's improvement plan. AS advised that assurance had been gained regarding the completeness of actions, with a continued focus on embedding learning into practice.
- Work continued to triangulate multiple sources of intelligence and data to support learning, improvement and assurance.

Questions and Discussion

- AM noted that the improvements made at Ardleigh, including safer staffing recruitment and strengthening of the substantive workforce, demonstrated the benefits of linking improvement actions to the Trust's People Strategy.

- DL asked how learning from inspections, alongside internal learning, could be implemented and sustained across services. AS advised that the Trust aimed to respond immediately to identified issues rather than waiting for formal recommendations, focusing on behaviours, outcomes and support for staff. Positive improvements in practice had already been observed during service visits, although continued support would be required to sustain progress.
- RJ commented that recurring themes were often identified through reviews, with implementation plans developed, but that standards were not always consistently maintained. RJ suggested that further reflection with staff would be valuable to understand barriers to embedding learning and to identify why some improvements had not been sustained.
- LL advised that organisational learning would be a key focus of a future Board seminar. TS highlighted the importance of learning from external partners and collaborative organisations, noting that there was further work to do in this area and that the forthcoming Board seminar would provide an opportunity to explore this in greater detail.

The Board of Directors received, noted the content of the report and the assurance provided regarding progress against the improvement plan.

Action:

1. **Consider undertaking a Board Seminar session including a focus on organisational learning. (DG)**

091/26 LEARNING FROM DEATHS Q4 2025/26

AS presented the report, which provided the Trust's nationally mandated quarterly reporting on Learning from Deaths activity and an overview of the key learning and improvements arising from mortality reviews. AS highlighted:

- The Learning from Deaths report would, in future, be incorporated within the Trust's wider Patient Safety Strategy reporting.
- Learning themes continued to align with those identified through the Patient Safety Strategy, including incident reporting, physical health monitoring, handover processes and escalation arrangements. Additional themes relating to organisational culture and communication had also been identified through reviews.
- Learning and improvement actions continued to be overseen through the Learning from Deaths Oversight Group and Learning Oversight Sub-Committee, with both immediate and longer-term actions implemented to support service improvement.

The Board of Directors received and noted the content of the report.

092/26 QUESTIONS TAKEN FROM THE GENERAL PUBLIC

Simon Cross, Public Governor and Lived Experience Ambassador – regarding the presentation how was co-production incorporated into the Alliance's work and how people with lived experience contributed. GBE confirmed that reviews are informed by feedback from both staff and service users.

093/26 BOARD ASSURANCE FRAMEWORK

TS presented the report, which provided a high-level summary of the Trust's Strategic Risks and Corporate Risk Register, including progress against actions established to mitigate identified risks. TS highlighted:

- The Board's Standing Committees had reviewed the Strategic Risks and Corporate Risk Register and had not recommended any changes to risk scores at this time.
- Four new risks had been escalated onto the Corporate Risk Register following review through the Trust's governance processes, relating to

neurodevelopmental service demand, autism spectrum disorder service demand, backlog maintenance and estates workforce.

The Board of Directors received and noted the content of the report, including the four new corporate risks.

094/26 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ANNUAL REPORT 2025-26

EW presented the report, which provided assurance that the Trust had effective organisational resilience arrangements in place to respond to major incidents, critical incidents and business continuity events. The report outlined progress during 2025/26 in meeting the requirements of the Civil Contingencies Act 2004 and NHS England's Emergency Preparedness, Resilience and Response Framework. EW highlighted:

- The Trust had achieved 100% compliance across all ten domains within the annual Emergency Preparedness, Resilience and Response self-assessment. The result reflected sustained improvement and maturity in organisational resilience arrangements over recent years.
- During the year, the Trust had successfully managed several complex business continuity incidents and had continued to strengthen its business continuity arrangements.
- The Trust remained fully engaged in system-wide and multi-agency resilience planning and partnership working.
- Overall, the report provided strong assurance that organisational resilience arrangements remained effective, compliant and subject to continuous improvement.

Questions and Discussion

- RS noted that references to key risks included low temperatures and severe weather events and suggested that future assessments should also consider risks associated with prolonged high temperatures, wildfires and water shortages, particularly following recent heatwaves.

The Board of Directors received and noted the content of the report.

095/26 PATIENT SAFETY INCIDENT RESPONSE PLAN

AS presented the report, which provided the Board of Directors with the Trust's Patient Safety Incident Response Plan (PSIRP) 2026-2028. The Plan set out how the Trust would respond to patient safety incidents in line with the NHS Patient Safety Incident Response Framework (PSIRF), with a focus on learning, continuous improvement and strengthening patient safety arrangements. AS highlighted:

- The PSIRP established a learning-focused, systems-based approach to incident investigation and improvement, ensuring that learning from patient safety incidents informed sustainable changes in practice.
- The Plan had been informed by patient safety intelligence and aligned with the Trust's quality priorities, providing clear governance and oversight arrangements for patient safety learning and improvement.
- The PSIRP had been reviewed by the Quality of Care Group and approved by the Quality Committee, which had received assurance that it met national requirements and provided an appropriate framework for patient safety oversight.

Questions and Discussion

- AM suggested that future reporting to the Quality Committee should clearly identify what had changed under the revised approach and demonstrate how learning was being applied and shared across the wider organisation. AS advised that an improvement plan sat alongside the PSIRP and that reporting would focus on evidencing the impact of implemented improvements. AS

advised that oversight of investigation timescales and delayed inquiries had been strengthened through a new dashboard, with progress also monitored through weekly Executive Team discussions.

The Board of Directors received and noted the content of the report.

096/26 PATIENT SAFETY STRATEGY Q1 2026/27

AS presented the report, which provided the Board of Directors with assurance regarding the effectiveness of the Trust's patient safety system. The report brought together intelligence from patient safety incidents, complaints, Duty of Candour activity, safety alerts, quality improvement work and organisational learning to provide an overview of patient safety performance and emerging risks. AS highlighted:

- The report provided a consolidated view of how safe care was being delivered across the Trust and identified areas requiring further action, oversight or support.
- Intelligence from a range of sources was being used to identify learning, monitor trends and support improvement activity. The report supported a greater focus on organisational learning and the consistent application of patient safety improvements across services.

Questions and Discussion

- LL observed that there remained variation in performance and culture across services, with some areas demonstrating strong learning cultures and others requiring further development. AM noted that there were opportunities to share learning more effectively across teams and clinical services and commented that this was both a leadership and organisational learning issue. AM advised that leadership development initiatives, including consideration of a leadership rotation programme, had been informed by the recent leadership review.
- RS welcomed the patient safety data presented and asked whether external benchmarking information was available to provide comparison with other organisations. AS advised that significant work had been undertaken to strengthen internal reporting processes and engagement. National work was also underway to improve the consistency of patient safety harm classifications. AS further advised that a weekly patient safety meeting involving all Care Units had been established to review emerging incidents, support shared learning and reduce unwarranted variation across the Trust.
- LL commented that strengthened governance and accountability arrangements were beginning to take shape and provided some assurance that appropriate oversight was in place. However, LL noted that further evidence of improvement and sustained performance would be required before greater assurance could be gained regarding delivery.

The Board of Directors received and noted the content of the report.

097/26 SAFEGUARDING ANNUAL REPORT

AS presented the report, which provided an overview of safeguarding activity undertaken across Trust services and with partner agencies during 2025/26, together with key priorities for 2026/27. AS highlighted:

- National benchmarking remained limited due to the multi-agency nature of safeguarding arrangements, which extended beyond health organisations. However, the Trust continued to learn from partner organisations and sector best practice.
- The report provided strong assurance regarding the effectiveness of safeguarding arrangements across the Trust.
- An increase in safeguarding referrals had been observed during the reporting period.

- Strong working relationships continued to be maintained with system partners to support safeguarding activity and shared learning. The Trust remained an active participant in local safeguarding partnerships, including attendance and engagement at the Essex Safeguarding Boards.

Questions and Discussion

- LL commented on safeguarding failures associated with communication breakdown and sought assurance regarding the controls in place to mitigate this risk. AS advised that the safeguarding team maintained strong visibility both internally and externally and played an active role in responding to areas of concern across the system. The Trust remained closely involved in safeguarding issues affecting both health services and the wider community.
- RS asked about the relaunch of the Safeguarding Champions Network and whether the existing network had been effective. AS advised that the network had provided valuable opportunities for staff engagement and development. The relaunch was intended to refresh membership, create opportunities for new participants and strengthen the network's effectiveness.

The Board of Directors received and noted the content of the report.

098/26 QUARTERLY REPORT ON SAFE WORKING OF RESIDENT DOCTORS

KS presented the report, which provided assurance that doctors in training were being rostered safely and that working hours remained compliant with contractual requirements. KS highlighted:

- The report covered performance during the first quarter of the financial year.
- The number of exception reports received during the quarter had reduced compared to previous reporting periods. The reduction in exception reporting reflected national variation in reporting activity rather than any systemic concerns within the Trust.

Questions and Discussion

- DL raised concerns regarding delays in trainees accessing payments arising from exception reporting fines and suggested that consideration be given to delegating approval authority to the Guardian of Safe Working Hours to avoid delays through the discretionary non-pay approval process. KS, AM and JD agreed that the process should be reviewed and that future payments would be managed outside of the discretionary non-pay panel arrangements to support more timely payment.

The Board of Directors received and noted the content of the report.

99/26 RESPONSIBLE OFFICERS AND REVALIDATION ANNUAL REPORT AND STATEMENT OF COMPLIANCE

KS presented the report, which provided information on the implementation of medical revalidation within the Trust for the 2025/26 appraisal year and supported the annual compliance statement submitted to the Higher Level Responsible Officer at NHS England. KS highlighted:

- The report provided the Trust's annual assurance regarding the effectiveness of its medical revalidation arrangements. The Trust had achieved a 97% appraisal completion rate during the reporting period. The remaining 3% of appraisals were being actively managed through established processes.

Questions and Discussion

- RS noted the ongoing shortage of appraisers and referred to actions identified in the previous year regarding the recruitment and retention of appraisers. RS suggested that the People Committee consider what additional measures could be implemented to address this issue. KS advised that the expectation was for

each appraiser to undertake approximately five appraisals per year on an unpaid basis. Work was underway to recruit additional appraisers and expand the available pool to improve resilience and capacity.

The Board of Directors received, noted the content of the report and approved the compliance statement, noting the Joint Interim Chief Executive Officer would submit the compliance statement to the Higher Responsible Officer at NHS England.

Action:

- 3. Submit the Responsible Officer and Revalidation statement of compliance to the Higher Responsible Officer at NHS England. (TS / KS)**

100/26 USE OF CORPORATE SEAL

TS presented the report which noted the corporate seal had been used on three occasions:

- 15.07.26 Agreement relating to sale and purchase of Bradd Close, South Ockendon, RM15 6SA
- 15.07.26 Agreement relating to sale and purchase of 15 Regent Road, Epping, CM16 5DL
- 15.07.26 Lease Renewal Oakley Court, Angel Close, Luton, LU4 9WT

The Board of Directors received and noted the content of the report.

101/26 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

None

103/26 NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT REQUIRE REMOVING

There were no items for escalation.

104/26 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

DL provided the following reflections:

- The presentation on the South Essex Trauma Alliance demonstrated the importance of co-production, partnership working and relationship-building.
- Governors remained an important link between the Trust and the communities it served.
- Discussions on cardiometabolic health highlighted the need for continued engagement with voluntary sector and community partners, alongside recognition of the relationship between acute system pressures and virtual ward occupancy.

RJ provided the following reflection:

- Themes relating to neurodiversity appeared across a number of reports and discussions. RJ suggested that the Trust should give greater consideration to how neurodivergence and co-morbidity may influence engagement with services and outcomes and explore how these issues could be more explicitly considered through the Board's committee structure and reporting arrangements.

105/26 REFLECTION ON RISKS, ISSUES OR CONCERNS INCLUDING RISKS FOR ESCALATION TO THE CRR OR BAF, RISKS OR ISSUES TO BE RAISED WITH OTHER STANDING COMMITTEES

There were no items for escalation.

106/26 QUESTION THE DIRECTORS SESSION

Stuart Scrivener, Lead Governor: Regarding the data quality issues noted in the Learning from Deaths report, are the Board / Non-Executive Directors satisfied that the issues are not preventing the identification of important themes or timely action and what assurance has been sought / timescales identified for the resolution of the data quality issues. MJ responded that learning was being drawn from multiple sources, including the Inquiry, Learning from Deaths reviews, Coroners' reports and CQC findings. Although the quality of historical data varied, common themes were emerging. A new dashboard had been developed to bring these sources together, support oversight of learning and strengthen assurance arrangements. Understanding would continue to evolve as further information became available. AS advised that the Trust had engaged with a partner organisation that had undertaken significant work on mortality reviews and was working with Local Authorities to improve the timeliness of receiving causes of death.

James McCarthy, Public Governor: The ongoing inquiry and news arising from it is bound to have an impact on our staff. What impact is it having on staff and potentially on the services they provide? What steps are being taken to monitor this? What steps are being taken to mitigate any risks here? Board members responded confirming that robust arrangements were in place to support colleagues through the process, including dedicated wellbeing and psychological support, clear communication, protected time and active monitoring of staff wellbeing. It was noted that, whilst the nature of the Inquiry and associated media coverage could be distressing for some staff, no significant impact on service delivery had been identified. The Trust also remained mindful of the impact on patients and families.

Simon Cross, Public Governor and Lived Experience Ambassador: With different organisations under pressure, what were EPUT's plans to meet the government's plan to equalise mental health services and if there was a danger that under-pressure may push issues onto other providers, including EPUT? TS emphasised that the Trust's efficiency programme focused on improving how services were delivered and reducing costs in areas such as procurement, estates and contracts, rather than reducing service provision. Equality impact assessments were undertaken to ensure efficiencies did not adversely affect patients or local communities. LL was assured that the Trust continued to maintain positive and constructive discussions with commissioners, which remained essential to delivering effective services.

How achievable with the neighbourhood model be going forward with all the ongoing pressures and move to getting a preventative model in place? Board members responded, noting the progress in developing integrated models across Essex, involving mental health services, primary care, voluntary sector providers and substance misuse services, although implementation was progressing at different rates across localities. It was recognised that successful neighbourhood models would require organisations to work collaboratively, align existing resources and avoid siloed approaches. The importance of estates, funding arrangements and partnership working was highlighted as key enablers of the neighbourhood strategy, particularly in supporting a shift towards prevention and community-based care. The Board emphasised the need to demonstrate the benefits of collaborative working through practical local examples and outcomes, helping to build momentum and support for wider implementation.

Regarding the Safeguarding Champions role, could this be extended to lived experience ambassadors? AS agreed that it was important to extend out as wide as possible, different people bring different perspective and lenses and keen to have those with lived experience in those roles.

107/26 DATE OF NEXT MEETING

The next meeting of the Board of Directors is to be held on Wednesday 07 October 2026.

Signed:

Date:

DRAFT

4. ACTION LOG AND MATTERS ARISING

☐ Standing item

 Chair

REFERENCES

Only PDFs are attached

 Action Log Part 1 05.08.2026.pdf

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting held on the 5 August 2026

Lead	Initials	Lead	Initials	Lead	Initials	Requires immediate attention /overdue for action	
Kallur Suresh	KS	Denver Greenhalgh	DG	Jenny Davis	JD	Action in progress within agreed timescale	
Lizzy Wells	LW	Trevor Smith	TS			Action Completed	
						Future Actions/ Not due	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
August 088/26	Ensure the report provides more information regarding performance and risks within Community Services, including emerging pressures relating to neurodiversity.	TS / LW	October 2026	This has been incorporated into the Integrated Performance Report for the Board of Directors in October 2026.	Closed	
	Undertake further scrutiny of delivery against the efficiency programme through the Finance and Performance Committee.	JD	October 2026	This was discussed at the Finance and Performance Committee at its meeting in September 2026.	Closed	
August 090/26	Consider undertaking a Board Seminar session including a focus on organisational learning.	DG	October 2026	This has been incorporated into the Board Development Plan.	Closed	
August 099/26	Submit the Responsible Officer and Revalidation statement of compliance to the Higher Responsible Officer at NHS England,	TS / KS	October 2026	The compliance statement was submitted to the Higher Responsible Officer at NHS England following the meeting.	Closed	
	Consideration to be given to Board Seminar session focusing on organisational learning.	DG	October 2026	This has been incorporated into the Board Development Plan.	Closed	

5. CHAIRS REPORT

☒ Information Item

☐ Chair

REFERENCES

Only PDFs are attached

 Chair's Report 07.10.2026 (1).pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1		7 October 2026		
Report Title:	Chair's Report				
Report Lead	Jackie Craissati, Interim Chair				
Report Author(s):	Jackie Craissati, Interim Chair				
Report discussed previously at:	N/A				
Level of Assurance:	Level 1	☒	Level 2	☐	Level 3
				☐	

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

Purpose of the Report		
This report provides the Board of Directors with a summary of key headlines from the Chair.	Decision	☐
	Discussion	☐
	Information	☒

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

Summary of Key Points

This report provides the Board of Directors with a summary of key headlines from the Chair.

Relationship to Trust Strategic Objectives

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

Which of the Trust Values are Being Delivered

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

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

Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	☐
Data quality issues	☐
Involvement of Service Users/Healthwatch	☒
Service impact/health improvement gains	☐
Financial implications:	Capital £ Revenue £ Non Recurrent £ ☐
Governance implications	☐
Impact on patient safety/quality	☐

Acronyms/Terms Used in the Report

	Acronym	Definition
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Supporting Reports/ Appendices /or further reading

Chair's Report

Lead



Jackie Craissati
Interim Chair

CHAIR'S REPORT

1.0 PURPOSE OF REPORT

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

2.0 CHAIR'S REPORT

2.1 National and System Activity

I attended the monthly East of England NHS Providers Chairs meeting, where the focus was on improving performance across the region, and on the new Deloitte's board development programme. EPUT will have an opportunity to participate in the latter programme, but ideally as one of the later cohorts, once our board has an opportunity to stabilise after the recent changes. Later this month I will be attending the NHS Alliance leader's forum, where the focus will be on neighbourhood health and Equality, Diversity and Inclusion.

2.2 Changes to Board of Directors

Following the sad death of EPUT Chair, Hattie Llewelyn-Davies, the Board implemented interim leadership arrangements in accordance with the Trust's Constitution. These arrangements were designed to ensure continuity of leadership, maintain effective governance and provide clear accountability during what has been a deeply difficult period for the organisation. I would like to thank Acting Chair, Loy Lobo for his leadership during this time, and for his generosity in ensuring a smooth handover.

I am honoured to have been appointed as Interim Chair and am pleased to be joining EPUT at this important time. I look forward to working closely with our Council of Governors, Board colleagues, staff, patients, carers and partners as we continue our shared commitment to delivering high-quality care and improving outcomes for the populations we serve.

2.3 Council of Governors

I chaired my first Council of Governors meeting on the 9 September. The Council received the outcome of the NED appraisals for 2025/26, confirming that all had been completed and that all NEDs were considered fit and proper following assessment against the NHS England Fit and Proper Persons Test.

2.4 Board Seminar to Discuss the CQC Well Led Outcome Report

Members of the wider senior management team joined the Board seminar held 2 September to consider and discuss the findings of the CQC Well Led report in detail and the further steps we need to take to improve our services. The Board welcomes the report and the challenge it brings to help us achieve our aim of ensuring our patients receive the best possible care. We had a lively and constructive discussion, with a central theme being the need to prioritise key actions and thoroughly embed them to achieve the greatest impact.

2.5 Chair and NED Visits

Visits are an important aspect of the non-executive role, enabling us to ground our discussions in the reality of front line delivery of services.

I recently visited the Linden and Crystal Centre with our Lead Governor and met with staff and patients on four of the wards. My first impressions were positive, with evidence of strong local leadership focused on ensuring positive patient and staff experience. Although not all the estate is fully modernised, the environment was clean and light with a calm atmosphere on the wards. However,

one of the ward gardens was not in an acceptable state and it seemed that our escalation process to resolve this had not been satisfactory. I'm pleased to note that the situation has now been rectified.

I joined a quality assurance visit to Plane ward at St Margarets Hospital, Epping. This is a discharge to assess ward for patients with physical health rehabilitation and caring needs. Although the findings will be reported more fully through our quality assurance governance processes, I noted that the environment was clean with pleasant facilities. The ward has to restrict the number of patients that can be accepted with cognitive deficits and associated behaviour that is challenging to manage; I wondered whether there were additional opportunities to integrate care more closely with the neighbouring mental health ward for older adults with dementia, thereby enabling an improved service to our acute hospital colleagues.

I have further visits scheduled this month to community health services at Rochford Hospital, and specialist services at Brockfield House.

In future reports, I will be including the numerous visits undertaken by the wider non-executive team.

Loy Lobo

I participated in Quality Assurance Visits to Cherrydown Ward in Basildon and Ardleigh Ward at The Lakes (with Mateen Jiwani). Both are acute inpatient wards for women experiencing a significant mental health crisis.

At Cherrydown, patients spoke very positively about the care they received, and the ward had a calm, cohesive atmosphere. We observed strong relationships between staff and patients, visible leadership from the ward manager and a well-run community meeting chaired by a patient. The activity coordinator and programme received particular praise. Training, appraisal and supervision compliance were good.

At Ardleigh patients praised several staff members and we saw examples of good occupational therapy involvement. Recent recruitment and the increased staffing establishment were also encouraging. However, Ardleigh requires more concentrated support and oversight. Concerns included inconsistent security practice, low compliance in some areas (training and supervision), incidents awaiting review with limited evidence of learning. Team and community meetings were either not taking place consistently or could not be evidenced. There were also unresolved environmental issues and concerns about access to food, hot drinks and functioning facilities.

Taken together, the visits demonstrated compassionate practice and the value of strong ward leadership. They also reinforced the need for quicker Estates responses, consistently person-centred care planning, and reliable governance evidence. Ardleigh ward has been receiving extensive executive support, and the Quality Committee awaits evidence of the impact of those interventions.

Richard Spencer

I visited Larkwood Ward as part of a planned Quality Assurance Visit, along with one of our Public Governors (Cort Williamson). Larkwood is a Psychiatric Intensive Care Unit (PICU) located at the St. Aubyn Centre in Colchester, the only NHS Adolescent PICU in the East of England. The visit was useful to see the generally good facilities available to patients to facilitate therapeutic care, and to meet members of an enthusiastic staff team. The Family Liaison Office role introduced as part of our Time to Care programme has brought clear benefits to improving engagement with patients and their families.

6. CHIEF EXECUTIVE OFFICER (CEO) REPORT

● Information Item

● Chief Executive

REFERENCES

Only PDFs are attached

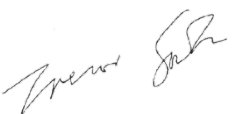
 CEO Report 07.10.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1			7 October 2026		
Report Title:	Chief Executive Officer (CEO Report)					
Report Lead	Trevor Smith, Interim Joint Chief Executive Officer					
Report Author(s):	Trevor Smith, Interim Joint Chief Executive Officer					
Report discussed previously at:	N/A					
Level of Assurance:	Level 1	☒	Level 2	☐	Level 3	☐

Risk Assessment of Report		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	☐
	SR4 Demand/ Capacity	☐
	SR5 Statutory Public Inquiry	☐
	SR6 Cyber Attack	☐
	SR7 Capital	☐
	SR8 Use of Resources	☐
	SR9 Digital and Data	☐
	SR10 Workforce Sustainability	☐
	SR11 Staff Retention	☐
	SR12 Organisational Development	☐
SR13 Quality Governance	☐	
Does this report mitigate the Strategic risk(s)?	N/A	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	No	
If yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	No	
Describe what measures will you use to monitor mitigation of the risk	N/A	
Are you requesting approval of financial / other resources within the paper?	No	
If yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	N/A	
Reflection on Equalities	The report identifies developments with the potential to support equality, diversity and inclusion and reduce health inequalities. No direct adverse equality impacts are identified from the matters reported.	

Purpose of the Report		
The report attached provides information on behalf of the CEO and Executive Team in respect of strategic developments, key matters and initiatives.	Decision	☐
	Discussion	☐
	Information	☒

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

Summary of Key Points			
The report attached provides information on behalf of the CEO and Executive Team in respect of:			
• National NHS Chief Executive Leadership Event • Thirlwall Inquiry Report • Lampard Inquiry October Hearings • Updates to Local MPs • Executive-to-Executive meetings with system partners. • One Essex Digital Summit • Strategic Investments and Improvements • Updates from Executive Portfolios (people, nursing, finance, operations, digital)			
Relationship to Trust Strategic Objectives			
SO1: We will deliver safe, high quality integrated care services			☒
SO2: We will enable each other to be the best that we can			☒
SO3: We will work together with our partners to make our services better			☒
SO4: We will help our communities to thrive			☒
Which of the Trust Values are Being Delivered			
1: We care			☒
2: We learn			☒
3: We empower			☒
Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			☐
Data quality issues			☐
Involvement of Service Users/Healthwatch			☐
Communication and consultation with stakeholders required			☐
Service impact/health improvement gains			☐
The report provides details of recent service developments.			
Financial implications:			☒
The report provides information on capital investments and funding.			
Governance implications			☒
The publication of the Thirlwell Inquiry includes to consider the findings and consider how these apply to the Trust. This will be taken forward through internal governance processes.			
Impact on patient safety/quality			☐
Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	ESR	Electronic Staff Record
CPD	Continued Professional Development	ICB	Integrated Care Board
DHSC	Department of Health and Social Care	MSEFT	Mid and South Essex Foundation Trust
DoL	Deprivation of Liberty	NHSPS	NHS Property Services
EDI	Equality, Diversity and Inclusion	SET	Southend, Essex, Thurrock
Supporting Reports/ Appendices /or further reading			
Chief Executive Officer (CEO) Report			
Lead			
 Trevor Smith Interim Joint Chief Executive Officer			

CHIEF EXECUTIVE OFFICER REPORT

1. CEO UPDATES**1.1 National NHS Chief Executive Leadership Event**

I recently attended the NHS Leadership event with ICBs, Trust chief executives and primary care provider leaders in central London. Discussions focused on the importance of delivery this year, performance, finance and winter planning, an update on the Intensive Recovery Programme and key lessons learnt, payment reforms and planning preparations, along with the key themes and matters arising from the Thirlwall Inquiry.

1.2 Thirlwall Inquiry Report Published

The Thirlwall Inquiry has now published its final report, examining the circumstances surrounding the actions of former neonatal nurse Lucy Letby and the wider organisational, professional and regulatory factors that contributed to missed opportunities to identify and act upon concerns. The report emphasises the importance of a culture where staff feel able to speak up, there's effective escalation and investigation of concerns, robust clinical governance, professional curiosity and Board oversight.

The report contains recommendations for healthcare organisations, regulators and national bodies aimed at strengthening patient safety and organisational learning. Every Trust and ICB Board have been asked to review the report ([The Report | The Thirlwall Inquiry](#)) and consider its findings. We need to consider any relevant learning and implications for EPUT. This should include assessing existing arrangements relating to patient safety, Freedom to Speak Up, incident management, clinical governance, escalation processes and Board assurance, with any identified actions to be incorporated into the Trust's improvement programmes and governance framework as appropriate.

1.3 Lampard Inquiry October Hearings

The next set of Lampard Inquiry Hearings are scheduled to begin on 5 October with EPUT staff again called to give evidence. We remain committed to doing all we can to support the Inquiry in its important work including attendance, participation and information submission. Baroness Lampard has stated her intention to issue interim recommendations, specifically on observations and the use of technology and resuscitation.

1.4 Updates to Local MPs

I recently met with and briefed local Members of Parliament officers on current issues at EPUT, including the CQC well led inspection report and our response to the Lampard Inquiry. I am also attending a system wide MP briefing at Westminster on 12 October which is organised by MSEFT.

1.5 Executive to Executive meetings

We are undertaking a number of meetings over the coming weeks with system partners; this includes the NHS Essex Integrated Care Board, Princess Alexandra Hospital NHS Trust, Mid and South Essex NHS Foundation Trust and fellow Mental Health providers hosted by the East of England Alliance. These sessions are intended to further develop strategic relationships, networks and explore areas of learning, improvement and opportunities for further integrated and collaborative working across mental health and community services.

1.6 One Essex Digital Summit

On 09 September, colleagues from across EPUT joined colleagues from Mid and South Essex NHS Foundation Trust, The Princess Alexandra Hospital NHS Trust, primary care, local authorities, hospices and wider system partners at the One Essex Digital Summit to explore how digital transformation can improve patient care, support our workforce and strengthen collaboration across Essex. Almost 200 people took part, making it one of the largest cross-system digital engagement events held in Essex to date. The summit focussed on the future of digital health and care, bringing

together leaders, clinicians, operational colleagues and digital professionals to share learning, explore innovation and discuss how organisations can work together to deliver the ambitions of the Essex Integrated Care System Digital Strategy. The summit reinforced the strong partnership working that already exists across Essex and generated valuable insights that will help shape future digital transformation activity across health and care organisations in the country.

2. EXECUTIVE UPDATES

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

National Staff Survey

The National Staff Survey launched on 23 September and will close on 27 November. We aim to increase our staff engagement survey response rate to 60% (from 52% in 2025) to ensure a more representative staff voice and to drive improvements in patient care and staff experience. To achieve this, we have plans for targeted communication and engagement with care units and corporate teams, including visible leadership presence across key inpatient and community sites. We anticipate receiving an initial report from our survey provider in December where we use this to develop local and Trust-wide actions from staff feedback.

Leadership Development

Our first cohort of leaders will be commencing 'The King's Fund' and 'brap' leadership programme on 29 September, which has been co-developed with participants who supported the cultural review. This will enable leaders to learn new skills and approaches to leading self and others, both through a compassionate and trauma-informed lens. This will differ from traditional leadership development programmes and allow participants from different backgrounds, levels and service areas to work together on real issues and challenges.

National Job Evaluation of Nursing Roles

The Trust has continued to progress the nationally mandated Band 5 Nursing Job Evaluation Review Programme. Governance arrangements are in place through a dedicated Steering Group operating in partnership with Staff Side, with delivery plans submitted in line with national requirements.

Work has focused on workforce mapping, job description validation, programme mobilisation and staff engagement planning. The programme remains on track, with a continued emphasis on maintaining staff confidence through transparent communications, partnership working and robust assurance processes. Key risks relating to capacity, staff engagement, potential appeals and equal pay implications continue to be actively managed through the programme governance structure.

New Corporate Induction

A great induction at EPUT is vital to ensure our staff feel welcomed into the organisation and supported in their role, setting the tone for a sense of belonging, commitment and long-term positive engagement. A revised and improved corporate induction commenced on 21 September, which was face-to-face, followed by four- or five-days further induction, dependent on whether new starters were clinical or non-clinical. This new induction is one of several changes within staff experience which will support a cultural shift towards greater accountability and developing a 'human organisation' led by clearly defined standards, behaviours and expectations.

Developments for Staff Appraisal

Over the last year, EPUT has been reviewing its appraisal process with the aim of enabling centralised recording and reporting. The NHS Electronic Staff Record (ESR) system includes

functionality to record supervision and appraisal activity, allowing trusts to move away from paper-based processes and instead record appraisals directly within ESR. EPUT has decided to implement this capability and is currently in the process of uploading the relevant appraisal templates. This will enable the Trust to access information on staff development needs identified through career conversations during appraisals, helping to inform future continuing professional development (CPD) plans and talent mapping activities.

In addition, all appraisal templates will include one personal objective relating to Equality, Diversity and Inclusion (EDI) and one personal objective linked to the Trust's Behavioural Framework.

These additions will support the Trust's commitment to fostering an inclusive culture and embedding Trust values across the workforce. Following the annual appraisal, staff will meet with their manager each quarter for a touchpoint one to one meeting, which will also be recorded within ESR. Clinical supervision and professional supervision activity will also be recorded within the system, providing a more comprehensive record of staff development and support. A training programme to support implementation of the new process will be rolled out during Quarter 3 for all staff.

2.2 Nursing and Quality – Ann Sheridan, Executive Nurse

Deprivation of Liberty (DoL)

Following the UK Supreme Court judgment of 2 June 2026, updated Department of Health and Social Care guidance has introduced a new approach to assessing deprivation of liberty (DoL), replacing reliance on the Cheshire West "acid test" with a holistic assessment of an individual's overall circumstances, including the purpose, impact and context of restrictions, as well as their wishes and feelings. The judgment recognises that valid consent may be expressed through a person's wishes and feelings even where they lack formal capacity, distinguishes between restriction and deprivation of liberty, and clarifies that restrictions must generally be against a person's will to constitute a DoL. While the legal test has changed, the Mental Capacity Act and DoLS remain in force, and providers are advised to review existing and borderline cases pragmatically rather than undertake wholesale cancellation of current authorisations.

World Patient Safety Day 2026

World Patient Safety Day was marked through two Trust-wide learning sessions hosted by the Lessons Team, showcasing improvement work, patient experience initiatives, and recent developments in patient safety across EPUT. The sessions provided an opportunity for staff to share learning, celebrate improvement activity, and promote safer care across the organisation. Attendance was strong, with 43 colleagues participating in the Day One Quality Improvement and Patient Experience session and 60 colleagues attending the Day Two Patient Safety: Developments and Safer Care session, demonstrating continued engagement with the Trust's patient safety agenda.

Flu Vaccination Campaign

The Trust's annual flu vaccination campaign launched on 1 October 2026, supported by an enhanced programme designed to maximise accessibility and increase staff vaccination uptake. A comprehensive delivery model has been established, including dedicated vaccination clinics across the Essex geography, the development of supporting information resources, and the training of peer vaccinators to increase local access and engagement. In addition, pharmacy voucher arrangements have been introduced, enabling staff who are unable to attend Trust clinics or sites to receive their vaccination through participating local pharmacies.

A communications campaign is already underway to raise awareness and promote participation and to further encourage participation, the campaign will incorporate a Trust-wide engagement initiative, "Race Across EPUT", introducing a friendly competitive element between Care Units. The initiative is intended to drive uptake, promote wider staff involvement, and support visible leadership engagement throughout the campaign.

2.3 Operations – Lizzy Wells, Interim Chief Operating Officer

Whole System Mental Health Pathway Review

The Southend, Essex and Thurrock Mental Health Strategic Implementation Group has commenced a system-wide review of mental health pathways following the establishment of a single Essex ICB. The review will bring together partners from across health, social care, the voluntary sector, Essex Police and people with lived experience to consider how services can best meet current and future population needs.

The review will focus on opportunities to improve access, patient flow, experience and outcomes across the mental health system and will help inform future priorities for the SET All Age Mental Health Strategy and wider Integrated Care System planning. EPUT is actively contributing through executive, clinical and lived experience leadership.

Community Service Review and Neighbourhood Health Committee

At its meeting on 20 August 2026, the Essex Neighbourhood Health Committee reviewed progress against the county-wide neighbourhood health agenda and the emerging findings of the Community Services Review. EPUT's Director of Strategy has been nominated to attend the Committee on behalf of all Essex community providers (EPUT, NELFT, Provide and ESNEFT), providing a coordinated provider perspective on neighbourhood development, community service transformation and future commissioning arrangements. The Committee reaffirmed the strategic direction towards integrated neighbourhood-based models of care and recognised the need to accelerate consistent implementation across Essex whilst addressing key enablers, including workforce, digital and information-sharing capability.

The Community Services Review was discussed at the committee and EPUT colleagues have attended subsequent workshops to discuss the interim findings. The review is expected to influence the future design and commissioning of community services across Essex, bringing greater emphasis to integrated pathways, prevention, consistency of service delivery and measurable outcomes. For EPUT, this represents an important strategic opportunity to shape future commissioning arrangements, strengthen collaborative delivery, and further position the Trust as a key partner in delivering joined-up physical and mental health services within neighbourhood-based models of care. The review is also being considered alongside wider system developments, including Community First and emerging neighbourhood operating models, helping to ensure future decisions are aligned within a coherent long-term strategic framework.

Mental Health Emergency Diversion Units

New Mental Health Emergency Diversion Units have opened in Harlow and Colchester, providing dedicated therapeutic environments to support people experiencing a mental health crisis. The units enhance the ability of Crisis Response Services to undertake face-to-face assessments in appropriate settings and support alternatives to Emergency Department attendance where this is clinically appropriate.

The initial phase is operating through existing Crisis Response Service pathways and resources, with EPUT working alongside system partners to evaluate the model and inform future development. A business case for subsequent phases is progressing through governance processes and will support consideration of future service enhancements.

New Operational Director of Inpatient and Urgent Care Service

Welcome to Sam Fuller who joined EPUT on the 21 September 2026, as the Director of Inpatient and Urgent Care Services. Sam has a wealth of experience working across different organisations including mental health, acute hospitals and most recently NHS England.

2.4 Finance – Jenny Davis, Interim Chief Finance Officer

Strategic Investments and Improvements

The Trust is in the process of final approvals with NHS England to support the development of a Neighbourhood Mental Health Hub in Clacton. The business case will see a £3.8m capital investment to redevelop facilities. The case has been developed with the support of commissioners, primary care, and VCSE partners.

The Trust continues to work to develop plans for Neighbourhood mental health hubs, in Thurrock, West, South and Mid Essex areas, as well as link to the wider Essex Neighbourhood Health Centre initiatives, alongside ICB and other partners.

The Trust has recently been awarded £350k capital funding to support the implementation of a digital platform to support Neurodiversity services. The software helps release clinical time to care by reducing the admin burden.

Out of Area Unification

The Trust continues to negotiate with Essex ICB around a proposal to transfer the Out of Area budgets to EPUT. This forms a key part of our Trust Flow programme and will be underpinned by a refresh of our Demand and Capacity model. EPUT remain firmly of the view that a unified approach provides the best opportunity to improve patient outcomes and experience, strengthen system oversight of out of area placements and create a sustainable platform through which efficiencies can be realised and reinvested in local services.

Charitable Funds Bidding

The 2026/27 Charitable Funds internal bidding process is currently open and provides staff with an opportunity to access funding for non-recurrent initiatives that deliver charitable benefit and would not ordinarily be funded through NHS budgets. Applications are being supported through a targeted communications campaign, incorporating guidance and examples of previously funded schemes. Submitted bids are subject to eligibility review, with applicants receiving feedback where amendments may improve alignment with funding criteria. Final bids will be considered by the Charitable Funds Committee following closure of the submission window at the end of October, with funding decisions expected after the November Committee meeting.

2.5 Nova / ESR Update – Zephan Trent, Executive Chief Digital and Information Officer

The Nova Programme continues to move forward at pace after it passed Gateway 3.0 in the summer. A number of design, build and assurance activities have progressed beyond planned timescales, requiring further replanning to validate scope, dependencies, capacity and delivery assumptions. Consideration is also being given to the resource implications of accelerating outstanding programme activity. Oracle Health and the programme team are working collaboratively to assess recovery and mitigation options to support a safe and deliverable implementation approach.

The programme is actively managing these risks and issues through established governance arrangements. The potential impacts on programme delivery, operational readiness and implementation timelines are currently being assessed and worked through as part of the programme management process, with mitigating actions being developed where required.

7. BOARD ASSURANCE FRAMEWORK

● Information Item

● Executive Director Governance

REFERENCES

Only PDFs are attached

 BAF Report 07.10.2026.pdf

SUMMARY REPORT		BOARD OF DIRECTORS PART 1			7 October 2026		
Report Title:		Board Assurance Framework Report					
Report Lead		Trevor Smith, Joint Interim Chief Executive Officer					
Report Author(s):		Denver Greenhalgh, Executive Director for Corporate Governance Nicola Jones, Director of Risk and Compliance Roberta Wahnig, Head of Risk and Incident Management					
Report discussed previously at:		Executive Board Assurance Framework Meeting and Board of Directors Standing Committees					
Level of Assurance:		Level 1	☐	Level 2	☒	Level 3	☐

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

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

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the September Strategic and Corporate Risk Registers.
2. Note the addition of the approved Assertive Outreach Team corporate risk, scored 16
3. Request any further information or action required.

Summary of Key Points

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

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

The Board is asked to note:

- Board Assurance Framework dashboard providing an oversight of the reporting period.
- There have been no changes in risk score.
- There have been no risks agreed for closure.

For note: Risk 2660 and Risk 2599 associated with service demand and capacity for neurodiversity services and autism services have been combined into one risk as meeting have now combined under the one ICB.

- One new risk has been escalated to the Corporate Risk Register

CRR2721: New Risk: Assertive Outreach Team (16)

The Trust does not currently have a consistent, commissioned Assertive Outreach Team model for approximately 597 high-risk patients across Essex. Existing controls provide partial mitigation but vary across localities and do not address the underlying workforce, service model and funding gaps. Executive Team approved the escalation of this risk to the Corporate Risk Register on 22 September 2026. Further work is required to develop the interim offer, governance arrangements, workforce model and funding approach.

- Strategic Risk register 'at a glance' for each individual risk with updates against each action being taken to increase risk controls provided by each Executive Responsible Officer. For note: The following risks are under review.

SR4 Demand and Capacity (15) – Demand for mental health services continues to exceed available capacity across the system. Transformation programmes and partnership initiatives are in place, many are at an early stage, and their long-term impact is yet to be realised. The Out of Area Placement reduction business case has been approved through key governance forums and is progressing through final approvals. Risk under review by the Director of Performance and Improvement to update with actions outlined within the business case and assess risk scores (both current and target) associated with the planned work flow.

SR5: Statutory Public Inquiry (16) - Inquiry information requests continue to be managed through additional resources and revised programme arrangements. The risk is under review to ensure the description, controls and assurances fully reflect the Trust's exposure, including the increasing financial impact.

SR13: Quality Governance (15) - A review concluded that the risk actions should now move from a focus on establishing processes to assurance of effectiveness to evidence EPUT has put in place systems for organisational learning. Focus being placed on clinical governance group / committee function, escalation arrangements and evidence that learning from patient safety incidents is embedded and measurable impact in terms of service improvement.

- Corporate Risk register 'at a glance' for each individual risk with updates against each action being taken to increase risk controls provided by each Executive Responsible Officer.

Relationship to Trust Strategic Objectives

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

Which of the Trust Values are Being Delivered

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

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

Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	☐
Data quality issues	☐
Involvement of Service Users/Healthwatch	☐
Communication and consultation with stakeholders required	☐
Service impact/health improvement gains	☐
Financial implications:	Capital £ Revenue £ Non Recurrent £ ☐
Governance implications	☒
Impact on patient safety/quality	☐

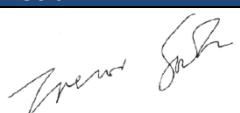
Acronyms/Terms Used in the Report

SR	Strategic Risk	CRR	Corporate Risk Register
BCP	Business Continuity Plan	AOT	Assertive Outreach Team
ROG	Risk Oversight Group	BAF	Board Assurance Framework

Supporting Reports/ Appendices /or further reading

Board Assurance Framework Dashboard
Strategic Risk Register
Corporate Risk Register

Lead


Trevor Smith
Joint Interim Chief Executive Officer



Essex Partnership University
NHS Foundation Trust

Board Assurance Framework

September 2026

EPUT

Strategic Risk Register at a Glance

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

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

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

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

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
SR3	All	Finance & Resources Infrastructure	TS	Safety, Experience, Compliance, Service Delivery, Reputation	5x3=15	15 > 15 > 15	Capacity and adaptability of support service infrastructure including Estates & Facilities, to support frontline services.	The risk remains unchanged. 2026 Premises Assurance Model assessment has been submitted to NHS England, with a refresh of the action plan (current status is 37 open actions). Arrangements are in place for oversight of the plan through quarterly reporting through the Finance and Performance Committee (next touch point being January 2027). A peer review arrangement for PAM has been established with East London NHS Foundation Trust. And, a new six-facet survey is planned in support of the PAM process next year.
SR4	All	Demand and Capacity	LW	Safety, Experience, Compliance, Service Delivery, Reputation	5x3=15	15 > 15 > 15	Long-term plan. White Paper. Transformation and innovation. National increase in demand. Need for expert areas and centres of excellence. Need for inpatient clinical model linked to community. Socioeconomic context & impact. Links to health inequalities.	Demand for mental health services continues to exceed available capacity across the system. Whilst a range of transformation programmes and partnership initiatives are in place, many remain at an early stage and their long-term impact is yet to be realised. The Out of Area Placement reduction business case has been approved by the Board of Directors. The Flow Improvement Programme has been established and is progressing with a timescale for completion of March 2029. The actions have been closed with a view to reviewing the risk and identifying further actions as the programme progresses.
SR5	All	Statutory Public Enquiry	CO	Compliance, Reputation	4x4=16	16 > 16 > 16	Statutory Public Inquiry into Mental Health services in Essex (Lampard Inquiry)	Inquiry information requests continue to be managed through additional resources and revised programme arrangements. The risk is under review to ensure the description, controls and assurances fully reflect the Trust's exposure, including the increasing financial impact. EPUT has received 241 substantive Rule 9 requests to date, with 239 responses submitted to the Inquiry. The remaining 2 on track for submission by their respective deadlines. S21 Notice issued have been met.

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
SR6	All	Cyber Security	ZT	Safety, Experience, Compliance, Service Delivery, Reputation	5x3=15		The risk of cyber-attacks on public services by hackers or hostile agencies. Vulnerabilities to systems and infrastructure.	The Trust continues to maintain a strong cyber security posture through DSPT/CAF compliance, cyber monitoring and assurance processes. The 2025/26 DSPT submission has been completed and planning has commenced for the 2026/27 submission. Additional actions have been added to strengthen assurance for emerging AI-related cyber security risks. Board cyber assurance training is scheduled for January 2027.
SR7	All	Capital	TS	Safety, Experience, Compliance, Service Delivery, Reputation	5x4=20		Need to ensure sufficient capital for essential works and transformation programmes in order to maintain and modernise	This remains one of the Trust's highest-rated risks. Whilst the Trust's cash position remains stronger than planned and the 2026/27 capital programme is progressing, significant capital pressures remain due to backlog maintenance requirements and the need to fund strategic transformation programmes. The Trust continues to seek additional external funding opportunities and maximise available capital resources.
SR8	All	Use of Resources	TS	Safety, Experience, Compliance, Service Delivery, Reputation	5x4=20		The need to effectively and efficiently manage its use of resources in order to meet its financial control total targets and its statutory financial duty	For Month 5 the Trust reported an in-month deficit of £1.9m which is £1.7 million adverse to plan. The year-to-date (YTD) deficit is £8.4m, representing a £4.5m adverse variance against plan. The financial NOF rating remains at a rating of 4. The position includes £2.6m of Deficit Support Funding (DSF) relating to the annual DSF entitlement of £6.3m in FY2627. The YTD position is supported by £9.1m on non recurrent solutions including lockdown underspends. In month adverse variances are driven by demand for Out of Area Placements which accounts for £1.5m of the YTD overspend. New assurance received through the CQC Well Led report which snoted that EPUT has a strong financial track record.
SR9	All	Digital and Data Strategy	ZT	Safety, Experience, Compliance, Service Delivery, Reputation	5x3=15		The risk of not being a digitally and data enabled. Resulting in poor and/or limited implementation of systems and technologies, with reduced quality and safety of care and lack of data intelligence to inform change / transformation	Progress continues with delivery of the Digital Target Operating Model alongside the Nova programme. The implementation action linked to the Unified EPR has been closed and oversight transferred to the dedicated Nova corporate risk to ensure focused governance of programme delivery and implementation risks.

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
SR10	All	Workforce Sustainability	AM	Staff Morale Skills Gap Workforce Sustainability	4x3=12		The risk of not being able to recruit and retain staff. Resulting in associated skills deficit, reliance on temporary staffing, impact on staff morale and quality of care provided to our service users.	Workforce planning controls have been strengthened, but the Trust remains 100wte above workforce plan at Month 5. New actions focus on Nova training, safer staffing implementation, timely roster approval and annual leave management, with continued emphasis on reducing temporary staffing dependence. Note new control for nurse rostering sign off and annual leave planning now being operational.
SR11	All	Staff Retention	AM	Staff Morale Skills Gap Workforce Sustainability	4x3=12		The risk of not being able to recruit and retain staff. Resulting in associated skills deficit, reliance on temporary staffing, impact on staff morale and quality of care provided to our service users.	The revised induction programme implemented in September 2026, supported by enhanced monitoring of starter and leaver experience. Further work includes leadership development, the cultural review, a revised appraisal framework and exploration of People and Culture AI initiatives. The Cultural Review has been completed, with the results and next steps to be presented to the public Board of Directors in October 2026.
SR12	All	Organisational Development	AM	Staff Morale Skills Gap Workforce Sustainability	4x4=16		The risk of not addressing cultural development and management of change, then we may not achieve a positive impact, resulting in suboptimal outcomes for staff and patient care.	Leadership development, talent mapping, EDI and absence management programmes are progressing. New actions address staff wellbeing and the organisational development support required for Nova, but the risk remains above target pending evidence of sustained cultural and workforce improvement. The leadership programme has commenced.
SR13	All	Quality Governance	AS	Safety Effectiveness Experience Regulator	5x3=15		Government Led Inquiry; Trust and Confidence in our services; Adverse regulatory inspection outcomes.	A review of SR13 has been completed and consideration is being given to the future focus of the risk.

Corporate Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
6	1	0	1

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

		Consequence				
		1	2	3	4	5
Likelihood	1					
	2					
	3				CRR11	
	4				2598, 2659 2599, 2660 2600, 2721	
	5					

% Risks with Controls	% Risks with Assurances	Actions Overdue	Extended Actions
100%	100%	1	2

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
CRR11	All	Suicide Prevention	KS	Safety	4x3=12	12 > 12 > 12	Implementation of suicide prevention strategy	A weekly executive-led emerging incident review process, chaired by the Chief Nurse, continues to strengthen oversight, learning, triangulation of themes, and timely action across care units. The Trust is progressing its transition from risk stratification to personalised safety planning, supported by updated clinical guidance, revised assessment templates and workforce development initiatives. Positive improvement activity continues, including a 17% reduction in self-harm incidents this quarter, expansion of STORM training capacity, and ongoing quality improvement work to reduce ligature incidents and strengthen suicide prevention across services.
2598	All	Nova Programme	ZT	Safety, Quality, Service Delivery, Reputation	4x4=16	16 > 16 > 16	Potential for implementation delays, system integration issues, technical challenges	The Nova programme remains a significant corporate risk due to the complexity of implementing a unified electronic patient record. New position statement due to be presented to the Board of Directors in October, after which the risk will be reviewed to consider current risks.
2600 (2599)	All	Service demand exceeding capacity for ND services, Autism	LW	Safety, Quality, Service Delivery, Reputation	4x4=16	16 > 16	ASD service demand will continue to exceed capacity	Autism service demand remains above available capacity. Additional temporary resource, commissioner oversight and Psyomics implementation are progressing, but there is not yet sufficient evidence of material improvement in waiting lists or the underlying capacity gap. Note Risk 2599 and 2600 have been combined into one risk entry as both now come under the same ICB.
2659	All	Increasing Backlog Maintenance Requirements	JD	Safety, Quality, Service Delivery, Reputation	4x4=16	16 > 16	Backlog Maintenance requirements from ageing Estate & infrastructure continue to increase, despite the multiple millions of capital and revenue investments in recent years.	The £117m estate maintenance backlog presents continued safety, compliance, operational and financial exposure. The Business Continuity Plan and Estates Strategy are in place, but the new six-facet survey has been delayed pending recruitment and further work is required to stratify the backlog by locality and severity.
2660	All	Failure to maintain a safe, compliant and resilient estate due to insufficient Estates workforce capacity	JD	Safety, Quality, Service Delivery, Reputation	4x4=16	16 > 16	Workforce shortages in specialist Estates roles, increasing statutory requirements, and contractor reliance may result in non-compliance, infrastructure failures, reduced resilience, increased costs, staff burnout, and harm to patient safety and organisational reputation.	Insufficient specialist Estates workforce capacity continues to affect statutory compliance, resilience and maintenance delivery. Contractor support and the new Core Services Team provide interim mitigation, while an independent review is assessing workforce requirements and future delivery options.

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
2721	All	Assertive Outreach Team service model	RP	Safety, Quality, Service Delivery, Reputation	4x4=16	 16	Absence of a consistent, commissioned Trust-wide AOT model for the identified high-risk cohort.	Executive decision pending or obtained on the interim minimum-standard offer and longer-term model, with further work required on commissioning, workforce, governance, funding and performance monitoring.

Strategic Risk Register

September 2026

SR3- Finance and Resources Infrastructure

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

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

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

Initial Risk Score C5 x L3 = 15		Current Risk Score C5 x L3 =15		Target Score C5 x L2 = 10		Note 1: Completed actions (1–7) have been removed from the report.	
Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: Finance & Performance Committee				Controls Assurance			
Key Controls		Level 1 (Management)		Level 2 (Oversight)		Level 3 (Independent)	
EPUT Strategy		EPUT Strategy (approved Jan '23) Estates Strategy (Board approved)		Finance and Performance Committee Report (update 2 x year)			
Operational Target Operating Model		Care Unit Leadership in place Procurement Team restructured to align with TOM		Accountability Framework			
Estates and Facilities, Contracting and Business Development, Finance Teams		Established Support services		PMO support in place reporting to Executive Restructure fully recruited to		IA Estates & Facilities Performance (Moderate/Moderate Opinion)	
Range of corporate, finance policies		Policy Register and procedures in place		Accountability Framework			
PMO, Capital Programme, E-expenses system,		Capital Steering Group		Capital Planning Group			
Audit Programme and ISO				Audit Committee			
Premises Assurance		Operational meetings for PFIs ERIC / PAM Groups <i>37 open actions following 2026 Assessment</i>		Premises Assurance Model in place with assessment outcome			
6-Facet Survey		Review of core premises undertaken through the Estates Strategy		6- Facet Survey completed		6-Facet Survey	
Business Continuity Plans		Business continuity plan in place - updated to reflect changes relating to asbestos, fire, water, and electrical safety.					
Actions (to modify risks)		By When	By Who	Gap	Update		
8	Deliver action plan from Premises Assurance Model (PAM)	Sep-27	MM	Control	The 2026 PAM submission is complete. The Finance and Performance Committee (24 September) received the revised action plan detailing measures being taken to address areas for improvement along with associated costs. The Committee will provide over of the plan through quarterly progress report. and will be reported back to the Committee on a quarterly basis. Next touch point being Jan 2027. For the 2027 self-assessment process peer review of the submission is planned through an arrangement with East London NHS Foundation Trust.		
9	New Action (Sept 26): 6 facet Survey planned	Mar-27	MM	Control	A new six-facet survey is planned for completion by March 2027, subject to confirmation of commissioning and delivery arrangements.		
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SR4- Demand and Capacity

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

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

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

<i>Initial Risk Score</i> C5 x L4 = 20	<i>Current Risk Score</i> C5 x L3 =15	<i>Target Score</i> C5 x L3 = 15	Note 1: Previous reported completed actions 1-6, 8-12 and 14 have been removed from the report. Note 2: this risk is currently under review by the director of Performance and Improvement and is expected to be presented to ROG in October.	
Executive Responsible Office: Executive Chief Operating Officer Director Lead: Director of Performance and Improvement Board Committee: Finance and Performance Committee			Controls Assurance	
Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)	
Operational staff integrated flow team including Discharge Co-ordination Teams, Clinical Patient Flow Leads, Clinical Director for Flow & Capacity, Associate Director for Flow, Bed Management Team	Flow & Capacity Staffing Established (Fully Established)			
Care Unit Leadership	Fully Established	Accountability Framework Meetings provide oversight to operational progress (to provide an assessment outside of AF)		
Target Operating Model / Accountability Framework / Flow and Capacity Policy. MAST roll out / Safety First Safety Always Strategy Integrated Flow Team Staffing Therapeutic Acute Inpatient Operating Model Introduction of the SMART tool Enhance Sit-rep Process - Locality Based Introduction of the Prioritisation Matrix	Integrated Flow and Care Unit Leadership CPA Review performance UEC in place	Accountability Framework Meetings Safety First Safety Always Final Report to Board (2024) Demand Flow & Capacity Steering Group		
MH UEC Project, MSE Connect Programme. Partnerships, Mutual Aid	Flow and Capacity Project MH Urgent Care Emergency Department opened 20 March 23 Development of ED Divergent in NEE and NW due to be operational in '26	Demand Flow and Capacity Steering Group ICB System UEC Task & Finish Monthly inpatient quality and safety group	Provider Collaborative(s) MH Collaborative Whole Essex system flow and capacity group	
Service Dashboards / Daily SitRep/ Performance Reporting	Updated OPEL framework x3 Locality Based Sit Reps Joint inpatient and community review meets EDD and CRFD reporting in ward review template on EPR, with daily reports providing status Flow report within Power BI SMART Tool Foundry Tool in development	Performance and Quality Report to Accountability Meetings and F&PC Safety KPI dashboard live and accessible	System oversight and assurance groups	
Business Continuity Plans	EPRR planning Business Continuity Plan in place			

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Target Operational Model - Inpatient		Performance Reporting Published alongside EPUT Strategy One year touch points and monitoring through accountability	
Community First Transformation Programme 4 key work streams			
Flow improvement programme		IPUC Steering group reporting to Accountability Framework to IPUC System Implementation Group (SIG)	

Actions (to modify risks)		By When	By Who	Gap	Update
7	Model Out of Area bed capacity/demand to inform terms of unification project with ICBs including appropriate level of resource transfer.	Completed	SC/DC	Control	Modelling is complete and has informed the terms of the unification project. Conversations continue with ICB colleagues to confirm the financial transfer of resources in order to develop new services. Full business case with investment and modelling of CIP trajectories to reduce OOAP has been presented and approved by Executive Team and Finance and Performance Committee in July and has been approved at Board of Directors in August 2026.
13	Flow improvement Programme - Internal (EPUT)	March '29	DC	Control	This programme is now underway and is fully established. It is a three-year programme due to be completed in March 2029 (with update of timeline to align with the project milestones). This is co-chaired by the ICB lead commissioner and includes members of the local authority, police, housing and wider stakeholders engaged as members. The risk will now be reviewed and further actions identified. This action will be expanded into further actions pending confirmation of unification resource.
13b	Demand and Capacity Length of Stay Programme (System) EPUT to hold the system to account for delivery.	Complete	DC	Mitigation	This action has now been marked as complete, the work will continue through the Reset Flow Improvement Programme, (Action 13), which provides the appropriate governance and delivery framework for implementation. Length of stay is now below NOF target Q1 reporting.
15	Deliver Community First Programme	Sep-26	KS	Control	Review underway to consider if there should be a separate risk associated with the 'community first programme'. The programme involves offer for assertive outreach patients and a proposal for patients with complex emotional needs and was presented to the Executive Team in May 2026, with agreement to commence implementation where operations were ready and noted that resource gaps needed to be assessed and associated business case to be developed for commissioner discussions.

SR5 - Statutory Public Inquiry (2140)

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

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

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

Initial Risk Score C5 x L4 = 20	Current Risk Score C4 x L4 = 16	Target Score C4 x L2 = 8	Note 1: Previous reported complete actions 1-7, 9, 10 & 11 have been removed from the Board report. Note 2: The risk is currently under review by the Programme Director – Lampard Inquiry, to ensure it clearly articulates the risk and potential impact to EPUT. This review will help determine whether the current description, controls and assurances adequately reflect the Trust's exposure. Financial impact continues to grow and should be more explicitly reflected within risk narratives	
Executive Responsible Office: Executive SRO for the Inquiry Board Committee: Audit Committee			Controls Assurance	
Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)	
Exchange portal in place to safely transfer information to the inquiry	Data protection impact assessment and reporting in place.			
Inquiry Team (Resource with skills and capacity to meet the needs of EPUT response to the Inquiry).	Executive SRO (Catherine O'Connell) Project Director 2 Associate Directors 1 Head of PMO Browne Jacobson Essex Chambers	Trust Board of Directors	S21 Notice issued in respect of eight Rule 9s request from the Lampard Inquiry (negative assurance) - All Section 21 requests have been met	
Financial Resource (To meet the needs of the EPUT response to the Inquiry)	Financial allocation £8.6m to end of 2026	Finance reports, approved by Finance and Performance Committee, Audit Committee and Board	External audit of provision for the Inquiry completed for 2024/25. (Note additional cost pressure of £6.6m to end of 2026 as consequence of accounting treatment).	
Inquiry Response Governance	Inquiry Project Team leadership through Project Director Multi-Disciplinary Working Group Schedule of work agreed with Legal Advisors / Counsel	Trust Board of Directors	S21 Notice issued in respect of eight Rule 9s request from the Lampard Inquiry (negative assurance)	
Learning Log (this is learning noted by the Project Team during searches not in relation to themes from specific incidents. Historic learning of past events within the Inquiry is led by the Quality Committee)	Inquiry Project Team Multi-Disciplinary Working Group	Executive Operational Sub Committee	Internal audit.	
Support for staff	Project Team (practical support and signposting) Here for You Provision (psychological support) Browne Jacobson (legal support) Executive & Leadership Team	Trust Board of Directors	Internal audit.	
Support for families	Contract with HPFT	Trust Board of Directors	Internal audit. No referrals made to date	
Communications Plan	Multi-disciplinary Project Working Group Multi-disciplinary Communications Group	Trust Board of Directors	Internal audit.	
Management Development Programme (Inquiry Module)	Led by Inquiry Team - sessions ongoing			

Actions (to modify risks)		By When	By Who	Gap	Update
8	Rule 9 progress	June '27 Note revised timeline in line with Lampard Inquiry timetable.	CBD	Assurance	The intensity of work is likely to continue between now and the end of the evidence gathering phase of the Inquiry, aligned to the published forward view on the Lampard Inquiry website. EPUT has received 241 substantive Rule 9 requests to date, with 239 responses submitted to the Inquiry. The remaining 2 on track for submission by their respective deadlines.
12	Ensure staff receiving individual Rule 9 requests from the Inquiry are reminded of the legal support available to them. And, facilitate time (supported with backfill) for the individuals to comply with the request.	June '27 Note revised timeline in line with Lampard Inquiry timetable.	CBD	Control	Operational recovery remains key focus. Additional resources and restructure of roles within the team is expected to create greater stability moving forward. Inquiry requests continue to be managed through additional resource within the team, and trajectory planning is progressing as planned.

SR6- Cyber Security

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

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

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

Initial Risk Score C5 x L4 = 20	Current Risk Score C3 x L5 = 15	Target Score C4 x L3 = 12	Note 1: Previous reported completed actions 1 - 10, 11 and 12 have been removed from the report. Note 2: Action 13 has been developed to provide further assurance and to identify any additional controls required to strengthen the mitigation of AI-related risks.	
Executive Responsible Office: Executive Director Strategy Transformation and Digital Board Committee: Finance and Performance Committee			Controls Assurance	
Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)	
Scanning systems for assessing vulnerabilities, both internal and through NHS England and NHS mail		Reporting into IGSSC with exception reporting to Digital Strategy Group		
Cyber Team in place	Substantive post holder (Aug '23)	IGSSC DSPT/CAF Received an overall High Internal Audit Assurance rating April 26	NHS England Data Security Protection Toolkit (DSPT/CAF)	
Range of policies and frameworks in place	Virtual and site audits Compliance with mandatory training – Cyber Assurance Framework	IGSSC;DSPT/CAF Received an overall High Internal Audit Assurance rating April 26	As above MSE ICS IG & Cyber Levelling Up Project (annual) BDO Audit actions completed	
Investment in prioritisation of projects to ensure support for operating systems and licenses	Prioritisation of digital capital allocation	CPPG – with priority decisions made at DSG		
IG & Cyber risk log	Risk working group reporting into IGSSC – owing and tracking actions from audits and assessments	IGSSC and Digital Strategy Group	DSPT/CAF Action plan Implementation following TIAA audit	
Business Continuity Plans and National Cyber Team processes	BCP in place	Successfully managed Cyber incident	Annual Testing as part of DSPT/CAF NHS England Data Security Centre, Penetration Testing,	
CareCert notifications from NHS England Cyber Alerts	Monitored and acted upon within 24 hours of their announcement	Reported to IGSSC	NHS England	
Cyber Essentials Accreditation	Certification achieved	Monitor controls through IGSSC	Accreditation certified	
MSE ICS DSPT & Cyber Maturity Baseline	Completed	Audit Committee	DSPT/CAF Received an overall High Internal Audit Assurance rating April 26	

Actions (to modify risks)		By When	By Who	Gap	Update
13	Engage with NHSE National cyber team to identify advice on new controls for AI cyber threat management and make recommendation to the IGSSC group for consideration.	TBC	AW	Assurance	National guidance for cyber risk management has been subject to delay. New timescales have not yet been published. It is EPUTs intention to use this guidance to review the risk/threat level that modern cyber security threats represent. Action timescale has been amended to 'TBC' in light of no timescales for the publication of national guidance. Action to be reviewed should the publication of guidance continue to be delayed.
14	Board Cyber security assurance training	Jan-27	AW	Assurance	Following Finance and Performance Committee support, National training for board cyber assurance has been organised for a board seminar on the 6 January 2027.
15	Preparation for the 26/27 DSPT-CAF submission in June 2027, acknowledging new directives and expectations to build on the 25/26 baseline.	Jul-27	AW	Assurance	New action. Planning underway for 2026/27 submission.

SR7- Capital

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

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

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

Initial Risk Score C5 x L4 = 20		Current Risk Score C5 x L4 = 20		Target Score C5 x L3 = 15		Note 1: Previously report completed actions 2 -7 have been removed from the report.	
Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: Finance and Performance Committee				Controls Assurance			
Key Controls		Level 1 (Management)		Level 2 (Oversight)		Level 3 (Independent)	
Finance Team (Response to new resource bids and financial control oversight)		Team in place		Decision making group in place and making recommendations to ET, FPC and BOD			
Purchasing / tendering policies		Policy Register				Internal Audit	
Estates & Digital Team (Response to new resource bids)		Team in place					
Capital funding allocation 2026/27		Capital Project Group forecasting		Capital Planning Group reporting to ET and onto Finance & Performance Committee			
Horizon scanning for investment / new resource opportunities		£new resources secured		Capital Planning Group reporting to ET and onto Finance & Performance Committee			
ICS representation re: financial allocations and MH/Community Services		EPR convergence business case developed with additional capital resources identified		ECFO or Deputy Attendance at ICS Meetings; CEO or Deputy membership of ICB; Chairing System Investment Group			
Prioritised capital plan to maximise the use of available capital resources		Capital Plan 2026/27 in place and prioritisation undertaken					
EPR Programme		Progress published June 23 outlining programme structure and governance principles and timelines		EPR Joint Oversight Committee EPR Programme Board Convergence and Delivery Board EPR FBC approved by Board		FBC Agreed, contract signed.	
Cash Application through NHSE		Cash forecasting with cash tolerance of 5 working days		Executive Team, Finance and Performance		NHSE review cash forecasting ever two weeks.	
Actions (to modify risks)		By When	By Who	Gap	Update		
1	Horizon scan to maximize opportunities both regional and national to source capital investment	Ongoing for financial year	JD	Control	Continue to seek additional external funding within the plan submitted, which covers the five-year period from 2026/27 onwards. This includes £33 million in external funding to be processed by NHSE for approval. In addition the Trust is in the process of bidding for additional sustainability funding from NHSE. Work continues to identify additional external funding opportunities.		
8	Delivery Capital Plan 2026/27	31-Mar-27	JD	Control	Opening capital plan for 2026/27 is £24.1m, plan approved during planning process. The Trust continues to progress with estates disposals/rationalisation to release additional CDEL and support mitigation of capital pressures. Capital expenditure is £0.3m below plan year to date, with total capital spend of £4.0m against plan. The sale of assets has helped to support the position. Remain on track with capital plan.		

SR8 - Use of Resources

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

Likelihood based on: EPUT financial risk and opportunities profile

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

Initial Risk Score C5 x L4 = 20	Current Risk Score C5 x L4 = 20	Target Score C5 x L3 = 15	Note 1: Previous reported completed actions 1,2,3 - 5,6,7-13 has been removed from the report.	
Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: Finance and Performance Committee			Controls Assurance	
Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)	
Finance Team (Response to new resource bids and financial control oversight)	Team Establishment	Use of Resources Assessment	Use of Resources NHSE Assessment Financial Assurance received substantial assurance (Feb 2026) IA Payroll including Salary Overpayments (2024/25) Reasonable Assurance opinion CQC Well Led Report (2026) - Noted that EPUT has a strong financial track record.	
Standing Financial Instructions Scheme of reservation and delegation Accountability Framework	Standing Financial Instructions in place Scheme of Delegation in place Accountability Framework in place	Financial Management KPIs Audit Committee F&PC Accountability Framework	IA E-rostering Reasonable Assurance (Nov 25) opinion. IA Consultant Job Plans Reasonable Assurance (Feb 26) opinion.	
Estates & Digital Team (Response to new resource bids)	Team in place			
Deliver efficiency savings and targets 25/26		Finance Report		
Finance reporting	Finance Reports AF Reports	EA of Accounts	Oversight Framework and ratings	
Budget setting	Completed mid year financial review. Key risk and opportunities assessments performed	Accountability framework reporting; Finance reporting to F&PC; National HFMA Checklist Audit	Annual VFM through external auditors identified no significant weaknesses	
Operational Plan 2026/27	Multi disciplinary team stood up	Finance and Workforce Committees	NHSE Oversight	
Forecast Outturn and risk/ opportunities assessments 25/26	Forecast outturn reports including risks and mitigations	Accountability Framework reporting and F&P	NHSE Oversight	
Enhanced controls in place for approval of temporary staffing use and recruitment to Corporate roles.	Management reports to Executive Team - Downward trend in temporary staffing use seen in month 1 (2025/26).	IA Temporary Staffing (2024/25)Reasonable Assurance Opinion F&P Committee July '25 - Reasonable assurance that temporary staffing controls were working as expected.	NHSE Oversight - Triple lock	

Actions (to modify risks)		By When	By Who	Gap	Update
14	Deliver Financial Efficiency Target 26/27	End March 2027	TS	Control	The Trust is focusing on FY26/ 27 schemes with a newly formed Transformation and Efficiency Group. The target efficiency for FY26/27 is £43.1m with 7 key themes identified for delivery. These are being monitored within TEG and via AF meetings.
15	Deliver Financial plan for 26/27	End March 2027	TS	Control	For Month 5 the Trust reported an in-month deficit of £1.9m which is £1.7 million adverse to plan. The year-to-date (YTD) deficit is £8.4m, representing a £4.5m adverse variance against plan. The financial NOF rating remains at a rating of 4. The position includes £2.6m of Deficit Support Funding (DSF) relating to the annual DSF entitlement of £6.3m in FY2627. The YTD position is supported by £9.1m on non recurrent solutions including lockdown underspends. In month adverse variances are driven by demand for Out of Area Placements which accounts for £1.5m of the YTD overspend.

SR9 - Digital and Data Strategy

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

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

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

Initial Risk Score C5 x L3 = 15		Current Risk Score C5 x L3 = 15		Target Score C5 x L2 = 10		Note 1: Previously reported complete action 1-10 have been removed from the report. Note 2: Action 12 (Datix action 17765) - This action is closed on the basis that the associated risk is now captured and actively managed through a separate risk entry, specifically focused on the monitoring and tracking of the NOVA risk to EPUT, thereby maintaining appropriate oversight and assurance.			
Executive Responsible Office: Executive Director of Strategy, Transformation and Digital Board Committee: Finance and Performance Committee				Controls Assurance					
Key Controls				Level 1 (Management)		Level 2 (Oversight)		Level 3 (Independent)	
Resources									
IT/Digital team Resource and skill set is appropriate and sustainable				Education and training in specific technology Target operating model - modernise digital services		Digital strategy resource management (RAID Log)			
Clinical Digital leadership are engaged with dedicated leads responsibilities defined.				CCIO/CNIO oversight					
Strategies & Policies									
Information Governance policies and controls are in place to provide secure and appropriately governed processes and procedures				Information governance controls processes		Information Governance Steering Sub-Committee reporting and assurance		Data Security and Protection toolkit assessment (Standards Met)	
Data quality is of a standard that assures national standards.				Data quality group reporting and assurance		Internal Audit		National data quality framework	
DSPT “standards met” can be achieved						Internal Audit		DSPT submission and Cyber assurance framework	
Investment									
Capital allocation to digital and data initiatives secured				Approved Digital capital plan				CDEL allocation from system for 23/24 schemes	
External funding is obtained for schemes that are supported by national envelopes				Cost modelling of the digital strategy programme		Digital, data and technology group assurance report			
Innovation									
The space and governance exists to support innovation				CIO discover opportunities from national forums and partners (incl. Academic)		Innovation strategy governance - Strategy Steering Group			
Academic partnerships promote innovation				CIO engagement with academic partners on digital innovation opportunities					
Actions (to modify risks)				By When	By Who	Gap	Update		
11	Digital Target operating model implementation - phase 2			Extended Oct'27	AW	Control	The programme timelines for Nova have previously been agreed by the Board and there are regular updates to the Board on the Nova programme. The update to the timeline for the Digital Target Operating model has been updated to bring it in line with the agreed Nova programme timelines. This was raised at F&P Committee requesting further detail on the challenges with the Nova Operating Model. This will be taken forward by the Nova Programme leads through Committee and updated in this action as appropriate.		

SR10: Workforce Sustainability (2145)

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

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

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

Initial Risk Score C4 x L4 = 16	Current Risk Score C4 x L3 = 12	Target Score C4 x L3 = 12	Note 1: Previously reported completed actions 1 -8 have been removed from the report. Note 2: New Actions 11 to 15.The risk has been updated to include a number of new assurance-focused actions designed to strengthen workforce planning, recruitment, roster management and staff retention arrangements. These actions provide enhanced oversight of key workforce controls and support delivery of the Trust's workforce strategy, with a particular focus on reducing dependency on temporary staffing
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Executive Responsible Office: Executive Director People and Culture
Director Lead: Director of OD and Culture
Board Committee: People Equality and Culture

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
People Strategy	People Strategy Implementation Plan overseen by Chief People Officer and People & Culture Group.	Approved by Board of Directors January 2024 with revised draft developed for ratification in June 2026.	
Recruitment and Retention Strategy	Recruitment & Retention Strategy	Recruitment Assurance Report & People Promise (Retention) Report	System People Board oversight of recruitment, retention and temporary staffing performance
Operational Plans	Accountability Framework meetings monitoring of plan delivery	PECC oversight reporting - month 6 actuals against the plan (noting the revised trajectory presented at the October '24 meeting).	
Recruitment Plan	People and Culture Group	Executive Team	Essex ICB People Board & NHSE oversight
People and Culture Governance	People and Culture Group	Executive Team	People Committee
People strategy implementation plan 2025/26	People and Culture Group	Executive Team	
Workforce Planning and Modelling Team	Care Unit and Corporate workforce plans Operational Planning meeting Workforce Planning meeting	PECC oversight of workforce modelling plans at Trust level.	Submission to system plans

Actions (to modify risks)		By When	By Who	Gap	Update
9	Adherence to the Workforce Plan for 26/27 as part of the overall Operational Planning process.	Mar-27	Executive Chief People Officer	Assurance	Action is associated to the substantive workforce and the temporary workforce plans. The People Strategy implementation continues, with bi-monthly updates to the People Committee. As at month 5 plan is 100 whole time equivalents above workforce plan. Oversight and targeted plans remain in place to reduce operating levels, with the objective of achieving alignment with planned workforce levels by the end of December 2026.
10	Developing a five year plan with professional leads for staff development.	Jan-27	GB / Professional Leads	Assurance	Facilitated discussion to take place in the summer with all professional leads. This will be reported to the Board in September and that the rollout remains on track. Model reviews are progressing as planned.
11	New Action: Ensure NOVA system training attendance takes into consideration rostering, annual leave and other training requirements to minimise the use of temporary staffing.	Jul-27	GB / GW / NOVA Training Team	Assurance	Training Manager and Director of Education have been invited to NOVA Training Pillar Meetings.
12	New Action: Commence Trust wide work experience programme and T Level placements.	Oct-26	GB / KD	Assurance	On target with Harlow and South East Essex Colleges.
13	New Action: Implementation of safer staffing based on MHOST assessment of inpatient units.	Nov-26	Corporate Nursing	Assurance	The Board approved the safer staffing (MHOST) paper in February '26, with an associated delay to implementation of the business case. The delay led to implementation of phase one to August 2026 and phase two is expected to be fully implemented as at November 2026. There is an associated delay of impact on delivery of expected reductions in temporary staff until later in the year.
14	New Action: Enhanced oversight of effective nurse rostering.	Nov-26	Corporate Nursing/Operations	Assurance	Reporting on nursing rosters demonstrate that there is insufficient assurance that rosters are not being signed off in the recommended 12 week period, with some rosters not approved until 2 weeks prior to the shift being undertaken. Weekly oversight led by DDQs has been put in place to support matrons and ward managers to approve rosters in a timely manner and support improved staff well-being, reduce absence rates and support better management of clinical staff.
15	New Action: Annual Leave planning for peak periods.	Nov-26	Associate Directors of People Service-Resourcing and Operational HR	Assurance	Reporting on annual leave booked as a proportion across the leave year is now in place at Trust and Care Unit/Corporate Group level in Accountability Framework meetings to demonstrate effective leave booked over each quarter of the year, enabling improved planning for peak periods.

SR11: Staff Retention

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

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

Initial Risk Score C4 x L4 = 16		Current Risk Score C4 x L3 = 12		Target Score C4 x L3 = 12 <i>Proposing C4 x L2 = 8</i>		Note 1: Previously reported completed actions 1 - 7 have been removed from the report. Note 2: Note the introduction of the revised induction programme from September 2026. Note 3: New actions focused on improving staff experience, leadership development and workforce transformation. T					
Executive Responsible Office: Chief People Officer Director Lead: Director of OD and Culture Board Committee: People Equality and Culture				Controls Assurance							
Key Controls				Level 1 (Management)		Level 2 (Oversight)		Level 3 (Independent)			
Staff Experience Team (aligned with Retention Strategy and priority areas)				Director of OD & Culture to oversee alignment and development of strategy aligned to oversight of recruitment plan overseen by Associate Director of People - Resourcing.		Operational Workforce Group and oversight and assurance at People Committee.					
A redesigned Local and Corporate Induction Programme has been approved by Executive Team and is being implemented from September 2026. The programme includes face-to-face corporate induction, strengthened onboarding arrangements and enhanced monitoring of staff experience through Starter and Leaver Surveys and quarterly reporting to People Committee.				Executive Team approval obtained, implementation group established and revised induction programme scheduled for implementation from September 2026.		Quarterly staff experience reporting to People Committee, supported by Starter and Leaver Experience Survey feedback provided through an independent external provider.					
People strategy implementation plan 2025/26				People and Culture Group		Executive Team					
People and Education Strategy				People Strategy Implementation Plan overseen by Chief People Officer and People & Culture Group.		Approved by Board of Directors January 2024 with revised draft developed for ratification in June 2026.					
People Promise investment by NHS England				This is supported by retention and well being plan undertaken by OD & Culture team.		People & Culture Indicators in IPR with oversight at People Committee with emphasis on turnover rates and trends. This also includes oversight of exit interview analysis.		Workforce Key Performance Indicators oversight at System People Board			
Corporate Induction Programme (launch September '26)								Staff Survey - People Promises scores			
Actions (to modify risks)				By When		By Who		Gap		Update	
8		Delivery of People Promise objectives with an emphasis on new starter experience.		Complete		Director of OD & Culture		Assurance		Action complete - The induction reform programme has now been approved and implementation with new arrangements are in place and has been established as a risk control.	
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Actions (to modify risks)		By When	By Who	Gap	Update
9	To complete and publish the outcome from the Cultural Review being undertaken by BRAP/Kings Fund.	Complete	Director of OD & Culture	Assurance	The cultural review was completed with feedback provided to the Board alongside areas of focus and possible development. The full Cultural review report and next steps will be presented to the public Board of Directors in October 2026.
10	To commence the new senior leadership programme from September 2026 and to develop a mid manager and aspirant leadership programme.	Mar-27	Director of OD & Culture & Director of Education	Assurance	New Senior Leadership programme has commenced with cohort 1 and 2, with evaluation to be undertaken in Summer '27. The programme has 6 formal sessions interspersed with short coaching group sessions. It is expected that a new aspirant and middle manager development programme, funded by a proportion of the apprenticeship levy will be implemented by March 2027 and delivered alongside partners at Anglia Ruskin University.
11	Develop a revised staff engagement champions model to a 'workforce ambassador' model that connects the senior leadership of the organisation with the operational care units and corporate teams.	Complete	AD of OD & Culture	Assurance	Action complete: Alongside the staff networks, engagement and co-creation of a new model of engagement with staff has been developed through 'staff cafes' which started in July 2026, ensuring representation and a voice across the Trust that can champion, help improve staff experience and act as an relational link between the care units, corporate teams and leadership. This will act as a precursor to what is likely to be a new workforce ambassador/engagement champion model in 2027-28.
12	Implement new appraisal framework aligned to National Management and Leadership Framework.	Oct-26	GB / KD	Assurance	Proposal approved by Executive Team. Work underway with NHSBSA to upload the templates centrally. Relevant policies being amended to reflect necessary changes.
13	Confirm 3 areas of AI implementation for People & Culture.	Oct-26	Operational HR/Resourcing & Education	Assurance	Working with development partners for People Services and AI proposals for system wide solution.

SR12: Organisational Development

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

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

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

Initial Risk Score C4 x L4= 16		Current Risk Score C4 x L4= 16		Target Score C4 x L3 = 12		Note 1: Previously reported completed actions 1- 9 have been removed from the report.	
Executive Responsible Office: Executive Director People and Culture Director Lead: Director of OD and Culture Board Committee: People Committee						Controls Assurance	
Key Controls		Level 1 (Management)		Level 2 (Oversight)		Level 3 (Independent)	
OD Team		The new Director of OD & Culture		Oversight will be provided and sought by People committee by Director of OD & Culture.			
People and Education Strategy		Oversight by Learning & Education Group		Oversight by People committee and approved by Board of Directors January 2024			
Key performance indicators.		Workforce Efficiency Group		Oversight by People Committee and Board within the Integrated Performance Report		Oversight by system People Board. Audit of Employee Relations received Reasonable assurance (Feb 2026)	
OD Practitioners Partnership							
Actions (to modify risks)		By When	By Who	Gap	Update		
10	Deliver the Senior Leadership Development Programme pilot with the King's Fund/brap	Complete	Director of OD & Culture	Assurance	Following the culture review, a pilot senior leadership programme has been completed and informed the curriculum for the full programme.		
11	Develop 3 year development plans that highlights talent mapping and support succession plans for each Care Unit as well as corporate teams.	Complete	Director of OD & Culture	Assurance	Action Complete: The OD & Culture team has now identified talent across 3 years with a focus on the new EPUT Leadership Programme by working with Care and Corporate Units.		
12	The introduction of revised EDI plan with review of objectives for Executive Directors and reviewed focus on EDI staff networks.	Dec-26	Director of OD & Culture	Assurance	The Executive have been provided with new areas for EDI objectives in February 2026 that includes implementation of reciprocal mentoring and revised focus on EDI responsibilities with an assurance report to July People Committee. Further detailed plans will be shared with August People Committee and then signed off at October Trust Board which has an EDI Focus.		
13	Deliver the Senior Leadership Development Programme with the King's Fund/brap for a further 70 colleagues, based on the culture review findings and pilot leadership programme.	July '27	Director of OD & Culture	Assurance	Service specification currently being co-developed with the King's Fund/brap with support from an internal steering group. Nomination forms and a talent mapping process will be undertaken to establish the first cohort starting in Autumn 2026. All Cohorts across the next 3 years have been mapped.		

Actions (to modify risks)		By When	By Who	Gap	Update
14	To develop a mid manager and aspirant leadership programme.	Mar-27	Director of OD & Culture	Assurance	It is expected that a new aspirant and middle manager development programme, funded by a proportion of the apprenticeship levy will be implemented by March 2027 and delivered alongside partners at Anglia Ruskin University.
15	The development of an Absence Management Plan which reflects reactive and proactive measures and interventions based on People Promises to reduce absence levels and improve staff experience	Oct-26	Director of OD & Culture	Assurance	Sickness Absence Management Plan is in draft form with OD&Culture providing proactive elements. Plan is complete and delivery group is scheduled for oversight with updates included in Care unit meetings. Touch points to be planned to ensure workstreams are Managed. Plan is aligned to NHS Standards.
16	New action: To support the development programme for staff well-being with a focus on enhancing staff attendance.	Mar-27	Director of OD & Culture/Associate Director of People Services- Operational HR	Assurance	Progress is underway to develop a staff wellbeing programme focused on supporting employee health and wellbeing, with the aim of improving attendance and reducing sickness absence.
17	New Action: To support the implementation of Nova from an OD perspective ensuring that the Trust realises the cultural benefits.	Mar-28	Director of OD & Culture/Associate Director of People Services- Operational HR	Assurance	Scoping of OD plan underway with NOVA programme team.

SR13 - Quality Governance (2353)

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

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

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

Initial Risk Score C5 x L4 = 20	Current Risk Score C5 x L3 =15	Target Score C5 x L2 = 10	Note 1: Previously reported completed actions 1-8 have been removed from the report. Note 2: A review of SR13 undertaken is developing a new set of actions which support a move from a focus on establishing processes to assurance of effectiveness to evidence EPUT has put in place systems for organisational learning. Focus being placed on clinical governance group / committee function, escalation arrangements and evidence that learning from patient safety incidents is embedded and measurable impact in terms of service improvement.	
Executive Responsible Office: Executive Chief Nurse Board Committee: Quality Committee			Controls Assurance	
Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)	
Lead roles and subject matter experts	Nursing and Quality Structure Medical Directorate Structure Care Unit Leadership Triumvirate (Including DDQS)		IA Safeguarding (outcome detail to be added) identified high level diagnostic safeguarding practice with the aim of integrating coherent governance & training system across partnership working	
Patient Safety Incident Management Team	Team Established		IA PSIRF (outcome detail to be added)	
Clinical (Quality) Governance Structure	Each meeting annual work plan, annual report and effectiveness reviews.		CQC inspection report for Adult MH Inpatient Wards and PICU (July '25) identified a breach in governance as a consequence of not having adequate oversight of the breaches within the Safe domain. IA reviewed Clinical Governance structure process - Reasonable assurance received Feb 26	
Learning Collaborative Partnership	Forum attendance and effectiveness review. Quarterly Learning events		CQC inspection report for Adult MH Inpatient Wards and PICU provided positive assurance of learning from incidents.	
Learning information communications plan			CQC inspection report for Adult MH Inpatient Wards and PICU provided positive assurance of learning from incidents.	
Patient Safety Dashboard	Reviewing dashboards from IPR - key quality measures to focus on metrics to support patient outcomes			
Clinical staff mandatory and essential training	Training tracker and reports	Training reports to PECC	CQC inspection reports 2024 - 2025 for Clifton Lodge, Brockfield House and Adult MH Inpatients and PICU provided positive assurance.	
ESLMS				

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)	
Patient Incident Response Plan			IA Falls Management (2024/25) Reasonable Assurance opinion IA Recording and Monitoring of Therapeutic Observations (2024/25) Reasonable Assurance opinion IA Care Plans and Risk Assessments (2024/25) Reasonable Assurance opinion	
Quality Governance Policy, Guidelines and SOPs	Register Monitoring		IA Compliance with policies - Site Visits (2024/25) Reasonable Assurance opinion. IA Board Assurance and Risk Management – Substantial Assurance opinion. Audit of Clinical Governance Arrangements received reasonable assurance (Feb 2026) Audit of safety plans received reasonable assurance (Feb 2026)	
Clinical Audit Programme	Annual Plan and Outputs	Quality Committee Oversight	National Audits / Confidential Inquiries Reports and Organisational reports	
Quality Assurance Framework: Quality of Care Strategy Quality Control Audits (Tendable) Quality Assurance Visits Compliance Reviews (Clinical Audit Plan / Compliance Team Reviews)	Quality of Care Strategy Quality Control Audits (Tendable) Quality Assurance Visits		IA Mortality Review Processes 2025 - Reasonable assurance opinion. CQC inspection reports 2024 - 2025 for Clifton Lodge (Good) , Brockfield House (Good) and Adult MH Inpatients and PICU (RI - an improved rating) provided positive assurance.	
Actions (to modify risks)	By When	By Who	Gap	Update
New actions under development				

Corporate Risk Register

September 2026

EPUT

CRR11 - Suicide Prevention (2285)

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

Initial Risk Score C4x L4 = 16	Current Risk Score C4 x L3 = 12	Target Score C4 x L2= 8	Note 1: Previous reported completed actions 1 - 5 have removed from the report for CRR11. Note 2: Progress has been made to strengthen suicide prevention arrangements through Trust-wide STORM training, executive participation in suicide prevention training, enhanced oversight of high-risk service users via the AOT improvement programme, and weekly review of incidents through the Emerging Incidents Review Group. A review is underway to consider the alignment of observation and engagement risks with suicide prevention oversight and to ensure co-production is embedded within future developments. The risk will be further refined to more clearly articulate the strategic risk and potential impact to EPUT.	
Executive Responsible Office: Executive Medical Director Director Lead: Interim Deputy Medical Director Mental Health Urgent & Inpatient Services Leads: Alan Hewitt, Deputy Director of Quality and Safety Board Committee: Quality Committee				
Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)	
Observation and Engagement Policy	Policy in place Personalised Engagement Boards			
Electronic observations recording tool	In trial phase			
Ward level oversight	Tenable Audit results reviewed at weekly huddles	Patient led safety huddles (Basildon)		
Observation and Engagement e-learning and training videos	STORM training (achieved year one target of 60% of registered staff)			
Self Harm Clinical Guideline Ligature Environmental Risk assessment and Management Policy		Suicide Prevention Group (Co-chaired with a Lived Experience Ambassador) Ligature Risk Reduction Group		
Engagement resources	Purchased equipment e.g. games / newspapers etc. Garden Protocol (with spots checks)			

Actions (to modify risks)		By When	By Who	Gap	Update
6	Implementation of the Suicide Prevention Framework (as aligned to the Quality of Care Strategy)	Dec '26	GW	Control	Q1 report presented to Quality Committee September 2026. The weekly executive-led emerging incident review process, chaired by the Chief Nurse, continues to strengthen oversight, learning, triangulation of themes, and timely action across care units. The Trust is progressing its transition from risk stratification to personalised safety planning, aligned with NHS England's Staying Safe from Suicide guidance, supported by updated clinical guidance, revised assessment templates and workforce development initiatives. Positive improvement activity continues, including a 17% reduction in self-harm incidents this quarter, expansion of STORM training capacity, and ongoing quality improvement work to reduce ligature incidents and strengthen suicide prevention across services.

CRR 2598 - Nova Programme

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

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

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

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

<i>Initial Risk Score</i> C4 x L4 = 16	<i>Current Risk Score</i> C4 x L4 =16	<i>Target Score</i> C4 x L2 = 8	Note 1: Previous reported completed action 1 has been removed from the report	
Executive Responsible Office: Executive Director of Strategy, Transformation and Digital Director Lead Board Committee: ET Week 1 & 3 and Joint Steering Board (JSB)		Controls Assurance		
Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)	
Governance and Assurance	Established governance framework with supplier representation embedded in core meetings Reporting and assurance process embedded Nova Implementation Group Design Authorities CODA and TDRA	Exec oversight though ET week 3 Regular SRO, CEO and Senior Oracle Health meetings Nova Joint Programme Board and Nova Joint Steering Board	Quarterly assurance reviews with NHSE and ICB on all Nova risks DHA assurance partner oversight Strategic Delivery Partner engagement	
Financial Controls	Defined accounting treatments embedded into programme processes Ongoing revalidation of the Business Case Regular financial monitoring Finance oversight Finance risk and assurance reviews Nova Implementation Group	Nova Joint Programme Board and Nova Joint Steering Board	Independent specialist/audit advice sought when required DHA assurance partner oversight	
First-of-Type	Established Mental Health, Community Care and Community & Mental Health PAS workstreams Unification Governance and dependencies with Acute work streams. Design Authorities CODA and TDRA Weekly Nova Change Control Group Weekly Nova Configuration Change Group Nova Implementation Group	Nova Joint Programme Board and Nova Joint Steering Board	DHA assurance partner oversight Strategic Delivery Partner engagement	

Key Controls	Level 1	Level 2	Level 3
Clinical Digital Safety	Clinical Safety Officers (CSOs) engaged in workstream development Ongoing training for additional CSOs to help ensure the system remains safe Regular review of robust Hazard Log Nova Clinical Safety Officer Working Group Design Authority CODA CCIO/CNIO oversight of workflow assurance Nova Implementation Group	Nova Joint Programme Board and Nova Joint Steering Board	DHA assurance partner oversight
Adoption and Embedding	Change and Engagement, Training and Nova Readiness Pillars in place to support adoption Transformation strategy and training approach established Defined service readiness criteria aligned to go-live requirements Design Authority CODA Nova Implementation Group Monitoring of system usage and uptake	Nova Joint Programme Board and Nova Joint Steering Board	DHA assurance partner oversight
Change and Engagement	Change and Engagement Pillar governance Communication Strategy and plan in place System partners and GP engagement Regular communications across the Trusts including regular slot on All Team Briefing and Senior Leader meetings Design Authority CODA Nova Implementation Group	Nova Joint Programme Board and Nova Joint Steering Board	DHA assurance partner oversight
Resourcing	Clear forward planning for operational staffing identifying required roles, skills and backfill Nova Implementation Group	Weekly Exec forums for escalations and concerns including resourcing Nova Joint Programme Board and Nova Joint Steering Board	Regional Team oversight DHA assurance partner oversight Strategic Delivery Partner support
Nova Strategy and Planning	Pillar strategies approved with delivery objectives in plan Domain plan assurance into Nova Implementation Group	Nova Joint Programme Board and Nova Joint Steering Board	DHA assurance partner oversight

Actions (to modify risks)		By When	By Who	Gap	Update
2	Complete design and build for localisation which incorporates workflows and tests scripts being fully approved	Complete	PD	Control	System Testing completed on 24/07/2026, with all planned test scripts executed. A work-off plan is in place to manage outstanding gaps, blocked items and approved CCR-(Configuration Change Requests) related activities through subsequent testing phases.
3	Strengthen EPUT operational leadership by appointing a Nova Director of Operations who will further support programme delivery	Complete	PD	Control	A successful candidate was appointed to the Nova Director of Operations role following interviews conducted in June 2026. Onboarding is progressing in line with the recruitment plan. The action has been extended and will remain open until the onboarding process is fully completed. Sarah Brazier has been appointed. Action complete.
4	Additional staff resources to be released to support programme delivery	Extended to Sep 2026	CEO	Control	Weekly executive escalation meetings established and reviewing additional staffing resource requests. Ongoing. Delays remain due to challenges releasing staff from operational duties to support Nova reviews. Continued engagement and escalation with service leads is underway to increase SME availability for upcoming testing phases.
5	Baseline and regularly monitor the programme plan to ensure key milestone dates are achieved, and that any changes are formally agreed with full understanding of associated impacts prior to approval	Nov 2026	PD	Control	Fortnightly reviews with the programme team of the baselined programme plan are in place. Weekly reviews are planned to commence to further strengthen oversight and progress tracking.
6	Develop and implement a Transformation Plan to support adoption and embedding of new ways of working, including change management, training, engagement, benefits realisation and post go-live sustainability arrangements.	Complete	PD	Control	The NOVA Transformation Strategy has been approved and provides the framework for preparing, supporting and enabling staff to adopt the unified EPR. Revised programme governance arrangements were approved in August, with work underway to align reporting, governance and programme management processes. Transformation planning continues to develop, including organisational readiness, adoption measures and benefits realisation, to support future ways of working and delivery of anticipated clinical, operational and organisational benefits.

CRR 2600 (2599) - Service demand exceeding capacity for ND services, Autism South & NE

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

Initial Risk Score C4x L5 = 20		Current Risk Score C4 x L4 = 16		Target Score C4 x L2= 8		Note 1: Risk approved by the Executive Team in June 2026 for escalation onto Corporate Risk Register. Note 2: Given the completed actions a review of risk will undertaken in the next review round.					
Executive Responsible Office: Chief Operating Officer Director Lead: Director of Psychology Services Leads: Deputy Clinical Director for Psychology Services and Lead Psychologist Board Committee: Finance and Performance						Controls Assurance					
Key Controls						Level 1 (Management)		Level 2 (Oversight)		Level 3 (Independent)	
ASD Service (for a set caseload is in place)						Establishment Monitoring of waiting list length and referral times		Commissioner Operational Planning and Contractual Meetings Regular performance reporting and meetings with/to management and commissioners			
Monitoring of waiting list for appropriateness of referral and outsourcing of activity.								Commissioner Operational Planning and Contractual Meetings			
Signposting to interim support resources where available						This information is provided along with waiting list letters to all patients. Monitoring of complaints associated with wait times.					
ICB approved referral and diagnostic pathway						In place					
Actions (to modify risks)						By When	By Who	Gap	Update		
1	Engage with Pharmacy to manage medication related pressure (initially in NE Essex)					Complete	SA/AO	Control	As described above - Current issue re medications (Melatonin and Clonidine) which the GP Feds do not prescribe and the GPs do not either if they relate to someone's ADHD. No further action to be taken		
2	Recruitment and training of additional specialist staff					Complete	SA	Assurance	Staff in place and additional psychology staffing resources to validate the waiting list. Nursing post have been approved at cost pressure for 6 month intervals.		
3	Signposting (regularly when contact with individuals) and offering training and consultation. Onward referrals for those who have some additional needs in terms of MH concerns, housing/social care needs. Supportive letters for individuals on the WL or who have had a diagnostic assessment for employers/benefits/further education around reasonable adjustments					Complete	SA	Assurance	Signposting information is included on service letters. Service offers training and consultation to other services (recent training for GPs was completed in March 2026). Supportive letters for individuals on the WL or who have had a diagnostic assessment around reasonable adjustments for example is given on a case by case basis.		

Actions (to modify risks)		By When	By Who	Gap	Update
4	Review and streamline referral and diagnostic pathways – data on referrers.	Complete	SA	Control	Pathway in place.
5	Digital solution to waiting list – (Psyomics bid)	Dec-26	AW/JL	Control	NHS funding allocated to contract Psyomics waitlist validation and waitlist support (value of £350k over three years) which is being progressed through finance / procurement to progress. Software product uses AI to structure information collected from the service user and map this to local pathways, while preserving access for people unable to use digital solutions. - structured intake form to capture initial pathway information - validation of current waiting list and backlog - psycho education and updates for those on the waiting list - information gathering ahead of assessment, aiming to reduce clinical time by 30% - outcomes collection and tracking over time, including annual reviews.
6	Put in place regularly review of service pressure and escalation protocols	Complete	SA/GW	Assurance	In place with Quality Contracting Performance Management with the ICB Stage 1 reviews flagged to senate - Complete Planning for additional service are ongoing discussion through the steering group.
7	Seek additional funding or partnership opportunities	Complete	SA	Control	Prescriber post - have identified the clinicians for this role started in June.
8	Complaints data review/ FOI/ Inquest review	Sep-26	SA/AO	Assurance	Service has met in May 2026 with the complaints and PALS team to look at a different way to manage the volume coming through and have a plan in place to trial through June 2026 Still awaiting progression with the plan for a regular report to send out to FOI requests but haven't had any for a short time, this links to publication scheme project (aim Sept 2026). Have had SAR requests increasing though.

CRR: 2659 Increasing Backlog Maintenance Requirements

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

Likelihood based on: The current backlog liability of £117 million which indicates a significant shortfall in the funding needed to address the estate's Backlog maintenance program.

Consequence based on: Inadequate investment in maintaining the NHS estate can lead to several serious issues. These include increased risk of asset failure, compromised patient safety, infection control breaches, reduced healthcare capacity, higher long-term costs, diminished staff morale, loss of public trust, regulatory violations, and a negative impact on care quality.

Initial Risk Score C4 x L4= 16		Current Risk Score C4 x L4= 16		Target Score C4 x L 2= 8		Note 1: Risk approved by the Executive Team in June 2026 for escalation onto Corporate Risk Register.	
Executive Responsible Office: Executive Chief Finance & Resources Director Director Lead: Director of Estates and Facilities Board Committee: Finance & Performance Committee				Note 2: Previous reported completed action 7 has been removed from the report for CRR2659			
Key Controls		Level 1		Level 2		Level 3	
PPM's currently in place for maintainable assets		PPM data reviewed and lists placed onto backlog for replacement		Estates Assurance Groups reporting into Health Safety and Security Committee			
Six facet and M&E maintainable asset registers		monitored and inform backlog program for replacement based on risk					
Capital and Backlog tie in with the Estates Strategy		Regular meetings held with teams and lists shared between the two ensuring investment prioritised where needed		Capital Programme Board			
Backlog PM and utilising consultants for support		Delivering Backlog maintenance program on time					
Ensuring call off orders agreed with firms							
Any available Capital contingencies prioritised where possible for Backlog maintenance.		Working alongside the capital team to ensure collaborative approach when it comes to investment across the Estate linked to Estates Strategy and reducing backlog liability					
Short circuiting our non-pay controls							
Ensure bids are placed in good time for external monies, ensuring investment into the right areas of the Estate		Regular reporting and review					
Continue prioritisation approach reviewing significant high risk items							
Actions (to modify risks)		By When	By Who	Gap	Update		
1	Review of the current Business Continuity Plan	Complete	MM	Control	Business Continuity Plan has been reviewed and in place.		
2	Better data reporting via 6 facet surveys, asset condition surveys, progress reports etc.	Ongoing	MM	Control	Control. Update each month at assurance meeting		

Actions (to modify risks)		By When	By Who	Gap	Update
3	Undertake new 6 facet survey in 2026	March '27	MM	Control	This is to be commissioned.
4	Look at and bid for other options available to us for additional investment such as CIR and SALIX funding etc.	Mar-27	TT	Control	Estates funding for 2026/27 confirmed and in process of bidding for sustainability funding.
5	Completion of the (ERIC) Estates Return information Collection	Complete	MM	Assurance	Completed and submitted.
6	Explore the options for another backlog project manager	Mar-27	ST	Control	Under review.
8	Estates strategy implementation	Mar-27	MM	Control	The Estates Strategy has been established, with updates provided bi-monthly to F&P, alongside a dedicated task and finish group.
9	To review the operating model	Dec-26	MM	Control	In progress.
10	Complete Estates recruitment/restructure (Core services team)	Complete	MM		The Core Services has been developed and are in place. Complete.
11	Ongoing exploration of Commercial financing options	Mar-27	MM	Control	In progress.
12	Complete a stratified review of the current maintenance backlog to understand the level of risk, in terms of locality (localised / trust wide) and severity (compliance / complexity)	Oct-26	JD	Control	In progress.

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

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

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

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

Initial Risk Score C4 x L5= 20		Current Risk Score C4 x L4= 16		Target Score C4 x L 2= 8		Note 1: Risk approved by the Executive Team in June 2026 for escalation onto Corporate Risk Register.					
Executive Responsible Office: Executive Chief Finance & Resources Director Director Lead: Director of Estates and Facilities Board Committee: Finance & Performance Committee				Controls Assurance							
				Key Controls		Level 1 (Management)		Level 2 (Oversight)		Level 3 (Independent)	
				Utilisation of contractors to supplement workforce		Contractor performance monitoring and periodic review reports					
				CAFM system used to monitor performance against KPIs		Regular KPI reports and variance analysis from CAFM					
Asset management and compliance oversight		Internal audit of asset data and statutory maintenance compliance									
Workforce and recruitment processes		HR recruitment updates and workforce planning review									
Governance oversight of Estates performance				Committee reporting (HSSC, Quality, or Estates Committee)							
Actions (to modify risks)		By When		By Who		Gap		Update			
1	Draft and submit an options paper to the Board for approval.	Extended December 2026		MM		Control		This action has been delayed due to the PwC review and the outcome will be utilised to review any potential options paper.			
2	Review and adjust the work plan to reflect reduced staffing levels and the operational impact under BCP	Jul-26		MM		Control		This remains under constant review.			
3	Following Board decision, implement the preferred option: either outsource the department or undertake large-scale recruitment to meet service demand.	Mar-27		MM		Control		Dependant on the outcome of the Board paper.			
4	Continue utilising contractors temporarily to reduce the backlog of outstanding tasks recorded on the CAFM system.	Ongoing		MM		Control		Timescale will be revised on the outcome of Board discussion on the paper.			
5	Upload the verified asset data from the completed asset survey into the CAFM system and align PPM schedules to each asset	Dec-26		MM		Control		In progress			
6	Review current practices, research potential alternative technical solutions to maintenance tasks	Mar-27		MM		Control		In progress			

CRR2721 - Inability to provide a consistent and sustainable Assertive Outreach Team service across Essex

There is a risk that the Trust is unable to provide a consistent, Trust-wide Assertive Outreach Team (AOT) service for high-risk patients across Essex due to fragmented service arrangements, insufficient workforce capacity, and a lack of dedicated funding. This may result in patients not receiving the level of assertive community support required, leading to increased risk of deterioration in mental health, disengagement from services, avoidable crises, hospital admissions, serious incidents, and an inability to fully meet national expectations arising from the Nottingham Inquiry.

Likelihood based on: The likelihood of harm occurring is considered Likely (4) because the Trust is managing approximately 597 high-risk patients without a consistent, commissioned Assertive Outreach Team model across Essex.

Consequence based on: The consequence is considered Major (4) because may result in patients not receiving the level of community support required to maintain engagement and manage risks effectively. This could lead to deterioration in mental health, increased crisis presentations, avoidable hospital admissions, serious incidents, delays in recovery, and poorer patient outcomes. In addition, the Trust may experience difficulties in demonstrating compliance with emerging national expectations following the Nottingham Inquiry, resulting in increased regulatory scrutiny, adverse inspection findings, reputational damage and reduced confidence from stakeholders.

<i>Initial Risk Score</i> C4 x L4 =16	<i>Current Risk Score</i> C4x L 4=16	<i>Target Score</i> C4x L2 = 8	Note 1: New risk approved by the Executive Team on September '26 for inclusion on the Corporate Risk Register. While existing controls provide some mitigation they do not fully address the underlying service gap and the Trust remains exposed to a high level of clinical, operational, regulatory and reputational risk.	
Executive Responsible Office: Executive Director of Nursing Director Lead: Director Nursing. Board Committee: Finance and Performance Committee			Controls Assurance	
Key Controls			Level 1	Level 2
Use of existing escalation pathways			Including CRHTT, Medical Review, Mental Health Act Assessment, Safeguarding and MAPPA where appropriate.	
Dynamic cohort identification through MaST			MaST in place with MDT oversight.	
Limited nurse-led outreach services in some localities.			This is in place in some localities	
Clinical risk assessment and incident management arrangements.			Individualised care planning, including risk formulation, relapse indicators, engagement strategies, crisis planning and escalation arrangements.	
Disengagement policy to prevent discharge following non-attendance.			Application of the local disengagement arrangements and CG77, including outreach attempts, welfare checks, risk assessment, MDT discussion and senior clinical escalation.	
Crisis 24 and Home First services providing out-of-hours support.			In place	

Actions (to modify risks)		By When	By Who	Gap	Update
1	Obtain a formally recorded Executive decision on implementation of the interim minimum-standard offer and the proposed longer-term AOT model.	Sep-26	KS	Control	The paper has been drafted for submission to Executive Team.
2	Implement the interim minimum-standard offer across CMHTs, with clear accountability, implementation milestones and completion criteria.	Dec-26	LW/ KS/ AS	Control	As above.
3	Re-engage with ICB and NHSE regarding potential funding opportunities.	Dec-26	AOT Team	Control	Business case in development.
4	Establish an AOT governance framework, performance dashboard and outcome-monitoring arrangements.	Mar-27	AOT Team	Assurance	In development.
5	Continue work to improve identification and monitoring of the cohort through digital solutions and system flags.	Ongoing	AOT Team	Control	MAST is established and helps to prioritise this patient cohort.

Risk Movement

Sept 2026

EPUT

Risk Movement and Milestones

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

Risk ID	Initial Score	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	June 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	June 26	July 26	Aug 26	Sep 26
SR1	20	15	15	Closed																						
SR3	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15
SR4	20	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15
SR5	20	15	15	8	8	8	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16
SR6	12	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15
SR7	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
SR8	15	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
SR9	20	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15
SR10	16		New	16	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
SR11	16		New	16	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
SR12	16		New	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16
SR13	20			New	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15

Risk Movement and Milestones

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

Risk ID	Initial Score	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun e 26	July 26	Aug 26	Sept 26
CRR11	16	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
CRR45	12	12	12	12	12	16	12	12	12	12	12	12	12	12	Closed											
CRR77	16	16	16	8	Close d																					
CRR81	12	12	12	12	Close d																					
CRR92	20	12	12	12	12	12	12	12	12	12	12	12	Closed													
CRR93	15	15	15	10	Close d																					
CRR94	16	20	20	10	Close d																					
CRR98	20	12	12	12	12	12	12	12	12	12	12	Closed														
CRR2598	16																			New	16	16	16	16	16	16
CRR2600	20																					New	16	16	16	16
CRR2659	16																					New	16	16	16	16
CRR2721	16																								New	16

8. STRATEGIC INITIATIVES

8.1 EPUT CULTURE REVIEW FINDINGS AND NEXT STEPS

● Discussion Item

● Chief People Officer

REFERENCES

Only PDFs are attached

 EPUT Culture Review Findings and Next Steps.pdf

SUMMARY REPORT		BOARD OF DIRECTORS PART 1			7 October 2026		
Report Title:		EPUT Culture Review Findings and Next Steps					
Report Lead		Andrew McMenemy – Executive Chief People Officer & Interim Deputy CEO.					
Report Author(s):		Paul Taylor – Director of OD and Culture					
Report discussed previously at:		People Committee – 27 August 2026 Board of Directors Seminar – 2 September 2026					
Level of Assurance:		Level 1	☐	Level 2	☐	Level 3	☒

Risk Assessment of Report		
Summary of risks highlighted in this report	The report provides the findings and next steps following the cultural review which will support risks associated with: - Addressing systemic leadership behaviours, capability and issues of race and other inequality,. - Addressing the workforce continuing to work in an environment of transactional and task orientated practice. - Taking action to remedy the over-reliance on compliance management, transactional communication (Microsoft Teams, e-mail), resulting in leaders continuing to react to external pressures and operate in a state of 'learnt helplessness' and poor relational safety. - Ensuring the Trust considers, reflects and acts on the issues identified in the review, ensuring the risk of non-delivery to both patient quality outcomes, financial stability and reputation is mitigated.	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	☐
	SR4 Demand/ Capacity	☐
	SR5 Statutory Public Inquiry	☐
	SR6 Cyber Attack	☐
	SR7 Capital	☐
	SR8 Use of Resources	☐
	SR9 Digital and Data	☐
	SR10 Workforce Sustainability	☒
	SR11 Staff Retention	☒
	SR12 Organisational Development	☒
	SR13 Quality Governance	☐
Does this report mitigate the Strategic risk(s)?	Yes – the culture review addresses several systemic issues related to identified areas of risk including equalities, staff experience, workforce sustainability and retention.	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	Yes	
If yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	If EPUT does not demonstrate equity of opportunity associated to staff development as well as eradicating discrimination and bias within recruitment and employee relations matters, then it will continue to have a culture	

	that is not fully representative and inclusive of all our staff and patients.
Describe what measures will you use to monitor mitigation of the risk	The measures provided in WRES, and the staff survey will support our ability to have oversight and monitor and progress alongside mitigations.
Are you requesting approval of financial / other resources within the paper?	No
If yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	N/A
Reflection on Equalities	One of the key lines of enquiry for the culture review focussed on anti-racist practice, sexual safety and experience of the workforce who have protected characteristics.

Purpose of the Report

This report provides the Board of Directors with the findings into organisational culture undertaken by brap and The King's Fund. It proposes a set of recommendations and next steps that seek to develop systems of learning, governance and approaches that re-humanise, connect the workforce, improve patient outcomes and enhance organisational performance.	Decision	☐
	Discussion	☒
	Information	☒

Recommendations/Action Required

The Board of Directors is asked to:

1. Note and discuss the findings of the cultural review undertaken by brap and The King's Fund alongside recommendations / next steps.

Summary of Key Points

In September 2025, EPUT commissioned brap and The King's Fund to conduct a 9-month strategic review into its organisational culture. Operating under exceptional scrutiny, including the Lampard Inquiry, financial constraints, and service pressures, the inquiry aimed to understand why cultural change is difficult to embed and how leadership, equality, and governance are experienced in practice.

The overall conclusion to the cultural review is that EPUT's central cultural problem is not a lack of knowledge. The challenge is to hold difficult knowledge, make sense of it collectively, and convert it into coherent action. Fear, control, and disconnection form a self-reinforcing loop with responses intended to protect can reduce autonomy, weaken relationships, and make learning and action harder.

Following its review by the People Committee in August and presentation to the Board of Directors in September, the report outlines several key priorities for organisational improvement. These include streamlining governance, embedding culture and anti-racism responsibilities directly across all directorates, re-humanising corporate support for frontline services, turning trauma-informed diagnostics and quality improvement into practical delivery plans and strengthening organisational learning by integrating staff feedback and incident data.

The Trust will be implementing a new Leadership Behaviour Framework alongside a year-long 'Leadership in Practice' development programme for 70 leaders to drive these strategic changes. In addition, the People and Culture directorate will co-ordinate a set of proposals that will address the culture review recommendations and work alongside both corporate and operational functions to agree an organisational-wide implementation plan.

Relationship to Trust Strategic Objectives

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

Which of the Trust Values are Being Delivered

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

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

Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	☒
The outcomes of the review are aligned to areas highlighted in the CQC Well-Led review.	
Data quality issues	☐
Involvement of Service Users/Healthwatch	☐
Communication and consultation with stakeholders required	☒
Following the report to Board there will be active engagement with those stakeholders who contributed alongside the wider organisation.	
Service impact/health improvement gains	☒
The purpose of the review is to support an improved culture that supports staff to meet the values of the Trust and therefore have a positive impact on quality and safety.	
Financial implications:	☐
Governance implications	☐
Impact on patient safety/quality	☒
The purpose of the review is to support an improved culture that supports staff to meet the values of the Trust and therefore have a positive impact on quality and safety.	

Acronyms/Terms Used in the Report

CEO	Chief Executive Officer	brap	Name of an organisation
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Supporting Reports/ Appendices /or further reading

Culture Review Report (The King's Fund/brap)

Lead



Andrew McMenemy
Executive Chief People Officer and Interim Deputy Chief Executive Officer

Learning in the Wild

Findings from a culture inquiry

EPUT organisational culture inquiry

brap and The King's Fund

About this version

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Acknowledgements

Thanks to everyone who took part in this culture inquiry. We are particularly indebted to participants in leadership group sessions and those who took part in co-design conversations in May 2026. A number of people sought us out after hearing about this work to relay their experiences of the trust. Considerations around anonymity prevent us naming them specifically, but we appreciate their openness.

Special thanks to Paul Taylor, Director of Organisational Development and Culture, Nicky Reeves, Head of Organisational Development, and Jo Debenham, Associate Director of Organisational Development and Culture for their patience and openness to trying out different approaches to OD.

INTRODUCTION

What this inquiry set out to do

In September 2025, Essex Partnership University Trust commissioned brap and The King's Fund to undertake a strategic inquiry into organisational culture. The work was intended to respond to long-standing issues around cultural misalignment and build a foundation for sustainable organisational change.

The inquiry took place in a period of exceptional scrutiny, financial constraint, and organisational uncertainty. Staff and leaders were working under the continuing shadow of the Lampard Inquiry, while also managing everyday service pressures.

The purpose was not only to describe culture, but to understand the organisational conditions that make change difficult to embed: how leadership, governance, relationships, equality, and learning are experienced in practice.

To Understand

...how culture is experienced across different parts of EPUT, including the conditions that shape leadership, voice, equality, learning, and care.

To Identify

...the organisational, relational, and structural dynamics that support good practice or make thoughtful, courageous, and inclusive leadership harder.

To Think About The Future

...and, in particular, think about what the findings mean for the development of a bespoke EPUT leadership programme.

How the inquiry developed

Over nine months, more than 140 people contributed through an adaptive process of listening, deeper inquiry, co-design, and synthesis. The process was in four phases.

1. Orientation

- early conversations with staff and leaders
- review of organisational context
- emerging cultural patterns identified

2. Deeper inquiry

- staff focus groups and conversations

- engagement with Guardians, staff side, trauma-informed care leads, and other specialist perspectives

3. Leadership and co-design

Testing the findings and shaping possible responses

- three leadership sessions
- Board and ELT engagement
- two co-design sessions in May 2026

4. Synthesis

Turning experience into organisational learning

- themes compared across sources
- organisational dynamics identified
- findings and next steps developed

Who we are

brap is a national equality and human rights charity and brings deep, innovative thinking and practical expertise in organisational culture, with a particular lens around leadership, equity, and inclusive outcomes for staff and patients. www.brap.org.uk

The King's Fund is a nationally recognised authority in healthcare leadership and system transformation. www.kingsfund.org.uk

FINDINGS

Participant quotations are anonymised. Quotations have been lightly edited for punctuation and obvious transcription errors. The source material uses the term 'BME'; this report retains it when reporting or quoting that material.

Finding 1: THE PROTECTION LOOP

Scrutiny, fear, and organisational self-protection reinforce one another

'People are frightened of processes. Frightened of being accused of something ... and the anxiety associated with this. It is paralysing.'

– Staff conversation, September 2025

Fear is an organising force

The evidence suggests that fear is doing organisational work. References to the Lampard Inquiry occurred in conversations with colleagues across different bands, professions, and operational settings. However, staff do not only respond to actual external scrutiny: they anticipate criticism, accusation, formal process, and future exposure, and organise their behaviour around it.

This produces defensive safety behaviour: decisions are checked repeatedly, delayed, or passed upwards; written records are treated cautiously; concerns are softened; and people seek reassurance before acting. Staff avoid putting things in writing and prefer to 'catch someone here and there' rather than leave a record that might be misunderstood or used against them

The Lampard Inquiry, coroners' processes, job security, and organisational shame all contribute to the same climate. Some leaders did not personally feel fearful, but recognised that colleagues in other roles, bands, and services do.

'Do I as a middle manager feel safe to raise concerns coming from my team? No. We're in the Inquiry. We're protecting ourselves because we don't know what is going to happen.'

– Staff conversation, September 2025

'I'm fearful as I may not have a job in six months.'

– Leadership session, February 2026

'The pressures keep you awake at night.'

– Leadership session, February 2026

Fear is not a background emotion. It is shaping how the organisation thinks, records, decides, and acts.

Finding 2: ASSURANCE WITHOUT CONFIDENCE

More governance is not necessarily producing greater organisational grip

'We want to work in a new way but our governance gets in the way.'

– Staff conversation, September 2025

Protection has become a constraint

EPUT has substantial assurance activity: panels, gateways, reports, financial approvals, data returns, and overlapping corporate requests. The 'triple lock' was described as reducing autonomy and, in some cases, preventing apparently modest activities (such as paying for travel for staff to attend training or celebration events). The problem, however, is not that governance exists – it is that, in a fearful climate, governance can become a substitute for confidence.

Participants described a paradox: the more anxiety is felt, the more control is added. The more control is added, the less authorised people feel to use judgement, innovate, or take proportionate decisions. The result is not simply frustration. It is a weakening of organisational grip: more artefacts of assurance, but less shared meaning about what matters, what is risky, and who is trusted to act.

'Governance – lots of gateways to go through before we can get a decision – makes us feel like we are not decision makers.'

– Staff conversation, September 2025

'Responding to queries is a full-time job.'

– Site leadership discussion, October 2025

'Lots of data, but little meaning.'

– Senior leader conversation, 2025

The trust is generating assurance artefacts while weakening the confidence and judgement needed to act.

Finding 3: LEADERSHIP UNDER COMPRESSION

Leadership is being squeezed into containment and mere task transmission

'There is a focus on management rather than leadership.'

– Staff conversation, September 2025

Containment crowds out leadership

Conversations with staff do not suggest that EPUT lacks capable leaders. Many staff praised their immediate managers who were visible, practical, and willing to get involved. However, we also heard – more clearly – that leadership is too often dependent on local conditions and individual relationships.

In wider organisational conditions of scrutiny, financial pressure, and uncertainty, leaders can be drawn into containment: passing pressure down, managing compliance, seeking reassurance, and escalating risk rather than creating direction and shared sense-making.

A perceived corporate-clinical divide is part of this. Decisions were described as being made without sufficient consultation about what was feasible, coupled with clinical and service leaders not always feeling able to challenge them or explain what would be required to make them workable. Some leaders contrasted the aspiration to be 'clinically led and corporately enabled' with an experience of being 'financially led and corporately enabled'; that is, service leads can feel better supported to manage financial considerations than patient care.

'We know a lot – but how is this held by leaders, and how does it turn into action?'

– Staff conversation, March 2026

'I have been on wards where you can go a whole day without seeing a manager.'

– Staff conversation, October 2025

'They [SLT] do visits and hear really positive things. Then after they leave, people start complaining. They don't do it in front of them because they don't want to be seen as failures.'

– Staff conversation, October 2025

EPUT does not lack capable leaders; it lacks reliable conditions in which good leadership can be repeated.

Finding 4: COMMUNICATION WITHOUT RELATIONSHIP

Information travels more reliably than attention, trust, and understanding

'There is something about just having a conversation – corridor conversations – and not using Teams.'

– Staff conversation, September 2025

Presence has become optional

EPUT does not appear short of communication. It appears short of the relational work that allows people to interpret, challenge, and act on what is communicated.

Email, Teams, and formal meetings can pass pressure through the system without creating shared understanding. Routine disengagement in meetings also signals what kind of attention colleagues can expect from one another.

These examples matter less as etiquette and more as culture. Participants suggested that when presence is optional, difficult messages are more likely to be softened, misunderstood, avoided, or pushed into process.

'In virtual meetings, 80 to 90 per cent of participants keep their cameras off. It feels disengaging, and it affects the morale of the people trying to lead the meeting.'

– Staff conversation, January 2026

'Senior staff, including executives and directors, can appear distracted [in meetings]. They are on their phones and not paying attention.'

– Staff conversation, December 2025

'New starters sometimes join induction meetings from sofas, in loungewear, or while cooking dinner. It sets an unprofessional tone from the beginning.'

– Staff conversation, December 2025

The problem is not a lack of communication. It is a lack of reliable presence, attention, and relational follow-through.

Finding 5: VOICE WITHOUT MOVEMENT

Speaking up too often produces process rather than visible change

'Having a conversation about what's really going on is just too problematic to bother.'

– Staff discussion, October 2025

Speaking up is not the same as being heard

Participants suggested EPUT is an organisation in which difficult issues are known, discussed informally, and repeatedly surfaced, but do not reliably become action.

As a consequence, formal routes can become overloaded when ordinary management relationships cannot hold tension. Grievances, complaints, and Freedom to Speak Up conversations may then carry work that should also sit with everyday challenge and accountability.

Repeated consultation without visible movement teaches people to ration their voice. The question becomes not only whether staff can speak, but whether anything will happen if they do.

'There is always an elephant in the room: difficult issues are known, but they are not directly addressed.'

– Staff discussion, October 2025

'The availability of Guardians may prevent people from developing skills around having awkward conversations and resolving tensions.'

– Staff conversation, January 2026

'If you don't chase it, you don't get it. We're very, very reactive.'

– Staff conversation, December 2025

Voice has cultural value only when it is safe, believed, and visibly acted upon.

Finding 6: ONE TRUST, MANY EPUTS

Local leadership, profession, hierarchy, geography, and identity shape different organisational realities

'We need a common sense of pride and purpose, rather than a common culture'

– Staff conversation, September 2025

Variation and inconsistency are both present in the trust

Participants did not describe one uniform culture. They described an organisation experienced differently by site, service, profession, geography, hierarchy, and identity.

Local solidarity can protect teams; however, under pressure, it can also narrow responsibility into a 'look after my bit' mentality, weakening cross-trust problem-solving.

Variation is inevitable. Inconsistent standards of care, dignity, voice, and accountability are not.

Finding 7: CARE IS BEING SQUEEZED OUT OF CARING

Workload and systems can lead to emotional depletion for staff (but not patients)

'How are you expected to be compassionate for twelve and a half hours?'

– Site focus group, January 2026

Meetings are more important than emotions

During a focus group, a participant discussed his lack of progression in the trust. Having recently failed an interview and frustrated by years of being overlooked, he broke down. His colleagues maintained a respectful silence. At the end of the session, someone patted him on the back... and asked if he had read a report relevant to their next meeting.

Many staff feel they are expected to absorb distress, conflict, uncertainty, and abuse while remaining calm and compassionate. Burnout is a clear example of this. The organisational and workload pressures put on managers can prevent them from seeing the human in front of them. Participants shared a number of examples, such as the staff member who returned to work after a period of mental ill health and was asked, 'You're not going to go off again, are you?'

'After I came back from leave [for stress] I heard my manager say, 'I'm fed up working with these snowflakes.'

– Staff conversation, April 2026

'I recently counted: I was asked to attend 21 meetings in one day.'

– Site leadership discussion, February 2026

'I miss those check-ins with your colleagues. We don't do that any more.'

– Staff workshop, October 2025

Staff do not feel the trust cares for them the way they care for patients.

Finding 8: TRAINING WITHOUT LEARNING

Attendance, courses, and compliance do not necessarily build capability

'I don't know whose idea it is to go, "Let's put 140 people on a call, and then we're going to talk at them for a day".'

– Staff focus group, February 2026

Learning spaces are not always used intentionally

The trust does not appear to lack training activity. The concern is whether training reliably builds practical judgement, shared standards, and confidence in the situations staff actually face.

Participants criticised large, passive online sessions with low engagement, weak preceptorship, limited protected time, and insufficient role-specific development.

Informal spaces for learning, such as huddles and conversations over tea, were also described as lost or inconsistent.

'There is no work at a leadership or management level to create a space to think and learn.'

– Staff conversation, October 2025

'I was in one of these massive Teams calls where we were all meant to share what we've learnt. All day. Only 6 to 10 per cent were responding to the polls... it's too easy to just go and make a cup of tea.'

– Staff group, October 2025

A learning culture is built in attendance but not always in practice.

Finding 9: EQUALITY REVEALS WHERE POWER SITS

There are patterns in whose behaviour is scrutinised, whose account is believed, and whose harm is absorbed

'BME staff experience gets lumped together.'

– Staff conversation, October 2025

Racism is raised, then displaced

Participants described systemic inequalities that were 'felt and sensed', alongside specific accounts of racism, sexism, and weak organisational response. Global majority staff described their mistakes as receiving 'poorer, harsher outcomes' and their work being scrutinised more intensely. One participant said errors were treated 'a little more heartily' for global majority staff. These accounts sit alongside concerns about blocked progression and how informal relationships are crucial in accessing opportunity.

Staff also described daily racial abuse from patients, including being told to 'go back to your country'. The problem, however, is not just the abuse, but a perceived absence of consequence and organisational protection. One situation was said to have continued for 19 months. Participants believed that only a small proportion of incidents were recorded because reporting did not lead to visible action.

Fundamentally, it appears conversations around equality are avoided. Many global majority participants, for example, relayed how, when racism is raised the conversation may quickly move towards the difficulties experienced by other groups, or towards a broader and less specific discussion of disadvantage.

'What response do you get if you report abuse? "Suck it up and carry on."'

– Staff conversation, January 2026

'Every year for nine years I have had malicious issues raised against me.'

– Global majority staff conversation, session, October 2025

'Women [managers] get treated a lot, lot harder than men.'

– Staff conversation, January 2026

Equality reveals where power sits: whose behaviour is scrutinised, whose account is believed, and whose harm is absorbed.

Finding 10: GOOD LEADERSHIP, BUT NOT BY DESIGN

Strong practice depends too heavily on local relationships and favourable conditions

'I love EPUT!'

– Staff conversation, September 2025

The trust has significant assets, unevenly distributed

The findings should not be read as an account of universal dysfunction. The material contains substantial loyalty, professional commitment, and affection for EPUT. Staff spoke with pride about their work, their colleagues, and the difference they make for patients.

Participants also described immediate managers who were available, practical, and willing to get involved. Some leaders said they felt trusted, consulted, and valued, particularly by their peers.

Candour was also possible when people had sufficient time, permission, and relational safety. The inquiry sessions themselves showed that staff and leaders can speak honestly across roles, listen to different experiences, and work through difficult issues together. Good work is therefore already happening, often through local initiative, professional commitment, and trusted relationships. The difficulty is that these strengths remain unevenly distributed. They depend too heavily on who manages a service, which relationships are available, and whether people can create space to think together.

'We can do some good stuff, things we can be proud of.'

– Leadership session, February 2026

'There is good work happening. People do care and want to be here.'

– Leadership session, March 2026

'Good happens when leadership is relational.'

– Leadership session, February 2026

People care – faced with patients, people feel compelled to work together and be at their best.

CONCLUSIONS

Conclusion 1: EPUT'S CENTRAL CULTURAL PROBLEM IS NOT A LACK OF KNOWLEDGE

The Trust already knows a great deal about its cultural difficulties.

Across the inquiry, staff, leaders, and internal partners described highly convergent themes: fear, fragmentation, overloaded governance, weak relational connection, racism, inequality, and a gap between stated values and lived experience.

The issue is not simply whether the trust has heard these things. It is whether it can hold difficult knowledge, make sense of it collectively, and convert it into coherent action.

WHAT THIS MEANS

The work ahead is less about producing another diagnosis and more about creating conditions for action, learning, and accountability.

Conclusion 2: FEAR, CONTROL, AND DISCONNECTION FORM A SELF-REINFORCING LOOP

The trust's response to pressure can reproduce the conditions that sustain pressure.

Sustained scrutiny increases anxiety. Anxiety generates checking, reporting, escalation, and formalisation. These responses provide short-term protection, but they also reduce autonomy, weaken relationships, and make it harder to learn or act.

When problems remain unresolved, the organisation becomes more exposed to further scrutiny. The loop then begins again.

WHAT THIS MEANS

Reducing fear will require changing the practices that convert anxiety into control, delay, and disconnection.

Emotions in play at EPUT



Conclusion 3: IN MANY CASES, ORGANISATIONAL STRUCTURES HAVE BECOME SOCIAL DEFENCES AGAINST ANXIETY

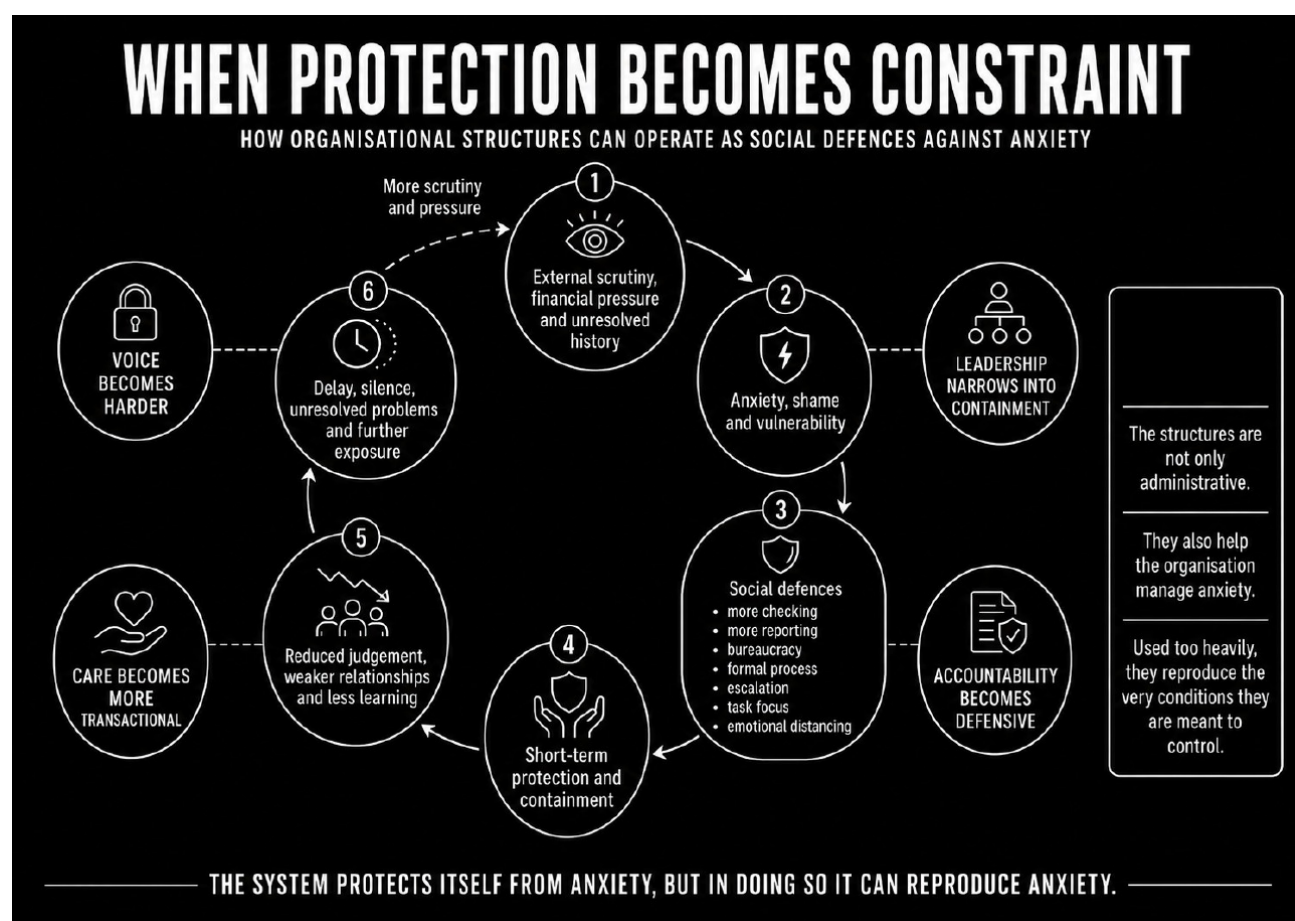
Over the page we have tried to show how EPUT has developed protective responses to the external scrutiny it faces. As Menzies Lyth has argued, administrative structures can take on emotional functions when used as social defences. Processes such as reporting, escalation, formalisation, and tighter control do not only organise work – they can also help people manage anxiety.

The difficulty is that while these structures can protect the organisation in the short term, they can weaken judgement, relationships, voice, and learning over time.

WHAT THIS MEANS

The task is not to remove structure. It is to ensure structure supports the primary task, rather than protecting people from the discomfort of doing it.

When protection becomes constraint



Conclusion 4: THE TRUST NEEDS TO BE ‘RE-HUMANISED’

People need to be experienced as human beings with lives, emotions, judgement, and purpose, not simply as cogs in a machine

Across the inquiry, staff described working arrangements in which instruction has displaced conversation, reporting displaced trust, compliance displaced judgement, and training displaced learning. Over time, this can reduce people to roles, tasks, and performance data. Re-humanising the trust means recognising that staff bring histories, pressures, families, identities, professional values, and emotional lives to work. These realities may shape how people care and how efficiently they work, but this justification should not be needed. Fundamentally, the trust should care for its staff's humanity the way it cares for its patients'.

WHAT THIS MEANS

EPUT should design work around people, rather than expecting people continually to adapt themselves to systems. Managers should understand the lives and pressures of the people they lead, not simply monitor their outputs. Systems should help people to think and care, rather than treating them as interchangeable parts.

Conclusion 5: THE LEADERSHIP CHALLENGE IS SYSTEMIC, NOT SIMPLY AN INDIVIDUAL CAPABILITY DEFICIT

A generic leadership programme will not be fit for purpose.

This inquiry did not reveal an absence of capable people; rather, it showed that leadership practice is shaped by scrutiny, hierarchy, time, relationships, authority, race, geography, and other conditions in which leaders work.

EPUT therefore needs development that strengthens leadership within the realities of work: live challenges, workplace experiments, courageous conversations, inclusive practice, and learning about the organisation as well as the individual.

WHAT THIS MEANS

A 'leadership in practice' model is better suited than a standard programme because it develops judgement and agency where leadership actually happens.

Conclusion 6: EQUALITY REVEALS WHERE POWER SITS

Racism needs to be held directly, not diluted into a generic equality conversation.

Many staff experience discomfort when inequality is mentioned. It is clear that conversations about racism in particular generate feelings of defensiveness, dismissiveness, and doubt. As a result, when racism is raised, the conversation may quickly move towards the difficulties experienced by other groups, or towards a broader and less specific discussion of disadvantage. This is not only a common avoidance technique, but may also reflect how different groups can feel that their experience must compete for attention and organisational legitimacy.

Within the trust, there can be a competition for who is most marginalised. This is not conducive to a more mature equality conversation. It can displace race-specific concerns and prevent the organisation from examining how racism shapes credibility, scrutiny, protection, progression, and response to harm.

WHAT THIS MEANS

EPUT needs to be more focused and braver on race: able to name racism, stay with discomfort, examine patterns, and act without setting different inequalities against one another.

NEXT STEPS & RECOMMENDATIONS

- **Review governance and assurance arrangements to ensure they support, rather than constrain, effective leadership and decision-making.** This understanding where assurance is being used to manage uncertainty and should include identifying where layers of approval, reporting, escalation, and oversight can be simplified, and where greater authority and judgement can safely sit closer to operational care.
- **Create clear ownership of the culture review findings across corporate directorates and operational care units.** Each area should consider how the findings are expressed in its own systems, relationships, and ways of working, with Executive Directors responsible for demonstrating what is changing in practice rather than culture being treated principally as a People and Culture responsibility.
- **Review how corporate functions support frontline services, with a particular focus on re-humanising organisational processes.** Policies, communications, meetings, performance arrangements, and support offers should be tested against the realities of different staff groups and care settings, including whether they enable conversation, relationships, professional judgement, and learning rather than adding further transactional burden. The trauma-informed diagnostic work will need to develop into a delivery plan so this becomes more than an aspiration and instead, a lived working reality for staff at all levels of the organisation.
- **Make tackling racism and other inequalities an explicit operational and governance responsibility.** Directorates and care units should be expected to understand inequalities within their own areas, respond visibly when racism or discrimination occurs, and demonstrate the action taken. Trust-level assurance should include workforce data, with relevant measures disaggregated to identify differences by ethnicity, role, band, and organisational area.
- **Strengthen the Trust's capacity to learn from experience.** Bring together intelligence from staff experience, incidents, complaints, workforce data, Freedom to Speak Up info and culture work to identify recurring organisational patterns, test responses and understand whether change is being experienced in practice.
- **A lack of organisation-wide quality improvement and learning** at the frontline and across the organisation is hampering real-time improvements in performance and outcomes for patients. A plan to implement and culturally embed 'Quality Improvement' and other initiatives to develop the skills and capacity for learning is recommended.
- **Implement a Leadership Behaviour Framework** aligned to the findings from the cultural inquiry, the trauma-informed diagnostic work, NHS Staff Standards and National Staff Survey (2025). This will make clear and set standards for leaders to re-humanise their work with teams, address inequalities in their area of practice and to take proactive and responsible action that will deliver the organisational priorities.

- Establish a **‘Leadership in Practice’ programme** as a year-long organisational intervention for 70 leaders across two cohorts. This will be a leadership-in-practice model, designed to develop judgement and agency in the live conditions that currently constrain leadership, including scrutiny, competing priorities, clinical risk, financial constraint, relational tension and unequal power.

9. QUALITY AND OPERATIONAL PERFORMANCE

9.1 INTEGRATED PERFORMANCE SCORECARD

● Information Item

● Chief Executive

REFERENCES

Only PDFs are attached

 Integrated Quality & Performance Report 07.10.2026.pdf

SUMMARY REPORT		BOARD OF DIRECTORS PART 1			7 October 2026		
Report Title:		Integrated Quality & Performance Report					
Report Lead		Trevor Smith, Interim Joint Chief Executive Officer					
Report Author(s):		Janette Leonard, Director of ITT					
Report discussed previously at:		Finance and Performance Committee Clinical Governance & Quality Committee					
Level of Assurance:		Level 1	☐	Level 2	☒	Level 3	☐

Risk Assessment of Report		
Summary of risks highlighted in this report	Key risks include increasing demand for urgent mental health services, continued inappropriate out of area placements, financial pressures arising from OAP costs and under-delivery of efficiencies impact use of resources and workforce indicators. Key controls and mitigations include: Flow Improvement Programme, delayed discharge and long-stay reduction work streams, the older adult Improvement programme, workforce recruitment and retention initiatives, safer staffing oversight, efficiency recovery plans, mandatory training monitoring, and scrutiny through the Executive, Finance & Performance Committee and Clinical Governance & Quality Committee. These arrangements provide assurance that performance and associated risks are being actively monitored and managed through the Board Assurance Framework and established governance processes.	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	☐
	SR4 Demand/Capacity	☒
	SR5 Statutory Public Inquiry	☐
	SR6 Cyber Attack	☐
	SR7 Capital	☒
	SR8 Use of Resources	☒
	SR9 Digital and Data	☒
	SR10 Workforce Sustainability	☒
	SR11 Staff Retention	☒
	SR12 Organisational Development	☐
	SR13 Quality Governance	☐
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Are you requesting approval of financial / other resources within the paper?	No
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	N/A
Reflection on Equalities	This report does not identify any specific adverse equality impacts. Improvement programmes focused on reducing delayed discharges, long lengths of stay and inappropriate out of area placements support equitable access to care and improved patient experience. No equality concerns requiring escalation have been identified.

Purpose of the Report

This report provides the Board of Directors with:

- A high-level summary of operational performance, quality indicators, safer staffing levels, finance and key NHS England metrics.
- The report is provided to the Board of Directors to draw attention to the key issues that are being considered by the standing committees of the Board.
- The content has been considered by those committees, and it is not the intention that further in-depth scrutiny is required at the Board meeting.
- The report includes the slides from the recent NHSE Mid-Year Review, as discussed at Finance & Performance Committee

Decision

☐

Discussion

☐

Information

☒

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Points

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

Performance

Mental Health

Mental Health Inpatient Capacity:

- Adult Occupancy reported at 96.3%, remaining above - Target <93%
- PICU Occupancy reported at 81.9%, within target - Target <88%
- Specialist Occupancy reported at 86.6%, within target - Target >95%
- Older Adult Occupancy reported at 89.3%, remaining above target – Target <86%

Adult Acute – demand has been increasing – s136 are up 56% on last year and MHA assessments are up 23% on last year – the vast majority of these result in the need to admit and yet we have not had a change in bed base or alternative services for many years which is resulting in a constant need for OAPs.

The Flow Improvement programme is continuing to progress, and we await for the outcome of the unification monies transfer from the ICB which this sub-committee has been well-sighted on.

Average Length of Stay:

Adult Average Length of Stay on Discharge

- Adult ALoS (Including the Assessment Unit) reported at 33.8 days continues to report below target <60 (National Oversight Framework)
- 123 discharges in August (44 Assessment Unit) – 18 long stays (60+ days) – there is a dedicated workstream in Flow Improvement now focussing on reducing long stays
- Long stay discharge breakdown:
 - **60+ days** – 9 discharges
 - **100+ days** – 7 discharges
 - **200+ days** – 2 discharges

Percentage of inpatients with over 60-day length of stay

August: 14.6%

In the most recently published National Oversight Framework league tables (2025/26 Q4), EPUT is ranked 5th out of 47 for **Percentage of inpatients with over 60-day length of stay**. (2025/26 Q1 EPUT ranked 25th out of 47, Q2 EPUT ranked 14th out of 47 and Q3 EPUT ranked 9th out of 47).

The System Delayed Discharges workstream is having real impact on discharging some of our longest delays by engaging weekly with our system partners and particularly with the Local Authorities.

Older Adult Average Length of Stay on Discharge

- Older Adult ALoS reported at 92.88 days and is reporting above target <90. Over the last 12 months ALoS is averaging above target (National Oversight Framework) and a new workstream for OA improvement is being scoped.
- 25 discharges in August – 16 long stays (60+ days)
- Long stay discharge breakdown:
 - **60+ days** – 5 discharges
 - **100+ days** – 9 discharges
 - **200+ days** – 2 discharges

The Older Adults Inpatient Improvement workstream is being launched at the September Flow Programme Board which will be looking at opportunities to improve Flow for the OA pathway in partnership with resourcing through Community First.

PICU average length of stay

- PICU ALoS reported at 34.00 days and is reporting within target – Target <50
- 8 discharges in August – 1 long stays (60+ days)
 - **60+ days** – 1 discharges

The Flow Team have been doing a focused piece of work to reduce PICU wherever safe to do so.

Rates of Delayed Transfer of Care:

Patients with a delayed transfer of care have all been reporting within target limits for the last 4 months, except for Older Adult. Older Adult has recently increased to 8.2% in August and this was due to 10 patient delays.

We are re-setting the process around EDD (Expected Discharge Date), MFA (Medically Fit for Assessment) and CRFD (Clinically Ready for Discharge) and will ensure reporting on these is updated in accordance for future reports.

Inappropriate Out of Area Placements:

- In August, a total of 44 patients were placed out of area, 4 of these were deemed “Inappropriate”
 - 2 placed in Adults
 - 2 placed in PICU
- At the end of August, **106** patients were placed out of area; **17** were deemed Inappropriate
 - Adult – 10
 - PICU - 7

The annual planning commitment is to reduce this to 0 by March 2029. The Resourcing to reduce OAPs Business Case has modelled through the key initiatives that will impact including Crisis Houses and Intensive step-down Facilities to facilitate this.

Community Health Services (appendix 1)**Virtual Ward Occupancy:**

MSE reported at 74% and West reported at 55%, both below target. However, there is high throughput in West due to quicker recovery than 14 days, as patients are cared for in their home. Overall virtual ward utilisation is to be further reviewed with commissioner and provider colleagues to support winter planning.

Urgent Community Response Team Two-Hour Performance:

Performance remained above target in July, reporting at 83.7%. This includes West Essex and Mid & South Care Units.

In the most recently published National Oversight Framework league tables (2025/26 Q4), EPUT is ranked 36th out of 38 for Urgent Community Response 2-hour performance. (2025/26 Q1 EPUT ranked 35th out of 37, Q2 EPUT ranked 36th out of 38 and 2025/26 Q3 EPUT ranked 37th out of 38).

Quality work is required as we are ranking low within NOF on this metric, however, performance has been above target consistently for 24 months.

52+ Weeks Wait:

Performance remained on target in August at 0%. This has consistently been on target for 9 months and has remained below 1% for 16 months. This data is inclusive of West Essex and South East Essex waiting lists.

In the most recently published National Oversight Framework league tables (2025/26 Q4), EPUT is ranked 14th out of 42 for **Percentage of patients waiting over 52 weeks for community services**. (2025/26 Q1 EPUT ranked 1st out of 41, Q2 EPUT ranked 12th out of 41 and 2025/26 Q3 EPUT ranked 14th out of 41).

ALOS South and West Community Health Services:

Consistently achieving target and has remained above target for over 24 months.

18 Week Waits:

WEX: 97%, above target of 95%

SEE: 94.2%, above target of 92%

Remaining consistently above target for the last 12 months.

Quality**Cardio Metabolic (Inpatient):**

Overall compliance reported at 77.49% in August and remains below target of >90%:

- Sixteen wards were fully compliant in month (Gosfield, Henneage, Tower, Chelmer, Kitwood, Roding, Ruby, Christopher Unit, Topaz, Cherrydown, Gloucester, Meadowview, Hadleigh, Larkwood (CAMHS), Poplar (CAMHS) and Byron Court)

Performance is achieving the required target when partial completions are included, as these cases are largely completed with only outstanding blood test results pending. The team undertakes a weekly review of blood test results and forwards these to medical staff as required.

From next week, the team will also provide training to key inpatient staff to enable daily monitoring and follow-up of outstanding blood results, with the aim of further improving performance and consistently achieving the target. The slight reduction in compliance observed during August was partly attributable to the arrival of new doctors on rotation who were becoming familiar with the system requirements.

Cardio Metabolic (Community):

Overall compliance reported at 63.70% in August, target (>65%). Performance is achieving the required target when partial completions are included. The team conducts weekly reviews and follow-up activity, including checking for newly available blood test results.

Capacity within the Recovery and Wellbeing Teams is impacted by the requirement to complete Physical Health Checks (PHCs) for patients on medical caseloads. To address this, ongoing engagement and support are being provided to individual teams to improve compliance.

Four of the six Recovery and Wellbeing Teams are now achieving the required target, compared with none at the same point last year. In addition, several patients continue to be recorded as having a Serious Mental Illness (SMI) when this is no longer applicable, and work is underway to review and correct these records.

NHS Talking Therapies:

Castle Point & Rochford, North East Essex and Southend-on-Sea experienced a decrease in referrals in August. Both the 6wk and 18wk wait to treatment are reporting 100%.

The moving to recovery indicator continues to report above the 50% target, with 56.0% reported in August.

Safety: No Harm / Low Harm Incident Rates

The August No Harm/Low Harm incident rate was 92.0%, which remains consistent with the recent trend, with performance ranging between 92.0% and 92.9% from June to September. During August, there was a reduction in overall incident reporting rates, following three consecutive months of increasing incident reporting activity.

The anticipated trajectory is for incident reporting rates to increase over time, as organisations with a strong safety culture typically demonstrate higher levels of reporting, particularly for incidents resulting in no harm or low harm. High reporting rates are generally indicative of an open and positive reporting culture that supports learning and improvement.

The most frequently reported incident categories continue to be self-harm, pressure ulcers, and physical assault. Self-harm and pressure ulcer incidents have remained consistently among the highest reported categories, while the third highest category alternates between physical assault and adult safeguarding concerns. These therefore remain recognised and established risk areas requiring continued oversight and improvement activity.

Mandatory Training:

Mandatory training course compliance reported at 90.0% in August, achieving the target of 90% for the second month in a row. Information Governance course compliance reported at 90.9% in August, not achieving the target of 95%. 3 Care Units achieved target; Mid and South, North and Specialist.

Workforce

Staff Sickness:

In M5 (August), staff sickness decreased marginally by 0.2 percentage points to 5.8%, although it remains above the Trust target. Oversight and accountability arrangements are in place to support targeted interventions in areas experiencing the highest levels of absence, with a continued focus on strengthening management ownership and supporting a sustained reduction in sickness absence.

Vacancy Rate & Turnover:

The vacancy rate remains stable at 9% and below the Trust target. Recruitment activity continues to focus on safer staffing establishment uplifts, with Phase 1 nearing completion and Phase 2 commencing in M5. Targeted recruitment activity also continues to address longstanding vacancy gaps and support workforce stability.

Workforce turnover remains stable and below the Trust target, providing assurance that retention levels are being maintained.

Workforce Plan and Temporary Staffing:

In M5, the Trust was operating 100 WTE above planned workforce levels. Substantive workforce was 34 WTE above plan, reflecting safer staffing establishment uplifts that were not incorporated into the original workforce plan. The M4–M5 workforce plan assumed a 12 WTE reduction in substantive staffing. Staff in post reduced by 11 WTE over the period, representing a variance of 1 WTE against plan.

August 2026 reported a slight deterioration in temporary staffing utilisation compared with July 2026. Usage remains above the planned trajectory, equating to 66 WTE above target; however, the variance against plan is narrowing. Oversight and targeted plans remain in place to reduce operating levels, with the objective of achieving alignment with planned workforce levels by the end of December 2026.

Staff Supervision / Appraisal:

Compliance with Supervision, 1:1 support, and appraisal requirements continues to remain below the Trust's KPI targets and has been on a minor downward trajectory since April. Trend patterns do indicate a drop in performance through July and August likely linked to annual leave periods and availability of staff across these months. Targeted actions remain in place and are being closely monitored through care group accountability structures.

Work is continuing in moving the recording and inputting of appraisal and supervision information to ESR which will improve reporting, with appraisals planned to be recorded on ESR from October 2026.

Ward Fill Rates:

August reported 23 wards having less than 90% fill rates against the target of <13, this remains outside of target. 2024-25 had an average of 15 wards not achieving target and in 2025-26, the average is 28 wards.

Finance (appendix 2)

M5 in-month actual deficit of £1.9m, £1.7m adverse to plan. The year-to-date (YTD) deficit is £8.4m, a £4.5m adverse variance. Key drivers include shortfalls in delivery of the efficiency programme including temporary staffing with the adverse position further impacted by continued Inpatient demand and resulting higher than planned levels of Out of Area placements.

Cash balances are £25.9m and remain sufficient to support operating activities. In-month capital spend was £1.6m, £0.4m overspent. Cumulative capital spend is £6.4m being £0.3m overspent. Capital spend has been offset by £1.7m relating to the asset disposals.

Mid-Year Review (appendix 3 & 4)

NHSE undertook their mid-year review of the Trust on 7th September. The review considered progress against delivery of the 2026/27 Annual Plan, operational performance, quality and safety, workforce, financial sustainability and winter preparedness.

NHS England acknowledged that the Trust is delivering against the majority of its annual plan objectives and recognised positive performance across a number of operational measures, including adult waiting times, talking therapies, perinatal services, virtual wards, urgent community response and mental health inpatient flow. Progress in strengthening governance, leadership and organisational improvement arrangements was also noted.

The review identified children and young people's waiting times, particularly within neurodevelopmental pathways, as the most significant performance challenge. NHS England requested further recovery and mitigation planning in partnership with commissioners and system partners.

NHS England highlighted the need for continued focus on patient safety improvement, workforce wellbeing, financial recovery, estate pressures and winter resilience. The Trust's response to recent serious incidents, actions to strengthen quality governance and preparations for winter were noted.

A number of actions were agreed, including development of a children and young people's waiting list recovery plan, provision of further assurance regarding virtual ward performance, implementation of actions arising from patient safety reviews, and submission of the Trust's Well-Led improvement plan.

Overall, NHS England concluded that the Trust is making progress in delivery of its annual plan and organisational improvement priorities, while maintaining focus on the key risks and challenges facing the organisation.

Board Assurance: The correspondence provides external feedback on the Trust's progress and identifies areas requiring continued oversight. The actions identified are being addressed through existing governance and performance management arrangements.

Relationship to Trust Strategic Objectives

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

Which of the Trust Values are Being Delivered

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

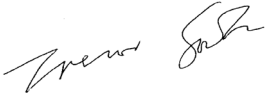
Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:

Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	☒
Data reflects on service provision and NOF ratings.	
Data quality issues	☐

Involvement of Service Users/Healthwatch	☐
Communication and consultation with stakeholders required	☐
Service impact/health improvement gains	☐
Financial implications:	☐
Governance implications	☒
Impact on patient safety/quality	☐
Key Performance Indicators provide insight into the safety and quality of services.	

Acronyms/Terms Used in the Report			
ALOS	Average Length of Stay	OAP	Out of Area Placement
CAMHS	Child and Adolescent Mental Health Services	OOA	Out of Area
CPA	Care Programme Approach	PICU	Psychiatric Intensive Care Unit
OA	Older Adult		

Supporting Reports/ Appendices /or further reading
EPUT Integrated Performance Report HERE Appendix 1: Community Performance Summary Appendix 2: Financial Dashboard Appendix 3: EPUT Mid-Point Review Appendix 4: EPUT Mid-Point Review Follow-Up Letter

Lead
 Trevor Smith Joint Interim Chief Executive Officer



Essex Partnership University
NHS Foundation Trust

Community Health Services

Month 5 – August 2026 (Appendix 1)



Summary

This report provides a summary of the below Community Health Services performance metrics that we have contractual targets set, for July & August.

Not all services have August data available at the time of this report being produced for Finance & Performance committee.

- Virtual Ward Occupancy (**July-26**)
- Urgent Community Response Team (UCRT) Two-Hour Performance (**July-26**)
- 52+ Weeks Wait (**August-26**)
- Inpatient ALOS (West: **August-26** and SEE: **August-26**)
- 18 Week Waits (West: **August-26** and SEE: **August-26**)
- WEX CHS Commissioner KPIs (**July-26**)

Virtual Ward Occupancy

July 2026

2.5.5 Virtual Ward Occupancy

Polarity
High is Good

Target
>80.0%

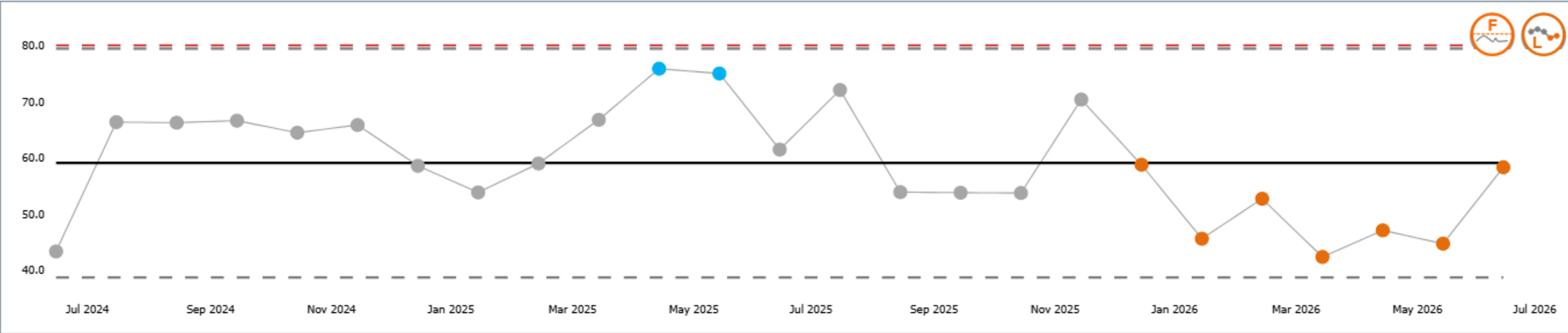
Performance
58.27%

Target achieved?
No

RAG status

12-month trend

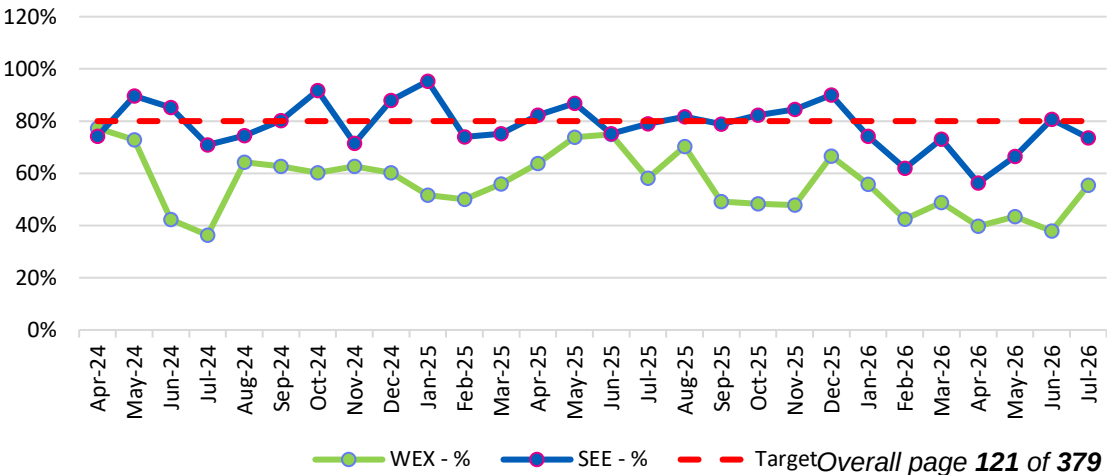
View indicator breakdown



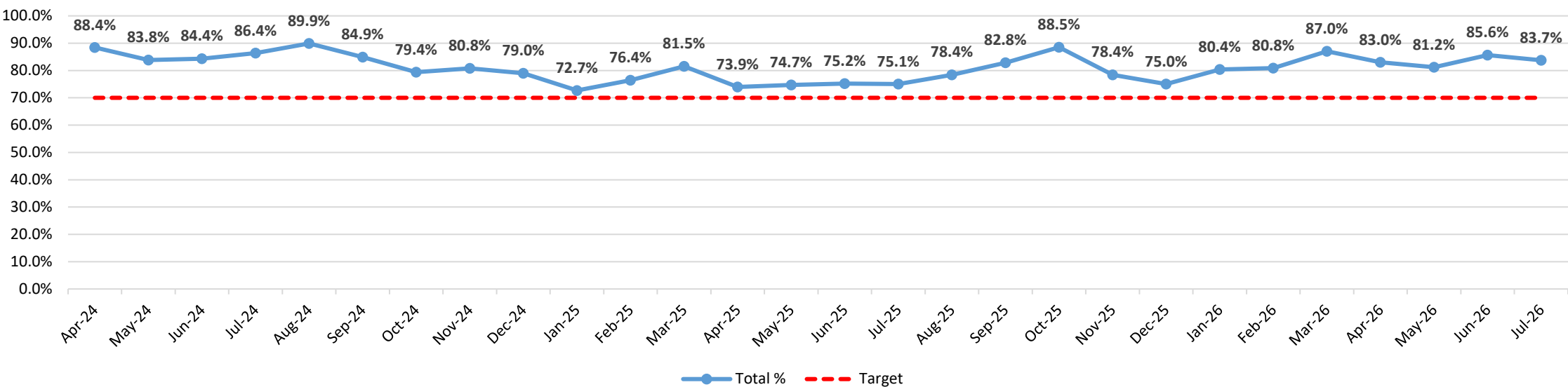
Analysis:

MSE reported at 74% and West reported at 55% in July, below target.

Virtual Ward Occupancy %



Urgent Community Response Team Two-Hour Performance



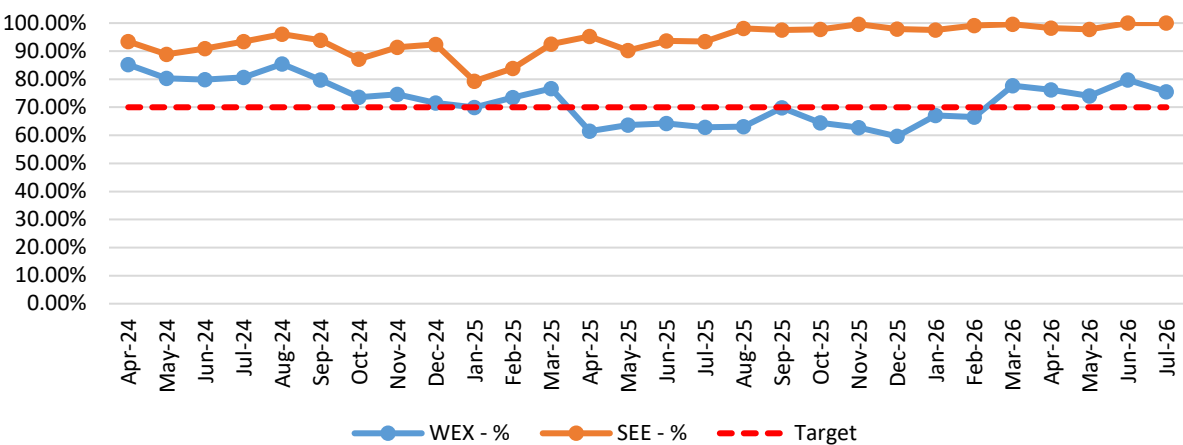
Analysis:

Performance remained above target in July, reporting at 83.7%. This includes West Essex and Mid & South Care Units.

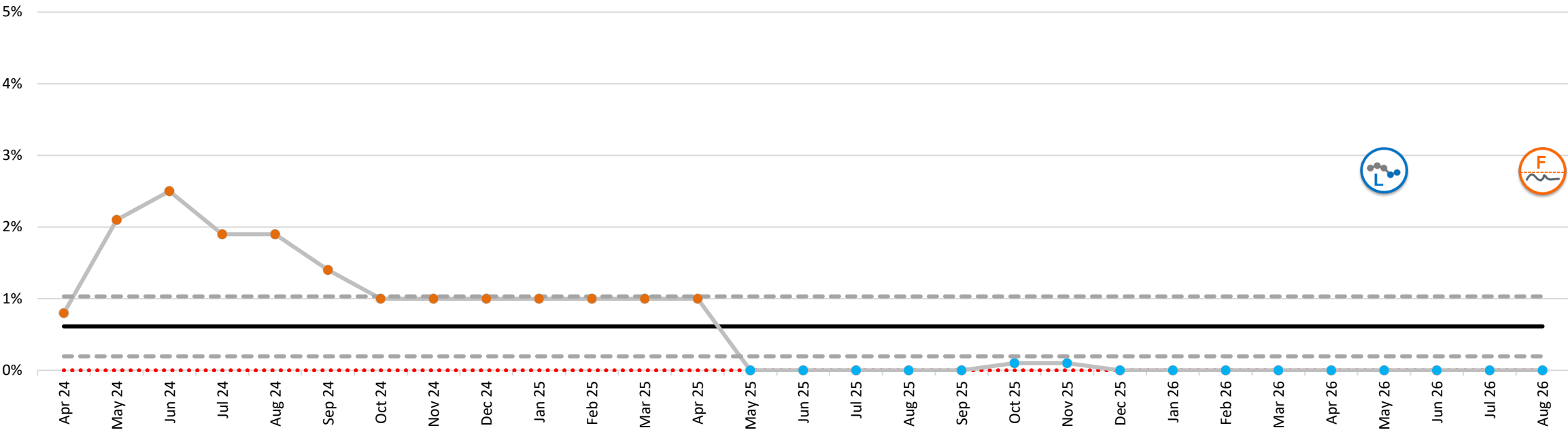
In the most recently published National Oversight Framework league tables (2025/26 Q4), EPUT is ranked 36th out of 38 for **Urgent Community Response 2-hour performance**. (2025/26 Q1 EPUT ranked 35th out of 37, Q2 EPUT ranked 36th out of 38 and 2025/26 Q3 EPUT ranked 37th out of 38).

Quality work is required as we are ranking low within NOF on this metric , however, performance has been above target consistently for 24 months.

UCRT 2 Hour Performance: SEE & WEX



Percentage of patients waiting over 52-weeks for community services



Analysis:

Performance remained on target in August at 0%. This has consistently been on target for 9 months and has remained below 1% for 16 months.

This data is inclusive of WEX and SEE waiting lists.

In the most recently published National Oversight Framework league tables (2025/26 Q4), EPUT is ranked 14th out of 42 for **Percentage of patients waiting over 52 weeks for community services**. (2025/26 Q1 EPUT ranked 1st out of 41, Q2 EPUT ranked 12th out of 41 and 2025/26 Q3 EPUT ranked 14th out of 41).



Analysis:
ALOS in South and West consistently achieve target month on month.

Polarity

High is Good

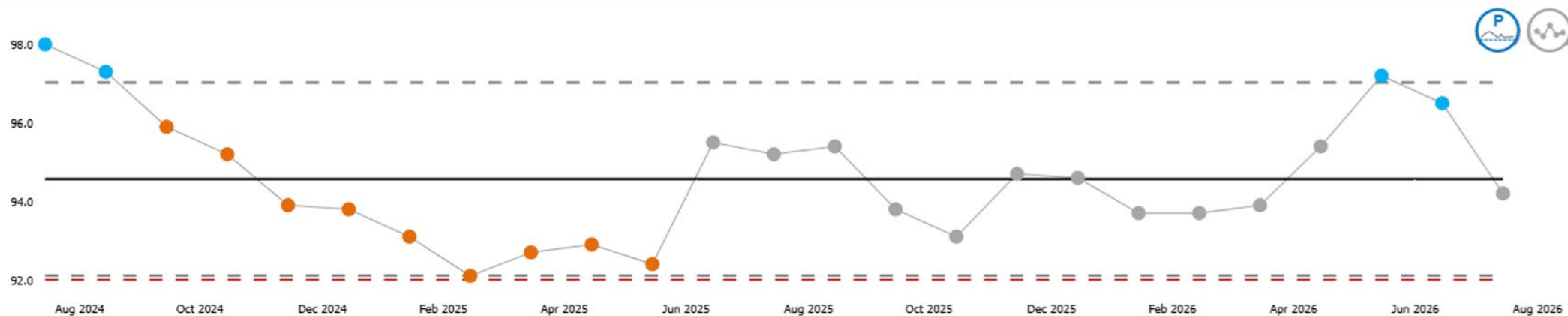
Target
>92.0%

Performance
94.20%

Target achieved?
Yes

RAG status

12-month trend

[View indicator breakdown](#)

Analysis:

18 Weeks referral to treatment remains consistently above target for WEX & SEE.

Polarity

High is Good

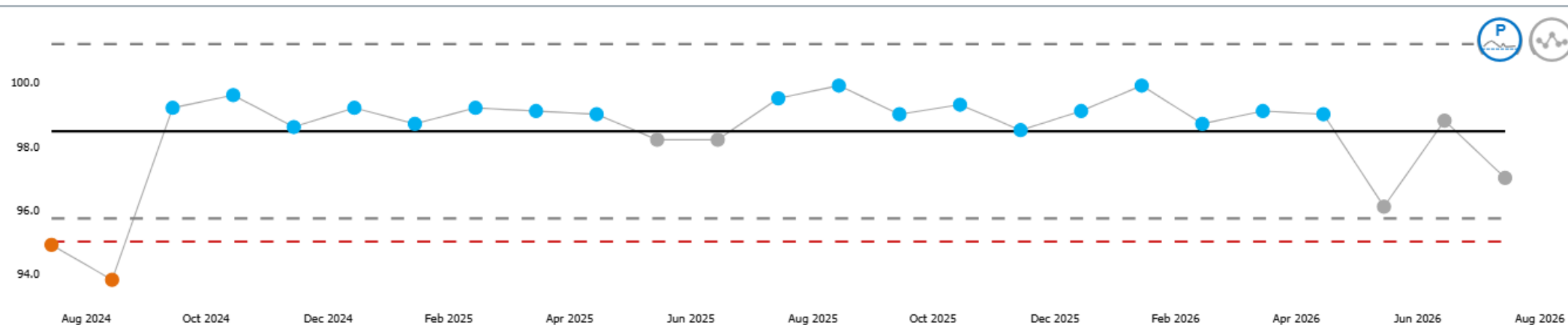
Target
>95.0%

Performance
97.00%

Target achieved?
Yes

RAG status

12-month trend
↓

[View indicator breakdown](#)

Analysis:

New commissioner KPIs have been agreed for CHS West reporting from April 2026.

There are a total of 45 metrics being tracked with a target threshold.

Overall performance for July is **89%** (40/45).

Service	Quality requirement/ Indicator	Threshold	Method of measurement	Frequency	Team	Breakdown	APR	MAY	JUN	JUL
UCR	Percentage of UCR responses within 2 hours	70%	UEC performance dashboard	Monthly		% within 2hrs	76%	74%	80%	76%
	Percentage of UCR cases subsequently conveyed to ED	Pending national guidance	To be defined between provider and commissioner			% to ED	9%	11%	8%	9%
Community Inpatient Beds	Community care beds – average occupancy. To also include occupied and available bed days and activity	85%	Average occupancy of patients in bed, Average beds available, occupied per ward	Monthly	Beech - Stroke	Percentage occupied	89%	89%	68%	89%
					Beech - Intermediate	Percentage occupied	72%	67%	75%	89%
					Plane	Percentage occupied	90%	83%	82%	94%
					Poplar	Percentage occupied	90%	83%	80%	88%
					Avocet	Percentage occupied	90%	80%	69%	92%
	Total for all wards	Percentage occupied	88%		82%	76%	91%			
	Average length of stay in Provider Community care beds for rehab patients excluding stroke and neuro	Maximum up to 19 days	Reported by ward		Beech		30	16	21	13
					Beech Intermediate		11	10	16	8
					Plane		28	17	13	13
					Poplar		6	5	7	7
Avocet					16	10	11	12		
Stroke Inpatient Beds	Percentage of appropriate patients who are assessed by a therapist and commence treatment within 24 hours of admission	85%	Numerator: Number of appropriate patients who are assessed and commence treatment within 24 hours of admission Total number of patients referred to the service from OT and Physio services	Monthly		% assessed within 24hrs	100%	100%	100%	86%
	Stroke average length of stay	Maximum up to 42 days	Number of patients who were discharged within the required LOS Total number of patients who were discharged			Stroke ALOS	41.5	23.7	44	
	Percentage of patients who have met 1 or more-person centred goals on discharge from inpatient	85%	Number of patients who were discharged with goals Target met Total number of patients who were discharged			% goals met	100%	50%	100%	100%
Early Supported Discharge (ICSS)	Number and percentage of applicable stroke patients who are offered or complete the 6 month review	95%	Stroke Dashboard	Quarterly		% 6mth review	100.0%	100.0%	100.0%	100.0%
	Percentage of patients who have met, 1 or more-person centred goals on discharge from Integrated Community Stroke Service (ICSS) LQR 129	85%	Numerator: Number of patients who have met 1 or more-person centred goals on discharge from ICSS Denominator: Total number of patients discharged from ICSS			% met goals	100%	93%	100%	100%
	Percentage of patients whose assessment and treatment is conducted within 1 working day of admission into the ESD service	90%	Numerator: Number of patients whose assessment and treatment is conducted within 1 working day of admission into the ESD service Denominator: Total number of appropriate patients	Monthly		% Assessed 1 day	TBC	TBC	18%	100%
Frailty/ Integrated Nursing and Therapy Service	Percentage of patients identified through Rockwood assessment as being moderate frail that have had a FREDA Assessment in Frailty at Home, Community Frailty and Bedded units.	70%	Numerator: Number of patients that have had a FREDA Assessment Denominator: Total number of patients identified through Rockwood assessment	Monthly		% pts with FREDA	Overall page 126 of 379			

Service	Quality requirement/ Indicator	Threshold	Method of measurement	Frequency	Team	Breakdown	APR	MAY	JUN	JUL
Integrated Nursing and Therapy Service	Percentage of Patients that are seen within the agreed timescales in the Integrated Nursing and Therapy Service	85%	District Nursing – Urgent 24-hour urgent response pathway	Monthly		% on time	51%	42%	51%	46%
			District Nursing Non-Urgent 48-hour response pathway			% on time	63%	58%	36%	55%
			Rehabilitation and Therapy – Urgent 2-week response pathway (Including Reablement)			% on time	48%	53%	52%	42%
			Rehabilitation and Therapy – Routine 3–6-week response pathway			% on time	55%	57%	62%	52%
			Domiciliary Phlebotomy Urgent response within 48 Hours			% on time	-	-	-	100%
			Domiciliary Phlebotomy service Routine response within 10 working days			% on time	48%	67%	43%	87%
Specialist Palliative Care/ End of Life Services/ Integrated Nursing and Therapy/ All services where applicable	Improved use of Advance Care Plans (ACP) (RESPECT in Hertfordshire PEACE in West Essex)	70%	Numerator: Number of patients who have an ACP Denominator: Number of patients on the End-of-Life Register	Quarterly		% with ACP	76%			
	Patients dying in their preferred place of death	70%	Number of patients achieving their preferred place of death through agreed read codes and data pathway	Quarterly		% achieving PPD	83%			
Care Coordination Centre	Urgent Referral Response (within 2 hours)	95%	Number of urgent referrals responded to within 30 mins, 1 hour, or 2 hours by service requested type / Total number of urgent referrals received	Monthly		% Urgent refs within 2hrs	100%	99%	92%	99%
	Same Day Referral Response	95%	· Number of same-day referrals responded to within 4hour or >4hours by service requested type/ Total number of same-day referrals · Referral to completed triage times - 15-30 mins for 2hr/4hr/same day referrals - 60 mins for all other non urgent refs.	Monthly		% Same day refs within 4hrs	99%	97%	98%	99%
	Routine Referral Response (within 48 hours)	95%	Number of routine referrals responded to within 1, 2, 3 or 3 days + by service requested type / Total number of routine referrals.	Monthly		% routine refs within 48hrs	100%	100%	99%	99%
	Referral Outcome	85%	Number of referrals accepted or declined with reason (by	Monthly		% accepted referrals	99%	99%	100%	100%
	Abandoned Calls	≤5%	Number of calls abandoned before being answered / Total	Monthly		% abandoned calls	3%	3%	2%	3%
Bladder and Bowel	Number of patients commencing treatment within 12 weeks of referral	95%	Provider activity submission	N/A		% within 12 weeks	100%	100%	98%	100%
Diabetes	Total % of patients referred routinely to be triaged within 5	95%	N/A	Monthly		% routine within 5 days	100%	100%	100%	96%
	% of patients with T1DM completing a structured education program within 12 months	50%		Quarterly		% complete Tier 1 within 12 mths	50%			
Heart Failure	The service provider will commence a patients care within: •Urgent patients will be contacted and assessed within 5-10 working days •Non-urgent patients will be contacted and assessed within 21 working days	90%	Monthly Performance Report	Monthly		% urgent within 10 days	100%	100%	100%	100%
						% non-urgent within 21 days	98%	99%	111%	97%

Service	Quality requirement/ Indicator	Threshold	Method of measurement	Frequency	Team	Breakdown	APR	MAY	JUN	JUL
Nutrition & Dietetics	Training sessions bi-annually run at Care Homes cover food-	75%	Community Performance Reporting	Monthly		% care homes trained	TBC	95%	95%	97%
	Routine referral response (within 8 weeks)	90%	Community Performance Reporting			% Routine within 8wks	100%	100%	100%	90%
	Measurable treatment goal(s) are identified by/agreed with patient at initial appointment and progress towards identified goal(s) monitored at review appointments	Percentage of patients who between consultations have • progressed towards identified treatment goal(s) • achieved their identified treatment goal(s)	Community Performance Reporting							
						% achieved goals	98.90%	98.12%	97.29%	97.27%
Podiatry	% of routine podiatry referrals seen within 8 weeks	95%	N/A	Monthly		% Routine within 8wks	99%	100%	100%	91%
	% of urgent podiatry referrals seen within 1 working day					% Urgent within 1 day	100%	100%	100%	100%
Pulmonary Rehab	Waiting times: Eligible patients will be offered a PR Programme within the agreed timescales	• 90 days for Community Referred Patients • 4 weeks for patients post discharge for exacerbation of COPD	Number of patients referred and offered a PR programme within the agreed timescales	Quarterly		Offered PR programme within 90 days	76			
						Community referred pts	144			
						% within 90 days	53%			
						Offered PR programme within 4 weeks	0			
						Pts exacerbation COPD pts	9			
						% within 4 weeks	0%			
Respiratory	The service provider will commence a patients care within: 5 working days of receipt for a routine referral 2 working days of receipt for an urgent referral	90%	Monthly Performance Report	Monthly		% Routine within 5 days	100%	100%	100%	97%
						% urgent within 2 days	100%	-	100%	-
SLT	Tier 1a: Individuals at extremely high risk of	95%	N/A	Monthly		% Tier 1a within 5 days	100%	100%	100%	100%
	Tier 2: Individuals at high psychosocial risk due to newly					% Tier 2 within 8wks	100%	100%	100%	100%
	Tier 3 - 12 weeks					% Tier 3 within 12wks	100%	100%	100%	100%
Wheelchair	% of episodes of care completed 18 weeks	95%	Monthly Performance Report	Monthly		% Adult pts within 18wks	95%	97%	92%	99.4%
						% Child pts within 18wks	82%	100%	88%	100%
Orthotics	% of custom referrals seen within 18 weeks	95%	N/A	Monthly		% Custom within 18wks	100%	100%	100%	100%
	% of Initial assessments within 6 weeks					% Initial within 6wks	100%	100%	100%	100%

Service	Quality requirement/ Indicator	Threshold	Method of measurement	Frequency	Team	Breakdown	APR	MAY	JUN	JUL
Integrated Nursing and Therapy Service	Percentage of Patients that are seen within the agreed timescales in the Integrated Nursing and Therapy Service	85%	District Nursing – Urgent 24-hour urgent response pathway	Monthly		% on time	51%	42%	51%	46%
			District Nursing Non-Urgent 48-hour response pathway			% on time	63%	58%	36%	55%
			Rehabilitation and Therapy – Urgent 2-week response pathway (Including Reablement)			% on time	48%	53%	52%	42%
			Rehabilitation and Therapy – Routine 3–6-week response pathway			% on time	55%	57%	62%	52%
			Domiciliary Phlebotomy Urgent response within 48 Hours			% on time	-	-	-	100%
			Domiciliary Phlebotomy service Routine response within 10 working days			% on time	48%	67%	43%	87%

Analysis:

ICCT Therapy waiting times remain above the expected standard with 241 patients waiting and an average wait of 23 weeks. A recovery plan is in place, including prioritisation of routine referrals, a targeted care home backlog initiative and maximising available clinic capacity. Recruitment to an additional Band 5 Physiotherapist post is underway to provide further capacity. Current actions are expected to reduce waiting times to approximately 18-19 weeks by October, with a revised trajectory to be confirmed once the new postholder start date is agreed.



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Financial Performance

Month 5 – August 2026 (Appendix 2)



FY2627 – Month 5 Financial Results



FY2627 FINANCIAL RESULTS

Month 5 Results with strong cash and capital position



INCOME &
EXPENDITURE



EFFICIENCY



CAPITAL



CASH

MONTH 5
POSITION

£1.9m

Actual deficit



£1.7m

Adverse to plan

£2.4m

Actual



£1.8m

Adverse to plan

£1.6m

Actual



£0.4m

Adverse to plan

£25.9m

Cash



£9.4m

Better than plan

YTD M5
POSITION

£8.4m

Actual deficit



£4.5m

Adverse to plan

£9.8m

Actual



£5.9m

Adverse to plan

£4.7m

Spend



£1.4m

Underspend to plan

£25.9m

Cash



£9.4m

Better than plan

Commentary:

- The 'in month' actual deficit is £1.9m, £1.7m adverse to plan. The YTD actual deficit is £8.4m, £4.5m adverse to plan. The position includes £2.6m of Deficit Support Funding (DSF) relating to the annual DSF entitlement of £6.3m in FY2627. The YTD position is supported by £9.1m on non recurrent solutions including lockdown underspends. In month adverse variances are driven by demand for Out of Area Placements which accounts for £1.5m of the YTD overspend.
- M5 efficiency delivery is £2.4m, £1.8m adverse to plan. The YTD delivery is £9.8m £5.9m adverse YTD. TEG actions include a requirement for all areas to increase efficiency identification including preparation for FY2728.
- Cash balance is £25.9m, £9.4m above plan. This includes £2.7m of asset sale proceeds.
- YTD capital expenditure is £6.4m £0.4m adverse to plan. Capital spend is offset by a £1.8m benefit relating to disposal of two assets, net position of £4.7m.

EPUT Mid Year Review

Monday 07 September 2026

Agenda

CEO Introduction & Overview

Annual Plan

- Performance
- Quality & Safety
- People
- Finance

Winter

Risk, Issues & Mitigations

Other Key Matters

- Nova
- Lampard

Summary Overview

Escalation/Support Requests

CEO Introduction & Overview

Annual Plan Progress: Performance

Annual Plan Performance

ANNUAL PLANNING INDICATORS				Mar-26	Apr-26	May-26	Jun-26	Jul-26
				Month 12	Month 1	Month 2	Month 3	Month 4
MH Inpatients	Number of active inappropriate adult acute out of areas placements (OAPs) at the end of the reporting period	end of period position	Plan		46	51	51	50
			Actual	30	36	36	35	31
	Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds	3-month rolling mean	Plan		60	60	60	60
			Actual	48	48	56	56	61
	Average Length of Stay for Patients in Older Adult Acute Mental Health Beds	3-month rolling mean	Plan		90	90	90	90
			Actual	111	110	105	96	91
Perinatal	Number of women accessing Specialist Community Perinatal Mental Health Services rolling 12 month	12-month rolling	Plan		2,181	2,181	2,181	2,181
			Actual	2,272	2,284	2,231	2,276	2,298
Talking Therapies	% of patients that achieved reliable recovery after receiving at least 2 appointments, that meet caseness at the start of treatment.	in period activity	Plan		51%	51%	51%	51%
			Actual	52%	52%	52%	52%	52%
	% of patients that achieved reliable improvement after receiving at least 2 appointments.	in period activity	Plan		69%	69%	69%	69%
			Actual	72%	74%	72%	77%	71%
Community Health Services	Community waiting list over 52 weeks	end of period position	Plan		0	0	0	1
			Actual	1	0	1	0	0
	Number of people on waiting lists for CYP services who are waiting over 52 weeks	end of period position	Plan		0	0	0	1
			Actual	0	0	1	0	0
	Number of people on waiting lists for adult services who are waiting over 52 weeks	end of period position	Plan		0	0	0	0
			Actual	1	0	0	0	0
	Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less as a proportion of the entire waiting list	end of period position	Plan		92%	92%	91%	92%
			Actual	93%	92%	92%	92%	90%
	Percentage of people on waiting lists for Adult Community Services per system who are waiting 18 weeks or less as proportion of entire Adult waiting list	end of period position	Plan		97%	97%	97%	97%
			Actual	97%	97%	98%	98%	97%
	Percentage of people on waiting lists for CYP Community Services per system who are waiting 18 weeks or less as proportion of entire CYP waiting list	end of period position	Plan		78%	78%	78%	78%
			Actual	83%	78%	79%	75%	67%
	Urgent Community Response (UCR) referrals (CHS - number responded in 2hrs)	in period activity	Plan		809	775	812	745
			Actual	621	590	603	628	666
	Urgent Community Response (UCR) referrals (CHS - % responded in 2hrs)	in period activity	Target		70%	70%	70%	70%
			Actual	85%	83%	81%	86%	83%
	Virtual ward occupancy	end of period position	Plan		60%	70%	70%	71%
			Actual	52%	68%	61%	64%	83%

Strong Performance

- Mental health inpatient flow continues to improve, particularly through reductions in OAPs and significant reductions in older adult length of stay.
- Talking Therapies and Perinatal services continue to outperform plan.
- Adults (physical health)community waiting times continue to outperform plan.
- No 52 week waits for either adult or CYP services.
- UCRT 2 hour response.

Areas for Improvement and Actions

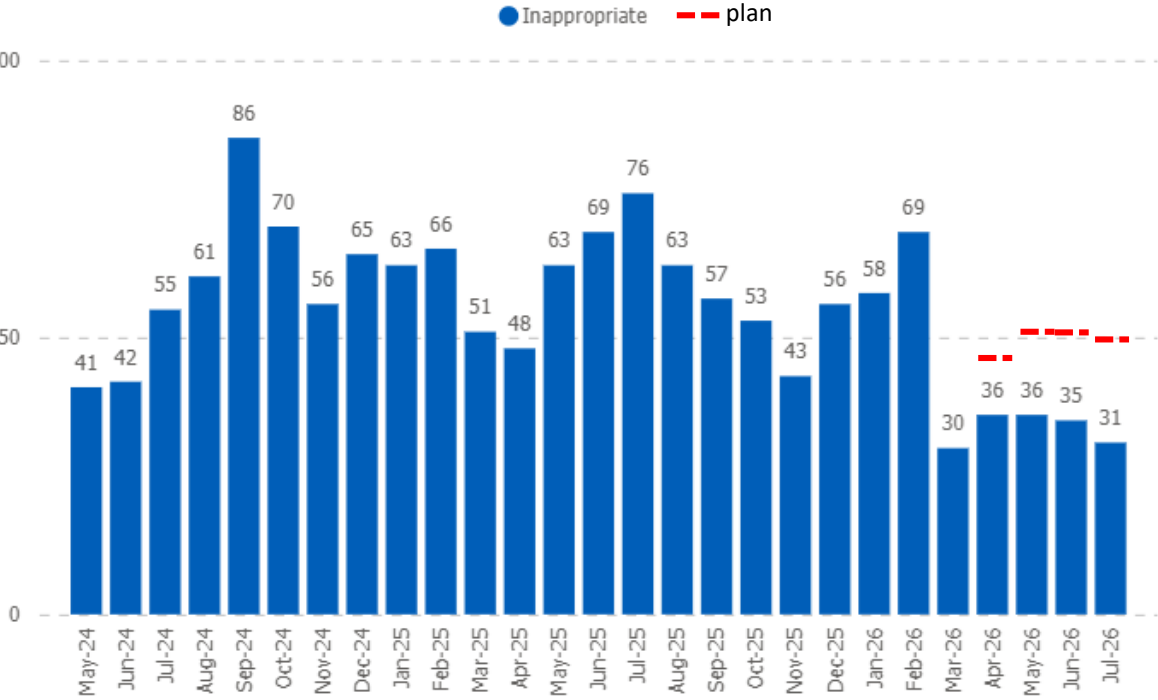
Area	Action
CYP waiting times (SE Essex physical community services)	Deep dive with NHSE undertaken into ASD/ADHD services. Recommendations being shared with ICB and EPUT
UCRT activity volumes	SE Essex is off plan. A system-wide improvement programme has been initiated focused on increasing appropriate referrals, improving visibility of UCR activity identified in other community services, strengthening pathway integration and supporting delivery of national referral ambitions. Progress is being overseen by a newly established MSECC UCRT Programme Steering Group

Inappropriate Out of Area Patients

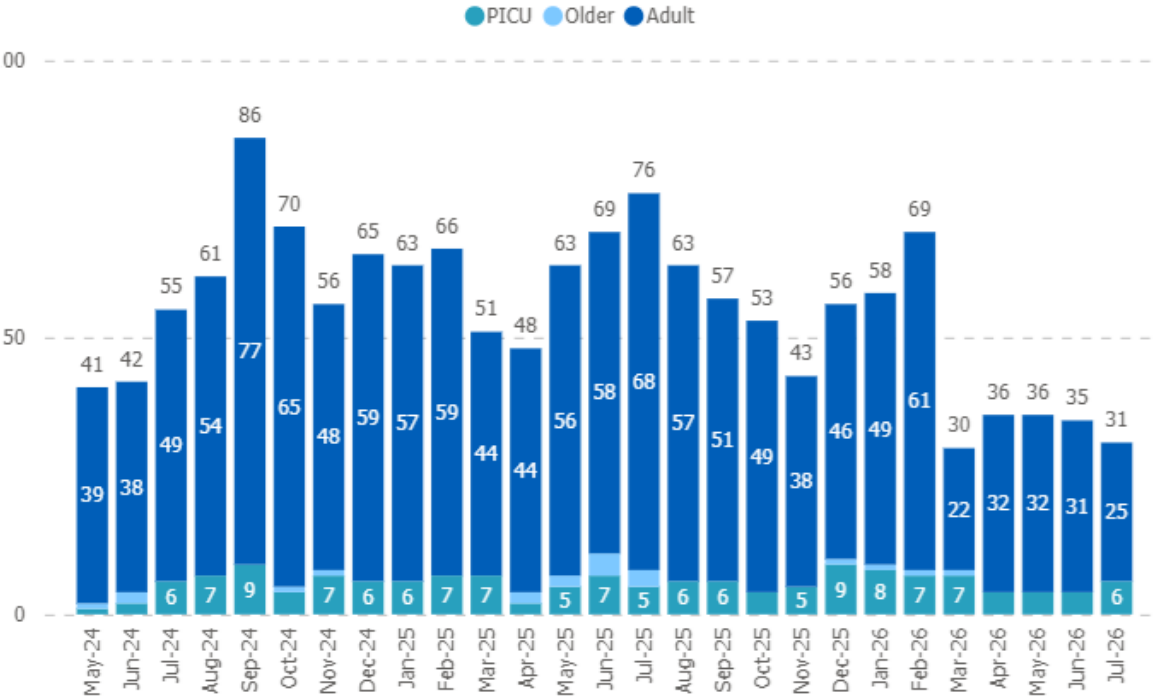
Inappropriate Out of Area Patients (remaining at month end)

Status	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Inappropriate	86	70	56	65	63	66	51	48	63	69	76	63	57	53	43	56	58	69	30	36	36	35	31
Annual Planning Submission (Inappropriate Out of Area patients at month end)																				46	51	51	50

End of month placements by status



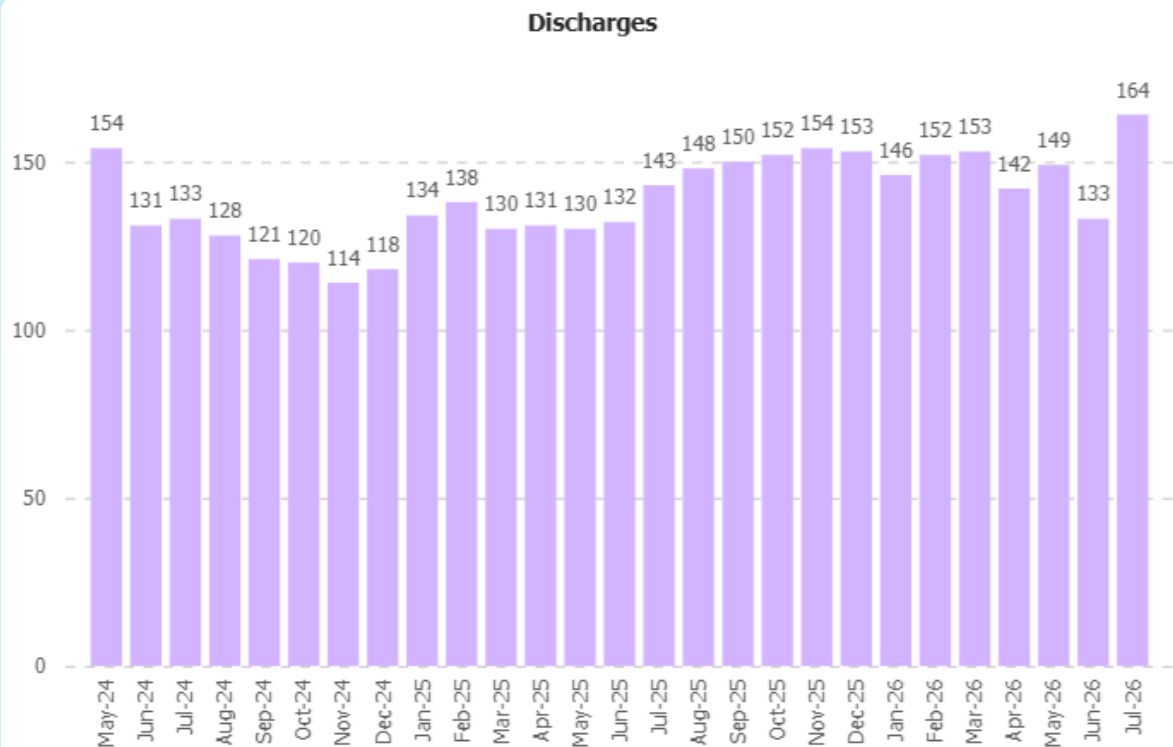
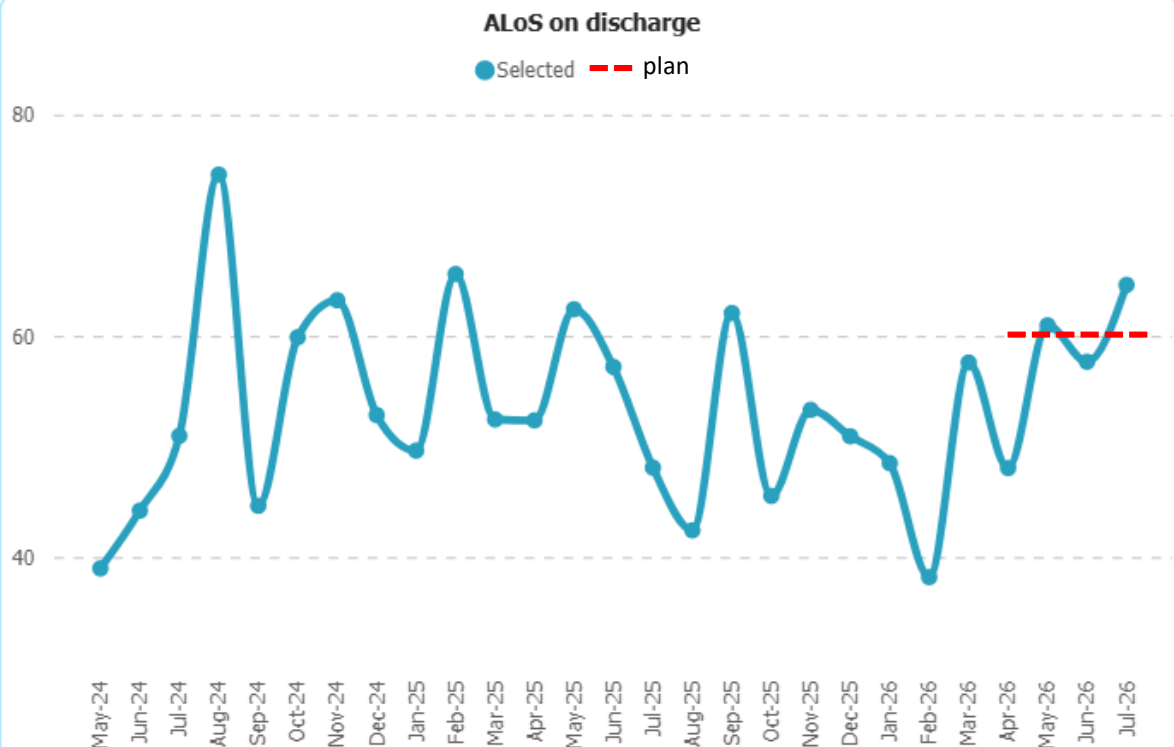
End of month placements by ward type



Adult and PICU ward average length of stay*

*Annual Planning ALOS was based on rolling 3 month average, the below charts are monthly actuals.

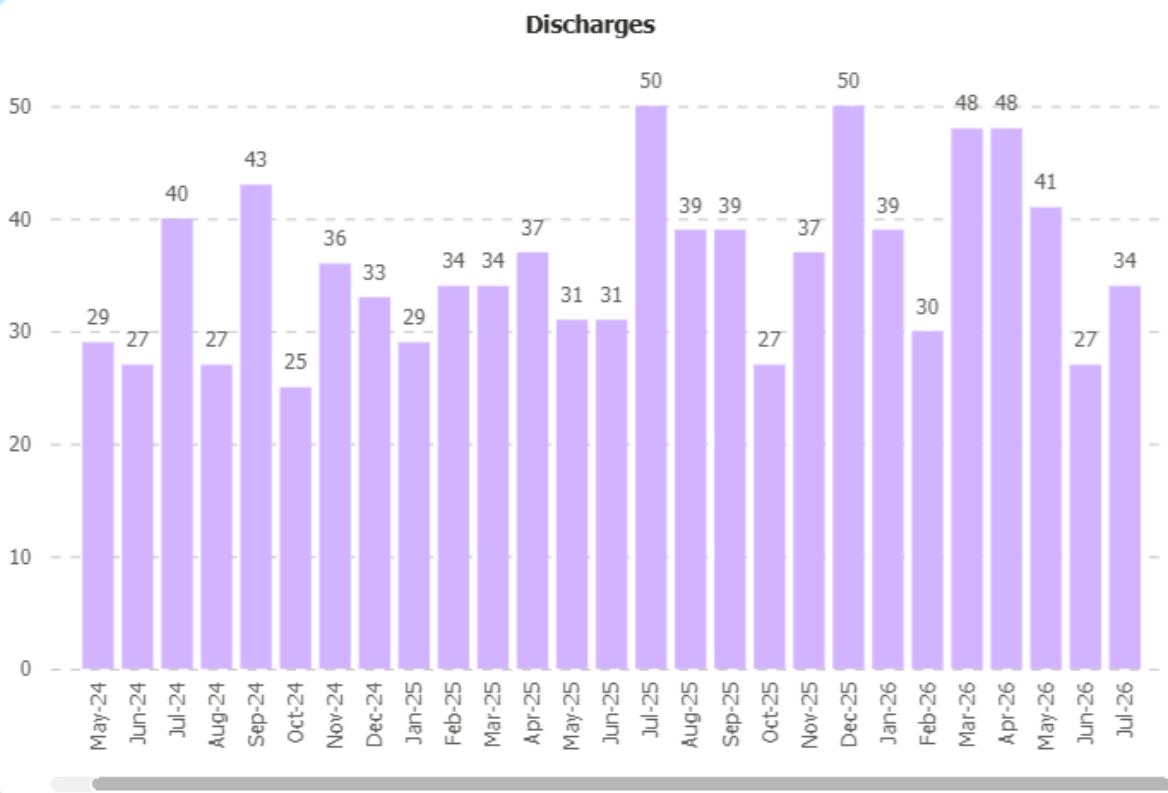
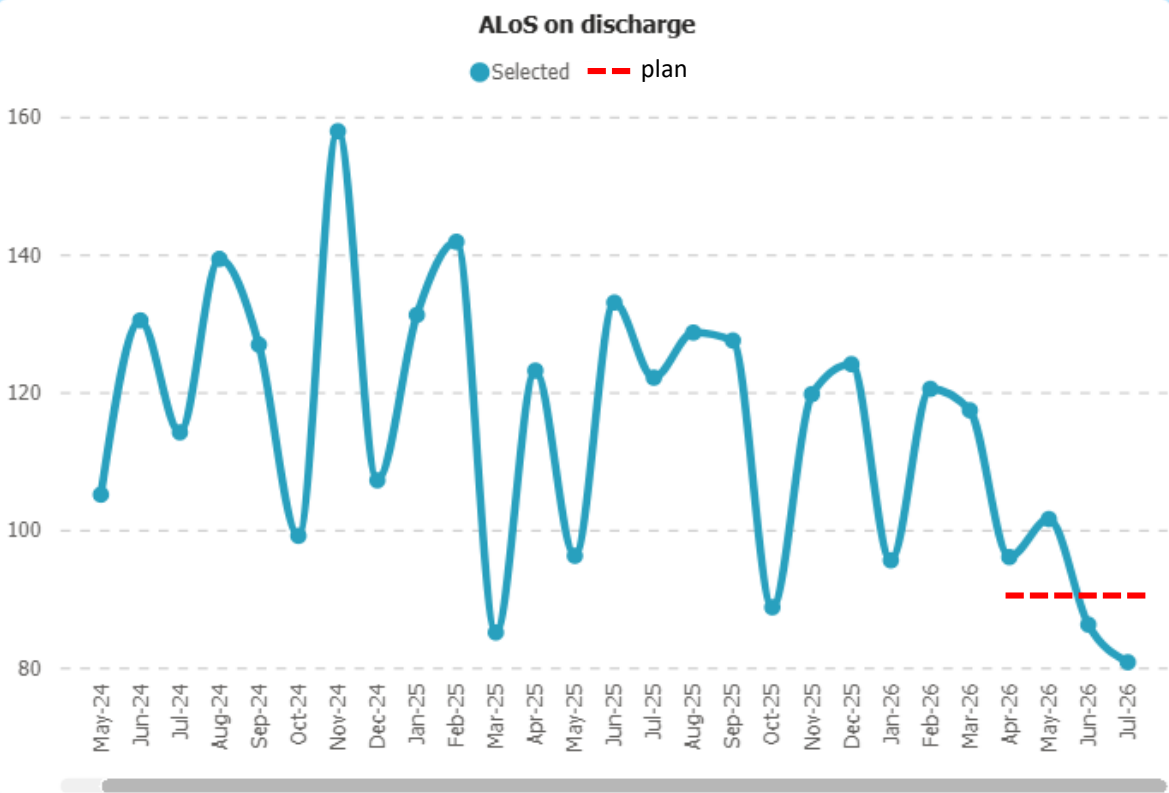
	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	
Discharges	120	114	118	134	138	130	131	130	132	143	148	150	152	154	153	146	152	153	142	149	133	164	
ALoS (Selected)	59.87	63.22	52.84	49.62	65.59	52.44	52.35	62.40	57.19	48.08	42.41	62.06	45.52	53.31	50.92	48.49	38.18	57.58	48.04	60.95	57.65	64.60	
Annual Planning Submission (Adult and PICU ward Average Length of Stay)																				60	60	60	60



Older Peoples ward average length of stay*

*Annual Planning ALOS was based on rolling 3 month average, the below charts are monthly actuals.

	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	
Discharges	25	36	33	29	34	34	37	31	31	50	39	39	27	37	50	39	30	48	48	41	27	34	
ALoS (Selected)	99.12	157.89	107.18	131.21	141.82	85.09	123.11	96.23	133.00	122.10	128.64	127.49	88.74	119.70	124.06	95.56	120.47	117.35	96.04	101.56	86.22	80.76	
Annual Planning Submission (Older Peoples ward Average Length of Stay)																				90	90	90	90



MH attendances and long waits in acute hospitals

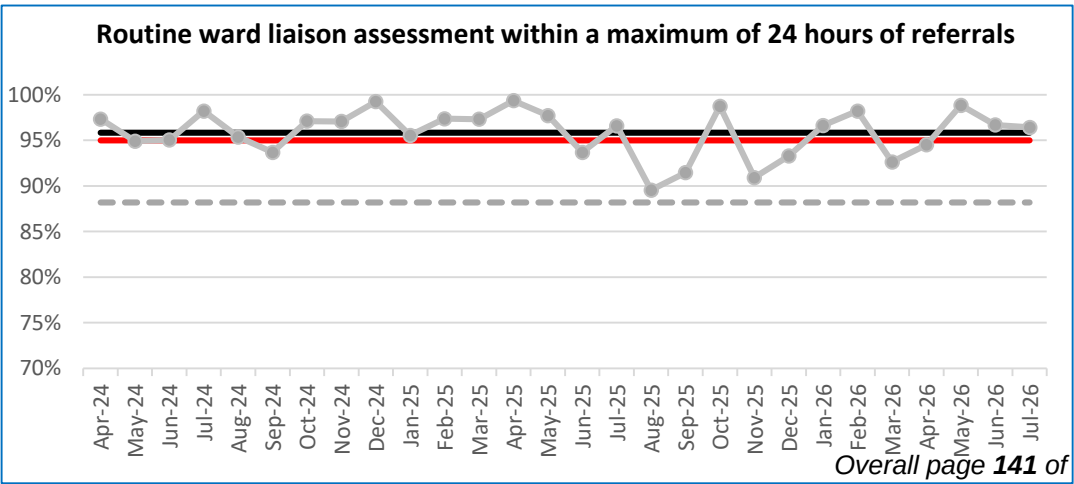
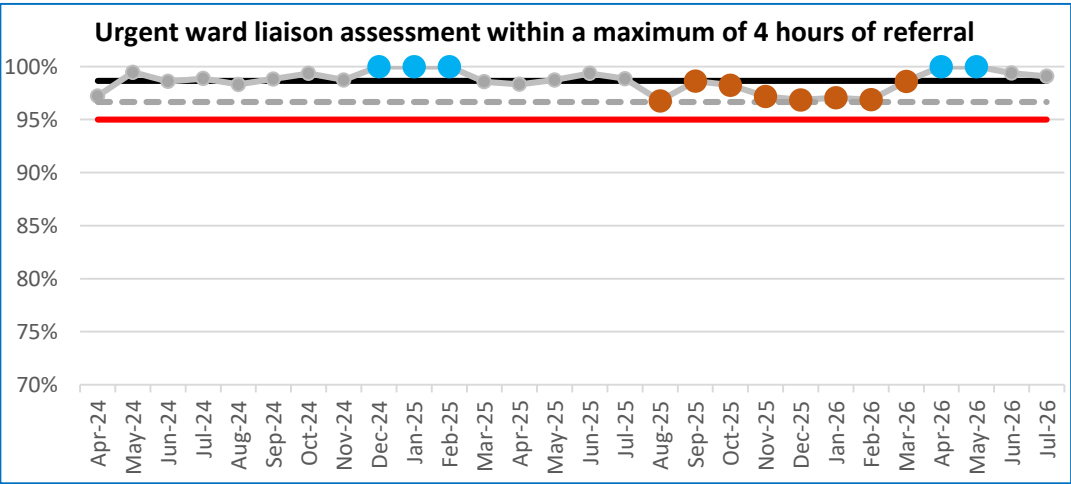
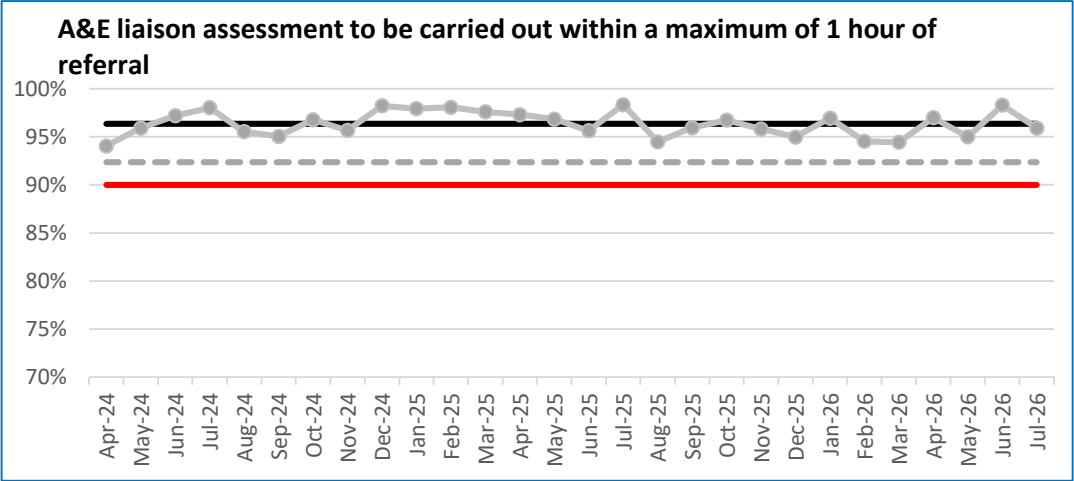
PERFORMANCE

The Trust-wide performance for July is:

- 1hr Response: 96% (target 90%)
- 4hr Response: 99% (target 95%)
- 24hr Response: 96% (target 95%)

West Essex 1hr performance had been impacted by vacancies, West also maintains their 4hr referrals performance following PAH approach to ward referrals impacting the team over night shift.

North Essex 24hr referrals performance has recovered following the consultant leaving, changeover of system use to EPIC whereby referrals were emailed, and data quality recording affected the performance reported. Recording of data has been addressed and consultant is now in post.



MH attendances in acute hospitals

PERFORMANCE

MH Liaison	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
A&E 1 hour referrals																
MSE	239	255	284	268	255	238	264	262	265	256	232	298	262	282	282	305
NEE	158	141	163	161	149	127	104	109	108	118	122	131	153	168	136	155
WEX	49	48	56	54	49	55	61	59	46	52	50	74	39	76	50	55
Total	446	444	503	483	453	420	429	430	419	426	404	503	454	526	468	515
Urgent ward 4 hour referrals																
MSE	107	134	118	146	131	115	145	121	130	117	102	126	141	113	125	165
NEE	7	12	14	9	6	12	11	4	12	6	13	8	3	5	14	28
WEX	6	12	23	20	18	19	15	17	17	13	13	10	8	20	23	24
Total	120	158	155	175	155	146	171	142	159	136	128	144	152	138	162	217
Routine ward 24 hour referrals																
MSE	113	134	142	133	111	100	97	122	87	113	98	128	94	111	119	133
NEE	38	37	59	66	82	54	48	52	48	55	53	56	62	53	54	55
WEX	3	5	5	7	8	10	13	13	14	10	17	6	8	10	8	8
Total	154	176	206	206	201	164	158	187	149	178	168	190	164	174	181	196

CB4C Pilot

Mid-Point Evidence and Evaluation Pack

Reporting period: 13–30 July 2026 (first three weeks of pilot)

Prepared for: WEHCP HCP stakeholders

Executive Summary

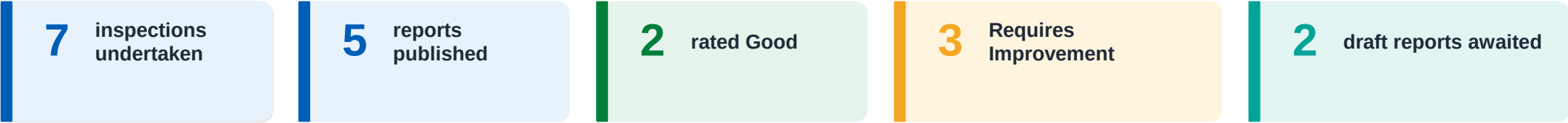
The UEC enhanced Call Before Convey (CB4C) pilot launched on 13th July 2026, embedding a joint decision-making Multidisciplinary Team (MDT), senior HatH/CATU clinician, UCR/HatH senior clinician, EEAST senior paramedic, and PAH ED/OPAL consultant, into ambulance conveyance decisions. The pilot's MDT operates Monday to Friday. This pack sets out the evidence from the pilot's first three working weeks (13–30 July, 14 working days) alongside corroborating data from Hospital at Home (HatH), the Community Assessment and Treatment Unit (CATU), and qualitative in-reach reflections from MADE week.

+135% CB4C referral volume vs pre-pilot baseline (working days)	98.8% CB4C acceptance rate (pilot period)	+74–80% HatH prevention-of-admission activity uplift, July vs Apr-Jun avg.	29 CATU admissions since pilot launch (13 Jul)
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Annual Plan Progress: Quality and Safety

Quality: CQC activity

Overall position: with the exception of the MH Rehabilitation Unit, the Trust continues to maintain or improve its position.



PUBLISHED OUTCOMES



REPORTS AWAITED

Information gathering phase following onsite inspections

MH Long Stay / Rehabilitation (June '26)

Repeat inspection associated with S29A notice

Inpatient MH Adult and PICU (July '26)

KEY QUALITY FOCUS

Ardleigh Ward, The Lakes, Colchester

Improvement remains fragile

Patients continue to experience long waits for alternative care settings

Constant dialogue with ICB and local authority colleagues

ASSURANCE AND OVERSIGHT

Substantial assurance

Internal audit opinion

Defined SOP for management and oversight of CQC improvement actions

ICB quality leads review evidence before actions are closed

Bi-monthly oversight by Board Quality Committee, with SitRep reporting to the Board of Directors

Quality: Well Led: Requires Improvement

Well led report published by CQC following the Trust's Well-Led inspection in March.

We welcome the feedback as an opportunity to recognise ongoing improvement priorities and the positive changes already made.

How we are using the report

- Feedback is being used to recognise progress and sharpen improvement priorities.
- Board-level reflection has involved senior clinical, operational and executive leaders.
- The central focus remains patient care, our people and the experience of our services.
- Formal action plan response to CQC

Improvements already under way

- Ward care has been redesigned with patients.
- Investment in mental health urgent care centres continues, with two more operationalising shortly.
- Community mental health services are under review to strengthen care at home.
- Partners are developing a first-of-type shared Electronic Patient Record across community, mental health and acute services.

Further improvement required

- Culture, including how we listen and respond when people speak up.
- Leadership, oversight and consistency of organisational learning.
- Faster, more consistent sharing of learning from incidents and action in response.
- The experience of some staff groups, ensuring everyone feels valued, included and supported.
- Investment in quality management system to support some of our response

Positives: Collegiate board, valued system partner, good financial management , ambitious and innovative plans for culture and EPR.

Annual Plan Progress: People

M4 Position: 199 WTE above Plan

PWR Submission	Month 1	Month 2	Month 3	Month 4
	WTE	WTE	WTE	WTE
Total Non Medical Clinical Substantive Staff	4765.06	4775.71	4796.22	4,800.65
Total Non Medical Non Clinical Substantive Staff	1292.46	1300.91	1304.11	1,292.18
Total Medical and Dental Substantive Staff	312.86	312.55	314.95	317.43
Total Other staff	7	7	6	6
Total WTE Substantive Staff	6377.38	6396.17	6421.28	6416.26
Planned WTE Substantive Staff	6419.34	6407.34	6395.34	6383.34
Bank Staff	852.21	868.72	838.67	869.28
Agency Staff (including, agency and contract)	66.31	62.74	75.15	62.51
Total Temp Staff	918.52	931.46	913.82	931.79
Planned WTE Temp Staff	766	766	766	766
Total WTE all Staff	7295.9	7327.63	7335.1	7348.05
Planned WTE all Staff	7185.34	7173.34	7161.34	7149.34
Difference WTE	103.56	154.29	173.76	198.71
Difference planned and actual %	1% over	2% over	2% over	3% over

Workforce Actions & Cost Controls

Substantive Workforce Actions

- Targeted reduction in medical vacancies, with a particular focus on consultant recruitment and vacancy management to reduce medical agency reliance to be delivered by end Q3.
- Enhanced controls for admin roles in place from month 4 in addition to current controls for all other roles.
- Implementation of MARS during 2026/27 with 20 wte reduction through M5 & M6.

Temporary Staff Actions

- Safer staffing stage one (July) and Stage 2 (November) – additional circa 100wte HCA and Registered nursing staff with proportionate reduction in temporary staff.
- Focused work on observation levels based on outcomes from other NHS Trusts demonstrating reductions in temporary staff.
- Staged reduction targets for temporary staff for both care units and corporate areas from Month 4.

Trajectory

- Substantive workforce stands at 32.92 WTE above plan. The above performance levels are aligned to safer staffing stage one establishment uplifts of 47 WTE of which 33.85 WTE have commenced in post since M1. Phase 2 recruitment commences in M5 with forecasted substantive uplift of 38 WTE delivered by M8 and temporary staffing reduction of 45 WTE by Month 9.
- Temporary staffing trajectory for Month 5 is currently tracking approximately 20 WTE above M4 position, primarily driven by increased patient acuity, sickness absence and annual leave cover. Enhanced oversight meetings are being convened to support the implementation of targeted measures and recovery actions to bring staffing levels back in line with the planned trajectory

Annual Plan Progress: Finance

FY2627: Month 4 Financial Results



FY2627 FINANCIAL RESULTS

Month 4 Results with strong cash and capital position



**INCOME &
EXPENDITURE**

£1.0m

Actual deficit



£1.3m

Adverse to plan

£6.5m

Actual deficit



£2.9m

Adverse to plan



EFFICIENCY

£1.9m

Actual



£2.4m

Adverse to plan

£7.4m

Actual



£4.1m

Adverse to plan



CAPITAL

£0.8m

Credit



£1.5m

Underspend to plan

£3.1m

Spend



£1.8m

Underspend to plan



CASH

£24.5m

Cash



£7.4m

Better than plan

£24.5m

Cash



£7.4m

Better than plan

Commentary:

- The 'in month' actual deficit is £1.0m, £1.3m adverse to plan. The YTD actual deficit is £6.5m, £2.9m adverse to plan. YTD position includes £2.1m of Deficit Support Funding (DSF) relating to the annual DSF entitlement of £6.3m in FY2627. YTD position supported by £6.9m on non recurrent solutions including lockdown underspends.
- Overspends in MH Inpatient Services (Demand led) and Medical, including out of area placements
- The Trust is continuing to forecast a break-even position.
- The efficiency programme is £2.4m adverse to plan in Month 4 and £4.1m adverse YTD. A pipeline of schemes are currently flowing through Quality Impact Assessment to move into delivery.
- The Inquiry costs incurred YTD are £2.3m YTD
- Cash balances are £7.4m above plan. This includes £2.7m of asset sale proceeds.
- YTD gross capital expenditure is £4.9m consistent to plan. Capital spend is offset by a £1.8m benefit relating to disposal of two assets. The YTD capital plan is £1.8m

01

Financial Recovery

Established and Active

- Overspends in MH Inpatient Services (Demand led) and Medical, including out of area placements. Gross overspends in these areas total £6.1m. These are offset by £3.2m of underspends in other Care Units and Corporate areas. Trust wide overspend £2.9m
- Inpatient Services placed in Internal Financial Recovery. Additional Financial controls, scrutiny and oversight in place.
- Financial literacy training to be rolled out to all staff with financial responsibilities, to support increased understanding, accountability and responsibility.
- Finance Committee oversight and efficiency deep dives.
- Exec led Transformation and Efficiency Group (TEG). Group meets every two weeks with mandated Care unit and corporate representation. Pay and Non pay Controls remaining supplemented by Accountability Meetings.

02

Risks and Mitigations

Active delivery and assurance

Key Risks

- Inquiry impact – Direct and Indirect
- Unknown Financial Risk associated with nurse revalidation exercise
- Cost of change
- Unfunded Services
- Recovery of Efficiency Programme

Mitigations

- Flow working group linked to acceleration of unification and interventions (x6) to reduce Out Of Area Placements
- Asset disposal – Profit on Sale
- Recovery of workforce plan – targeted Medical recruitment to address agency.
- National support Inquiry costs
- MHIS Retention and Growth recovery opportunities
- Resolution of NHSPS Dispute

03

Capital Investment

- MH Emergency Diversion Units – Harlow and Colchester – Construction Completed
- Landermere Neighbourhood MH Hub business case submitted to NHSE
- Backlog Maintenance and Estates safety priority schemes underway
- Nova Programme ongoing
- Asset disposal – two completed and a further eight properties being actively marketed
- Application to NHSE/DHSC move CDEL credit from disposals to FY27/28 in progress

Winter Plan

AIM: A single, coordinated Trust-wide plan with clear executive ownership and multidisciplinary input

How the plan is being developed



Governance and accountability

EXECUTIVE OVERSIGHT

Elizabeth Wells
Interim Executive Chief Operating Officer

BOARD ASSURANCE

- Finance and Performance , Quality Committee and Board reviewed and signed off approach during late August/Early September
- Final review by Finance and Performance Committee with delegated sign off from Trust Board on 24th September ahead of submission by 30th September

CURRENT POSITION/NEXT STEPS

- Working draft shared with ICB to inform ICB planning.
- Local winter planning assurance workshop planned 23rd Sept alongside Essex wide workshop on 25th Sept

Winter 2026/27: Flu Vaccinations

Aim

As part of the Trust's organisational winter plan which is due by the end of August 26, there is a requirement to include a staff flu vaccination programme ready to launch when vaccines become available, and provide confirmation that preparatory actions under way

Priority 1

Agree approaches to increase uptake by 16%+ on 25/26 uptake- >45% of frontline eligible staff.

Learning from 25/26 uptake

- In July we launched a short, anonymous survey to ask staff their preferences for if and how they would want to have their flu vaccination.
- So far we have had just over 370 responses (7% of target eligible staff):
- 83% of staff who responded saying they will take up the offer of a flu vaccination this winter.
- 51% would prefer a peer vaccination clinic at their workplace or close by.
- 33% prefer a voucher to take to a community pharmacy chain.
- Just under 12% prefer to attend their GP surgery when invited, and the remainder do not intend to have a flu jab.
- 25/26 actual 1820 vaccinated was split by 58% Gp/pharmacy and 42% trust clinic/peer.
- These figures have guided decision making.

Priority 2

Ensure robust plans and resources are approved and implemented.

Planning

- Planning for this winter's staff flu vaccination programme is underway, weekly meetings commenced in June 26 with action log, owners and emerging risks and escalation recorded.
- Local care unit leaders have key roles in organising clinics to best suit the needs of their staff, recognising a mix of community and inpatient teams trust wide and a large eligible cohort of circa 5700 staff in patient facing roles.
- Corporate vaccinators prioritisation, along with local managers will be supporting peer vaccinators to allocate time to facilitating the clinics within their shift patterns and around their day to day job commitments and back fill requirements if clinical staff cannot provide both peer vaccination and role concurrently.
- Peer vaccination training under review to ensure comparable approach to other regional organisations.
- Pharmacy review and medicines management sign off of group directions in accordance with national publication.
- Group agreement for 3 routes confirmed as **Clinics** (care unit geography), **inpatient roving peer vaccinators** (all wards), **vouchers** Prioritising community staff who are unable to easily access clinic locations.
- Additional opportunities include: Alignment to corporate induction and other face to face training opportunities- lunchtime "flu crew" , partner trust offer (west Essex specifically)
- Pharmacy ordering complete, scoping voucher companies to best meet trust needs
- Finalising communication strategy , resources, executive paper for sign off and training programme for RAVS, cold chain and vaccination.

Priority 3

Ensure accurate reporting and oversight methods both internally and externally.

Reporting methods

- Performance lead to ensure RAVs recording enables accurate upload to support national oversight.
- ESR team provision of care unit slits of eligible frontline staff., to ensure baseline for trajectory oversight and accountability reporting
- Workforce monitoring of sickness data to highlight absence for flu reason to support reporting
- IPC team reporting on nosocomial flu infection involving staff in the work place
- Budget oversight reporting once budget confirmed to ensure cost efficiencies against 25/26 spend.
- National oversight Quality dashboard currently reports EPUT total in both mental health and community tabs- to explore this with regional quality leads.
- Explore with national team RAVS reporting of staff who are eligible for both Flu and Covid how these are captured through GP submission.

Governance route

Weekly flu planning and management meeting chaired by director of Nursing /DIPC reporting fortnightly to Executive Group meeting between October and January.

Care unit accountability monthly reporting trajectory against success measures and report escalations and mitigations.

Bimonthly reporting into EPUT People committee

Reporting into the Winter planning system governance routes from the internal governance data.

Success measures

Increase uptake by at least 16% on 25/26 = 29%-45%. Circa 5700 eligible staff increase from 1820 to at least 2565.

Frontline sickness rates do not exceed seasonal sickness targets related to Flu reasons logged.

Nosocomial Flu outbreaks with staff involvement are lower or equal to 25/26.

Cost efficiencies on programme spend of 10% on 25/26 costs.

Mental health Emergency Department Diversions

To support and ensure the delivery of the operational model of the two mental health Emergency Department Diversion units being created. One in North Essex — Emerald Centre — and the other in West Essex — Derwent Centre. The diversion units will be fit-for-purpose alternatives to Acute Emergency Departments (ED) for mental health patients in crisis without

Routes into Urgent Care:

Phase Zero: NHS 111/Primary Care – early identification and direct referral
Phase One: Ambulance and Police – alternative destination to ED
Rapid streaming from minor injuries and UCD.

ED Diversion Response:

Clinical triage and formulation, calm accessible and non-ED environment, safety plan and brief intervention, warm hand over to crisis teams, third sector and primary care and drug and alcohol workers.

Winter System Impact:

Fewer avoidable ED attendances – ED capacity protected for acute physical illness and injury
Reduced waits and crowding – less pressure on cubicles, more appropriate space for mental health review, reduction in high flow through waiting areas.
Improved ambulance flow – reduced conveyance and hand overs.
Fewer escalations and admissions – earlier support reduces repeat attendance and crisis deterioration.

Risks and Issues

11 Strategic risks

6 Corporate Risks

- EPUT operates an integrated, Board-led risk management framework in which strategic and corporate risks are owned by Executive Directors, monitored through Board committees, and reported through the Board Assurance Framework.
- The approach combines risk scoring, defined controls, independent assurance and action-based mitigation plans to provide oversight of risks to delivery of the Trust’s strategic objectives.
- Risks are routinely reviewed, escalated where necessary and supported by structured governance arrangements that provide assurance from service delivery teams through to Board level.

Strategic BAF Risks		
Risk ID	Strategic Risk Title	Score
SR3	Finance & Resources Infrastructure	15
SR4	Demand and Capacity	15
SR5	Statutory Public Inquiry	16
SR6	Cyber Security	15
SR7	Capital	20
SR8	Use of Resources	20
SR9	Digital and Data Strategy	15
SR10	Workforce Sustainability	12
SR11	Staff Retention	12
SR12	Organisational Development	16
SR13	Quality Governance	15

Corporate Risks		
Risk ID	Corporate Risk Title	Score
CRR11	Suicide Prevention	12
CRR2598	Nova Programme	16
CRR2599	ND Services, ADHD, MSE NE and West	16
CRR2600	Service demand exceeding capacity for ND services, Autism South & NE	16
CRR2659	Increasing Backlog Maintenance Requirements	16
CRR2660	Failure to maintain a safe, compliant and resilient estate due to insufficient Estates workforce capacity	16

New corporate risks added to the risk register:
 ND Services, ADHD, MSE NE and West
 Service demand exceeding capacity for ND services, Autism South
 Increasing Backlog Maintenance Requirements
 Failure to maintain a safe, compliant and resilient estate due to
 insufficient Estates workforce capacity

Quality & patient safety, and Suicide preventions risks
 currently under review.

Incident backlogs a specific area of focus

KEY RISK AREA	WHAT	MITIGATION
Demand	15 / 16 Demand and capacity is 15. ND and autism risks are both 16 due to referrals, backlogs, waits and limited capacity.	OOA business case, Reset Flow and community demand/capacity work; pathway, workforce, digital and commissioner actions for ND services.
Nova	16 Integration complexity, milestones, readiness, adoption and benefits realisation create a corporate risk rated 16.	Joint governance, independent assurance, readiness criteria, transformation plan and milestone monitoring. Test go-live and benefit protection.
Organisational development	16 Ineffective cultural development and change support may result in suboptimal outcomes for staff and patient care.	Cultural review, senior leadership programme, middle-manager development and absence plan. Test delivery and evidence of impact.
Capital and Use of Resource	20 Capital and use of resources are both rated 20. £5.6m YTD deficit, £1.5m adverse to plan; efficiency delivery £1.7m adverse YTD.	£43.1m efficiency plan overseen through TEG and the Accountability Framework. Test recovery trajectories for OOA, pay and schemes.
Estates	16 Two new risks at 16. £117m maintenance backlog and specialist workforce constraints create compliance, resilience, cost and safety exposure.	Stratified backlog review, prioritised capital, BCP and asset-data actions. Board decision on the Estates operating model and workforce option.

Other Key Matters

Both trusts remain committed to an integrated solution

Programme retains the June 2027 MSEFT and October 2027 EPUT go-live dates. Progress and controls have strengthened since the February Community /Mental health reset, but the programme requires intervention on reporting capability, primary care integration, Community /Mental health delivery and the release of operational resources to protect go-live.

EVIDENCED PROGRESS SINCE FEBRUARY RESET

Requirements / clinical validation complete	HIGH
Capability-led delivery model established	HIGH
Joint Community /Mental health prototype maturity reviews in place	HIGH
Enhanced design/build started in threshold-ready area	MEDIUM
PMO controls, planning and governance strengthened	MEDIUM

KEY MILESTONES



KEY ISSUES

Technical REPORTING

Current capability is not sufficient for the expected extraction and reporting approach.

IMPACT

Reported loss of 14 weeks' development time; Trial Load 2 assessed at critical risk; tactical and strategic solution still needs a single recommendation.

EXECUTIVE ACTION

Lock the tactical go-live reporting route, ETL/CDL plan, acceptance criteria, resources, cost and reconciliation evidence.

TPP / SYSTEMONE

No equivalent bidirectional tasking or live record link currently exists between Nova and SystmOne/EMIS.

IMPACT

JSB supports integration as the preferred option, but achievement depends on NHS England and TPP engagement; contingency remains necessary.

EXECUTIVE ACTION

Secure NHS England approval and supplier commitments; prove the staged GP Connect route and maintain clinically safe mitigations.

Community/Mental health DELIVERY

The reset improved control, but the current completion path and Gateway 3.1 trajectory remain provisional.

IMPACT

Design/build time is eroding; testing scope remains uncertain; workload exceeds confirmed capacity; planning layers require reconciliation.

EXECUTIVE ACTION

Approve one integrated recovery plan covering scope, throughput, capacity, design, data, build, FSV2 and test impact.

Summary

The pattern of Rule 9 requests has changed over time. Between October 2025 and February 2026, EPUT saw a significant increase in volume. From March 2026 onwards, volumes reduced but requests became more complex, often requiring detailed analysis across multiple services and evidence spanning 24 years. Seven Rule 9s received in June 2026 contained more than 400 main questions and over 1,000 points when sub-questions were included.

Responding to requests of this nature requires significant input from senior clinical, operational and corporate colleagues across EPUT. Input includes organisational memory, contributing to response development, information analysis, and sign-off. As an example, for the seven R9s received in June, we estimate that over 1,500 hours (200 plus days) of input were required from colleagues outside of the Programme Team.

There has also been a recent reduction in the original response window for complex Rule 9s. Between March and May 2026, the average period from receipt to original due date was 36 days; whereas for requests received in July and August, this reduced to 17.5 days.

Rule 9 requests represent only part of EPUT's response to the Inquiry. The Trust also provides Case Summaries and other direct information requests, many of which are comparable in scope, complexity and evidential requirements.

During 2026 to date, EPUT has responded to more than 120 of these additional requests, alongside its 238 Rule 9 responses.

Rule 9s received by colleagues directly from the Inquiry:

In addition to the Rule 9s received by EPUT, the Inquiry directly approaches individual staff members with Rule 9s for them to answer. These are increasingly the same colleagues who are supporting the corporate response to Rule 9s received by EPUT. Circa 60 such Rules 9s have been received.

Future hearings and timetable

The October hearings, commencing on 5 October 2026, has been refocused as an Interim Recommendations Hearing and will consider further evidence on Observations and the Use of Technology and Resuscitation, the two themes examined by the Chair in July.

The Inquiry has indicated that this will include evidence relating both to mental health care in Essex and, where appropriate, the wider national context, to inform consideration of any interim recommendations.

Known Hearing dates (the previous information on the Lampard Inquiry website has been changed to the following):

5 October – 22 October:

The Interim Recommendations Hearing

- Evidence in relation to Emergency Response and Resuscitation
- Evidence in relation to Observations and Use of Technology

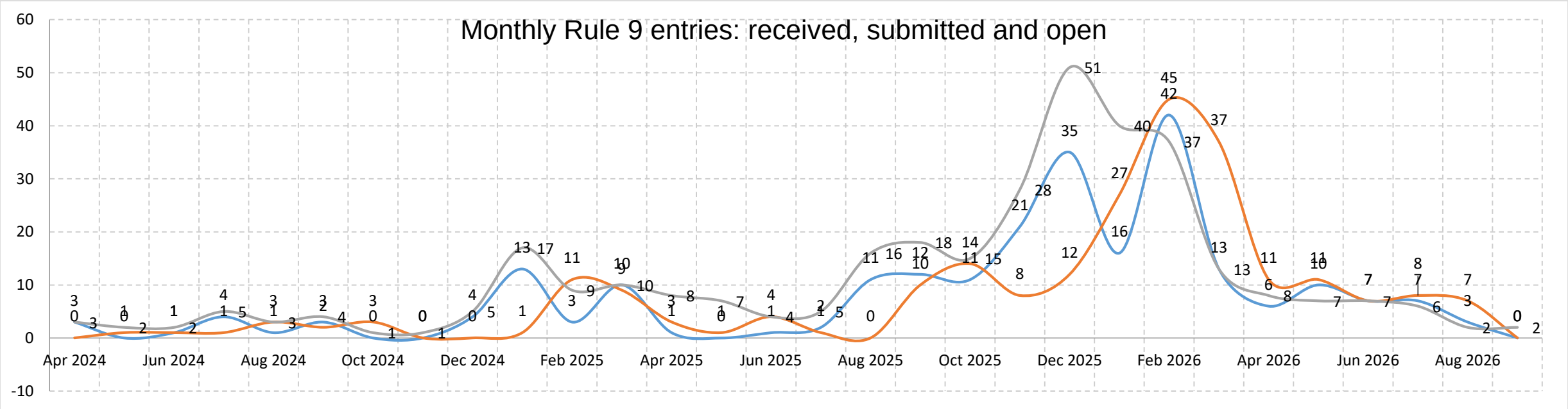
All of the following are listed as “Thematic Issues and Illustrative Cases tbc”

- 25 January – 11 February 2027
- 26 April – 13 May 2027
- 14 June – 1 July 2027

Informed by the January 2026 timetable, the following subjects are yet to be heard at Hearings:

- Admissions and assessments
- Co-occurring/Older Adult healthcare;
- Sexual Safety;
- Safeguarding.
- Environmental Risk;
- Regulation/CQC;
- Restraint;
- Medication;
- Police involvement.
- CAMHS;
- Neurodevelopmental;
- EUPD/BPD;
- Substance Misuse;
- Perinatal;
- Leave;
- Discharge.
- Info-sharing/record systems;
- Culture & Candour;
- Governance/Oversight & Accountability;

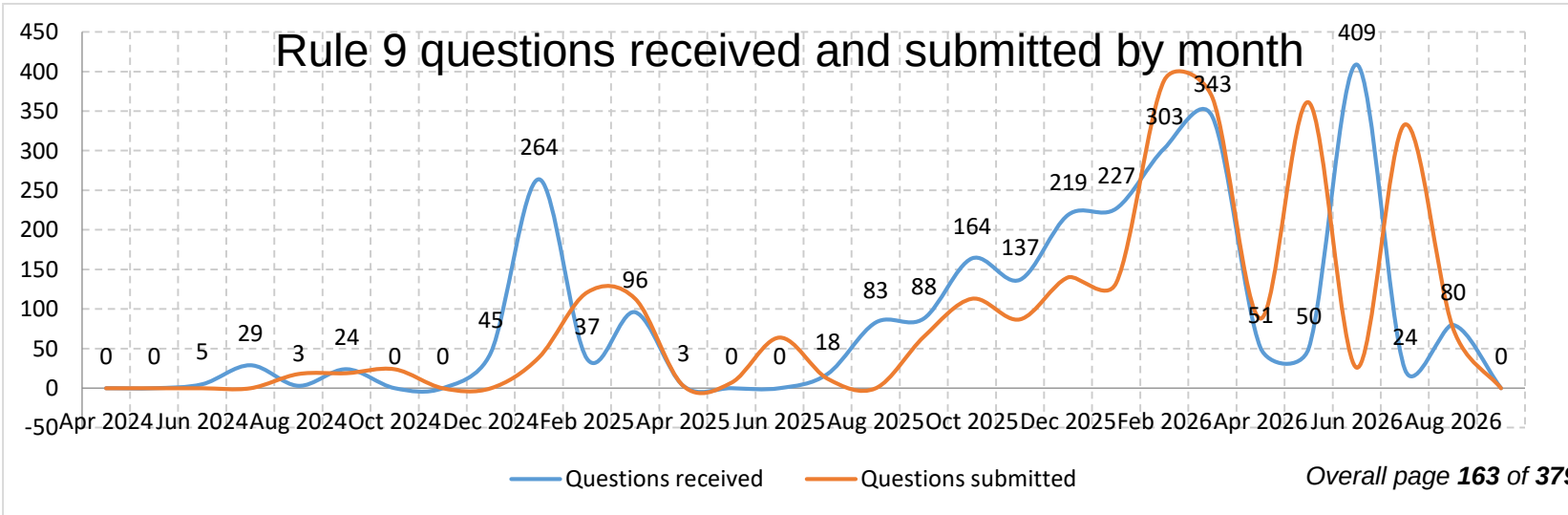
Lampard Inquiry : Numbers and Activity



Numbers and activity

Since the beginning of the Inquiry:

- Total number of R9s received: 240
- As of 4 September 2026: 238 submitted
- “Other” requests received: 123 (in 2026)
- Overdue: 0 (last overdue was 5th March 2026)



Summary Overview

01

FIRST FIVE MONTHS

Delivered / established

- CQC: CAMHS rated Good; Well Led Requires Improvement
- £0.1m revenue surplus; £47m capital investment, the largest in Trust history
- Unmodified audit opinion and Inquiry Provision replenished
- Interim Board arrangements established and appointments made: Chair, Joint CEOs, DCEO, CFO and COO
- Continuity for 2 existing NEDs being offered 1 year extensions
- Senior Leadership Development Programme initiated
- Consultant Strategy Day and Nursing Conference: Reclaiming our Professional Pride and Re-connecting with Patients
- Inquiry Rule 9s delivered to time, with three extensions agreed; July hearings concluded

02

CURRENT ACTIVITIES

Active delivery and assurance

- Ardleigh Ward reset following rapid review and ongoing concerns
- Winter plans and flu vaccinations
- CQC Well Led Action Plan
- Cultural Review and Leadership Development Programme
- Plans to develop a system wide People & Culture service
- Provider Capability Assessment
- Inquiry Rule 9s and preparation for October hearings, 5–22 October
- NOVA
- Community First
- Two new Associate NEDs joining the Board- bringing the lived experience of MH and physical health
- Working with HPFT on medically led review of Clinical Observations

03

SECOND HALF PRIORITIES

Grip, recovery and delivery

- Financial recovery, including site disposals
- Out-of-area unification and reduction, independent sector beds and step-down opportunities
- Winter plan implementation and Flu vaccinations
- FY27/28 planning, including demand and capacity and efficiency plans
- Reflection on strategic priorities aligned to 10 year plan : Accountability Framework and Target Operating Model refresh
- Inquiry and inquests
- Staff Survey
- Raising mental health inpatient nursing standards
- Introducing a Trust wide Quality Management System

DELIVER!

Escalation/Support Requests

Quality Management system

- Support to develop a programme for quality improvement

Demand and Capacity

- Analytical support for developing a sustainable model D&C model

NOVA

- TPP/SystmOne – NHS England support to resolve integration requirements
- HDI — NHS England reporting-lead support to assure the proposed approach



Trevor Smith and Alexandra Green
Interim Chief Executive Officers
Essex Partnership University NHS
Foundation Trust

NHS England – East of England
2-4 Victoria House
Capital Park
Fulbourn
Cambridge
CB21 5XB

14 September 2026

Dear Trevor and Alex

Essex Partnership University NHS Foundation Trust (EPUT) Mid-Year Provider Review Meeting – 7 September 2026

Thank you to colleagues from EPUT for their participation in the Mid-Year Review meeting held on 7 September 2026. The meeting provided an opportunity to review progress against the Trust's 2026/27 Annual Plan, discuss confidence in year-end delivery, consider preparations for winter, and identify any support required from NHS England (NHSE) to support delivery over the remainder of the year.

We noted that the Trust remains committed to delivery of its annual plan despite a challenging operating environment, including significant quality, workforce and financial pressures. We also recognised the actions taken to strengthen organisational resilience, maintain system leadership and respond to several serious incidents that have occurred during the year.

Meeting Summary and Key Points

Board Approved 2026/27 Annual Plan: Financial and Operational

The Trust reported positive delivery against the majority of its annual plan commitments and expressed confidence in achieving year-end delivery across most indicators. Areas of strong performance included adult community waiting times, talking therapies, perinatal services, virtual ward occupancy, urgent community response times and mental health inpatient flow.

The principal area of concern remains children and young people's community waiting times, driven largely by demand associated with ADHD and autism pathways. The Trust

acknowledged that demand currently exceeds commissioned capacity and that confidence in achieving full recovery by year-end is limited. NHSE welcomed the ongoing review work and requested that EPUT work with ICB colleagues to develop a clear recovery and mitigation plan, including the identification of any regional or national support requirements.

The Trust also outlined progress through its Community First programme, the development of neighbourhood-based models of care and wider work to reduce variation across community mental health services.

Performance

The Trust reported largely positive operational delivery, with performance remaining on trajectory in many areas. Particular strengths were noted in adult waiting times, where performance continues to exceed plan, alongside sustained improvement in inpatient flow and the elimination of 52-week waits.

NHS England sought assurance regarding the sustainability of recent improvements in virtual ward occupancy, which had increased significantly during the most recent reporting period. The Trust advised that performance in West Essex had remained above 80% through August and agreed to provide a further update on Trust-wide performance.

The discussion also considered urgent community response performance in South East Essex, where reporting and activity capture issues are being addressed through the newly established programme steering group. The Trust expressed confidence that improvements would be realised during the coming quarter.

Winter preparedness arrangements were described as being well advanced. The Trust has implemented a multi-channel staff flu vaccination programme, including peer vaccination, community-site delivery, voucher schemes and GP access. Confidence was expressed in achieving a significant improvement in vaccination uptake during 2026/27.

Local Risks and Issues

The most significant delivery risk identified during the discussion related to children and young people's waiting times and broader neurodevelopmental demand pressures. NHSE noted both the scale of demand and the importance of developing a comprehensive response across Essex providers and commissioners.

Further discussion focused on patient safety risks following a number of recent serious incidents, including several involving patients on leave or approaching discharge. NHSE welcomed the immediate actions taken by the Trust and the emphasis being placed on safety planning, multidisciplinary decision-making, therapeutic engagement and dynamic risk assessment. However, continued oversight will be required to ensure learning is embedded consistently across services.

Financial sustainability also remains a key risk. Whilst the Trust reiterated its forecast to achieve break-even by year-end, this position is dependent upon delivery of recovery plans and a range of non-recurrent mitigations. Inquiry-related costs continue to present a significant risk to both financial performance and organisational capacity.

Quality and Safety

Quality and safety featured prominently throughout the discussion. Positive progress was noted following recent CQC activity, including Good ratings for community health inpatient services and inpatient children and young people's services. However, concerns remain regarding some inpatient services and the ongoing challenges associated with patient flow and care delivery on Ardleigh Ward.

The Trust described a range of immediate and longer-term actions in response to recent incidents, including strengthened approaches to enhanced care, therapeutic observation, multidisciplinary safety planning, leave arrangements and governance. NHSE welcomed this response and recognised the significant leadership effort being demonstrated across clinical and operational teams.

The Trust also outlined substantial progress in strengthening governance and well-led arrangements. Work is underway to develop the organisational response to the recent Well-Led review, supported by a cultural review, leadership development programme and further work to strengthen quality governance, organisational learning and Freedom to Speak Up arrangements.

Workforce discussions highlighted positive progress in medical recruitment and reductions in temporary staffing reliance. However, sickness absence remains elevated and will require continued attention. NHSE welcomed the improved staff survey results whilst recognising the impact that inquiries, inquests and regulatory scrutiny continue to have on staff wellbeing.

Financial recovery plans remain in place across inpatient, urgent care and medical services, supported by workforce measures, efficiency programmes and non-recurrent mitigations. The Trust also highlighted concerns regarding inquiry costs, significant estate backlog pressures and uncertainty regarding the proposed Landermere Neighbourhood Mental Health Hub scheme.

We noted the following actions and next steps:

- **Action:** Develop and submit a children and young people's waiting list recovery and mitigation plan following consideration of the regional review recommendations, including any requirements for regional or national support, following discussions with the ICB (EPUT).

- **Action:** Provide a post-meeting update regarding August virtual ward occupancy and evidence of sustainability of recent performance improvements. (EPUT).
- **Action:** Complete the urgent review of patient leave arrangements and strengthen multidisciplinary decision-making and dynamic risk assessment processes. Immediate priority (EPUT).
- **Action:** Share the findings and recommendations arising from the independent review of the Leo vision-based patient monitoring programme, following completion of the review in November 2026. (EPUT).
- **Action:** Submit the formal response and improvement plan arising from the Well-Led review, by the end of September 2026. (EPUT).
- **Action:** Continue discussions with regional and national colleagues regarding the Landermere Neighbourhood Mental Health Hub proposal and associated options appraisal. (EPUT/NHSE).

Additional Items for Consideration

Whilst not discussed in detail, NHS England would like to highlight several areas requiring ongoing attention:

- Continued deterioration in children and young people's neurodevelopmental waiting times and the wider demand-capacity mismatch across Essex.
- The ongoing impact of inquiry and inquest activity on staff wellbeing, organisational capacity and financial sustainability.
- Delivery of recurrent efficiencies and the development of a sustainable financial position beyond 2026/27.
- The substantial estate backlog and implications for future service delivery.
- The forthcoming coronial hearing relating to a historic patient death and any associated organisational, regulatory or reputational implications.

Oversight During the Winter Period

The Trust outlined a proactive approach to winter planning, including work to improve vaccination uptake, optimise mental health emergency department diversion services and strengthen system-wide working with acute provider partners. NHSE welcomes this progress and will continue to monitor delivery through established oversight arrangements.

Particular attention will be given to children and young people's waiting times, workforce performance, financial recovery, patient safety and winter resilience. NHSE and the Trust will continue to work collaboratively through routine oversight meetings, escalation processes where required, and targeted support arrangements.

Next Steps

Overall, the review provided assurance that EPUT continues to deliver strongly across many aspects of its annual plan despite operating within a highly complex environment. We recognise the progress being made in performance improvement, workforce development, cultural transformation and system leadership. At the same time, it remains important that focus is maintained on the key challenges discussed, particularly children and young people's waiting times, quality and safety improvement, workforce pressures, financial sustainability and winter preparedness.

We will continue to work closely with you and your colleagues to support delivery and improvement across the system and look forward to receiving updates on the actions outlined above.

Thank you again for your time, openness and engagement during the review.

Yours sincerely,

A handwritten signature in dark ink, appearing to read 'Clare Panniker', followed by a small dot.

Clare Panniker

Regional Director

NHS England – East of England

9.2 PATIENT EXPERIENCE & COMPLAINTS ANNUAL REPORT

● Decision Item

● Chief Medical Officer

REFERENCES

Only PDFs are attached



Patient Experience and Complaints Annual Report 07.10.2026.pdf

SUMMARY REPORT		BOARD OF DIRECTORS PART 1			7 October 2026		
Report Title:		Patient Experience and Complaints Annual Report					
Report Lead		Dr Kallur Suresh, Executive Medical Director					
Report Author(s):		Matthew Sisto, Director of Patient Experience, Partnerships, and Population Health / Director of Research Lucy Beach, Director of Safety and Patient Safety Specialist Claire Lawrence, Head of Complaints & PALS					
Report discussed previously at:		Quality Committee 13 May 2026 and 16 June 2026					
Level of Assurance:		Level 1	☐	Level 2	☒	Level 3	☐

Risk Assessment of Report		
Summary of risks highlighted in this report	The risk associated with the rise in complaints relating to waiting times and access, particularly ADHD services, which has contributed to increasing complaint volumes, a growing investigative backlog, and higher Ombudsman referrals. Despite these pressures, there is strong assurance regarding the quality of complaint handling, compassion of responses, organisational learning and governance oversight. This report highlights several risks to the Trust's work with patients, carers and communities. Demand for involvement now exceeds the resource available, delivery varies across services, and growth in the lived experience workforce has slowed, with few substantive peer roles in place. A 21% fall in patient feedback has also reduced the Trust's ability to identify emerging risks.	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	☐
	SR4 Demand/ Capacity	☐
	SR5 Statutory Public Inquiry	☐
	SR6 Cyber Attack	☐
	SR7 Capital	☐
	SR8 Use of Resources	☐
	SR9 Digital and Data	☐
	SR10 Workforce Sustainability	☐
	SR11 Staff Retention	☐
	SR12 Organisational Development	☐
	SR13 Quality Governance	☐
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	No	
If yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	
Are you requesting approval of financial / other resources within the paper?	No	

If yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	No
Reflection on Equalities	This report demonstrates a strong commitment to advancing equality, diversity and inclusion through initiatives. However, the report also highlights ongoing inequalities in access, experience and outcomes for some racialised communities and under-representation of some minority groups in the PALS and complaints process. This reinforces the need for continued targeted action, data-driven improvement, and meaningful coproduction to reduce health disparities across EPUT.

Purpose of the Report			
This report provides the Patient Experience, Lived Experience & Volunteering Annual Report 2025/26 and Complaints and Compliments Annual Report 2025/26	Decision		☒
	Discussion		☐
	Information		☒

Recommendations/Action Required
The Board of Directors is asked to: 1. Receive and note the Patient Experience, Lived Experience & Volunteering Annual Report 2025/26 2. Receive and note the Complaints and Compliments Annual Report 2025/26

Summary of Key Points
Patient Experience, Lived Experience & Volunteering Annual Report 2025/26 The annual report provides an overview of how the Trust has collaborated with patients, carers, and communities during April 2025 – March 2026 to improve care, experience, and outcomes. During the reporting period, the Trust continued to strengthen its approach to patient experience, lived experience, and volunteering, demonstrating a clear shift from consultation towards meaningful coproduction. The Trust expanded its lived experience and volunteer community to more than 820 people, embedded peer support roles across inpatient services, and maintained strong patient experience scores, with an average rating of 4.8 out of 5 and over 94% positive feedback. The report highlights the growing impact of lived experience in shaping services, influencing strategic decision-making, and improving care delivery. Peer workers are now established as a core component of many inpatient services, helping to improve engagement, support recovery, and strengthen relationships between patients, families, and staff. The Trust has also continued to develop its health inequalities programme through initiatives such as the Patient and Carer Race Equality Framework (PCREF) and the COMPASS programme, which aim to address disparities in access, experience, and outcomes for racialised communities. While significant progress has been made, the report identifies several challenges, including declining patient feedback response rates, variation in delivery across services, limited substantive lived experience roles, and the need to further embed health equity and coproduction at care-unit level. Priorities for 2026/27 therefore focus on strengthening infrastructure, expanding the peer and lived experience workforce, standardising delivery expectations, reducing inequalities through targeted action, and increasing local ownership and accountability for patient experience improvement. The annual report was considered and approved by the Quality Committee on the 13 May 2026 and is recommended to the Board of Directors for approval. The Board can take assurance that arrangements for capturing and responding to patient, carer and community feedback remain in place, and that progress has been made in embedding lived experience, coproduction and health inequalities initiatives across the Trust. The Board should note the reduction in

patient feedback response rates and the continuing need to strengthen workforce capacity and consistency of delivery

Complaints and Compliments Annual Report 2025/26

The annual report provides a summary of the work and activity relating to complaints and compliments for 2025/26. During the reporting period, activity increased during 2025/26, with more than 1,000 complaints and concerns managed by the Trust. Formal complaints increased significantly by 31%, whilst overall complaint and concern activity rose by 2%. The increase was driven primarily by waiting times and access issues, particularly within ADHD services. At the same time, the Trust improved average complaint response times, reduced complaint re-opening rates, and maintained high performance against agreed complaint timescales. Independent quality reviews concluded that complaint investigations and response letters were consistently good or excellent.

The Quality Committee discussed the annual report at its meeting on the 16 June 2026. Discussed the risks highlighted in the report including the experience of individuals awaiting a response to their complaint, increased complaints for waiting times and access to ADHD services reflected in Corporate Risk Register and consideration for a more detailed, clinically led approach to reviewing complaints going forward. The Committee recommended the annual report to the Board of Directors for approval.

The Board can take assurance that the Trust's complaints process remains in place and compliant with the Local Authority Social Services and NHS Complaints Regulations 2009. The Board should note the significant increase in complaint volumes and outstanding caseload, and that actions are in place to reduce the backlog during 2026/27.

Relationship to Trust Strategic Objectives

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

Which of the Trust Values are Being Delivered

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

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

Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	☒
The report supports compliance with CQC requirements relating to the experiences of care and support commissioning contracts through highlighting issues associated with the accessibility of services,	
Data quality issues	☒
The report identifies potential data quality limitations relating to the under-representation of some demographic groups within complaints data and highlights some limitations in feedback volumes and demographic data completeness.	
Involvement of Service Users/Healthwatch	☒
The report demonstrates active involvement of service users, families and carers	
Communication and consultation with stakeholders required	☐
Service impact/health improvement gains	☐
Financial implications:	☐
Governance implications	☐
Impact on patient safety/quality	☒

The report provides details of the experience of patients accessing and utilising Trust service

Acronyms/Terms Used in the Report

FFT	Friends and Family test	ECC	Essex County Council
IWGC	I Want Great Care	VCSE	Voluntary, Community, Social Enterprise
LEA	Lived Experience Ambassador	<i>Acronym</i>	<i>Definition</i>
PCREF	Patient and Carer Race Equality Framework	<i>Acronym</i>	<i>Definition</i>

Supporting Reports/ Appendices /or further reading

Patient Experience, Lived Experience & Volunteering Annual Report 2025/26
Complaints and Compliments Annual Report 2025/26

Lead



Dr Kallur Suresh
Executive Medical Director

Patient Experience, Lived Experience & Volunteering

Annual Report 2025/2026

April 2025

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1. Purpose

This report provides an overview of how EPUT has collaborated with patients, carers, and communities during April 2025 – March 2026 to improve care, experience, and outcomes.

It brings together progress across:

- Patient and service user experience
- Lived experience and peer workforce
- Volunteering
- Reducing health inequalities

It also sets out the Trust's patient experience teams priorities for the year ahead.

2. Strategic Context

Over the past year, there has been a clear shift in how the Trust collaborates with people and communities.

Traditionally, in years gone by involvement was often something done alongside services. For example, asking for feedback after care had been delivered. 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

This approach is known as **coproduction**, meaning services are designed and improved *with people, not for them*.

For example:

People with lived experience are now involved in **recruitment panels for senior roles**, helping ensure leaders understand patient needs

Lived experience input has shaped major programmes such as **Time to Care and COMPASS**, ensuring services better reflect real-world experiences

This shift supports the Trust's ambition to deliver care that is:

More personalised

- More equitable
- More effective

3. Headline Achievements

3.1 Growth and Reach

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

3.2 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 peoples needs.

During 2025/26:

- Peer roles have become a **core part of inpatient services**, rather than a pilot. Transitioning away from pilot required considerable time and effort from the peer leadership team.
- The peer workforce are now contributing to day-to-day care delivery across dozens of inpatient services

Best practice example:

On inpatient wards, peer workers:

- Support patients during difficult moments
- Help de-escalate situations
- Encourage engagement with care and recovery

This often leads to:

- Improved trust between patients, families, and staff
- Reduced incidents
- Better overall patient experience
- Improved outcomes

In addition to this, family and carer ambassadors are improving the way we support families and carers of people in our care.

3.3 Patient Experience

Patient feedback remains strong:

- Nearly *5000 reviews submitted between April 2025, and March 2026 (**estimated based on forecast responses for March 2026*)
- On average the Trust retained a rating of 4.8 stars out of 5
- With over 94% of feedback being positive, and less than 2% being negative

What this means:

Most people report a good experience of care, which provides reassurance about service quality.

Best practice example:

Services are increasingly using feedback to make visible improvements through “You Said, We Did” approaches, showing patients how their input has led to real change.

3.4 System & Strategic Influence

EPUT continues to be recognised across the system as a leader in:

- Coproduction
- Lived experience practice
- Community engagement

For example:

- Supporting system partners with coproduction approaches
- Delivering large-scale events such as the **Coproduction Conference 2025**
- Contributing to system-wide programmes on mental health and inequalities

Key takeaway: *The Trust has not only grown its activity, but also strengthened its influence, credibility, and impact.*

4. Patient and Service User Experience

4.1 Understanding Patient Experience

Patient experience refers to how people feel about the care they receive, including:

- Whether they feel listened to
- Whether they feel safe
- Whether their needs are met

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 ensures 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.

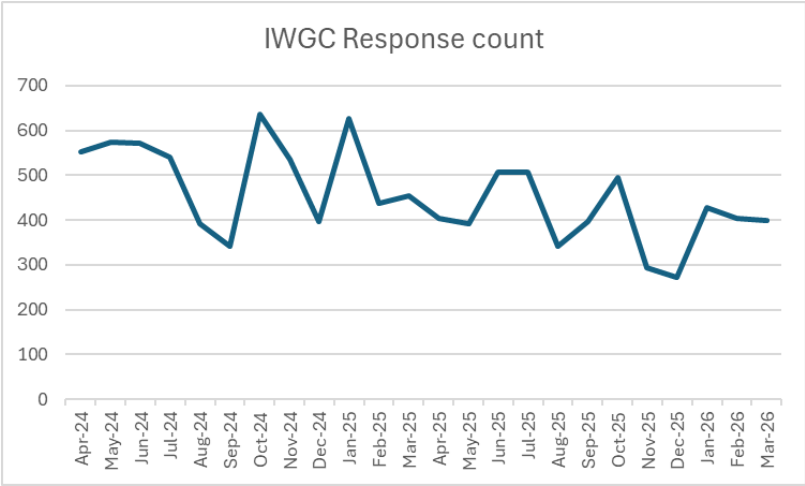
During 2025/26:

- Experience scores remained consistently high
- Feedback was collected through multiple channels, including online, paper, and QR codes
- This helps ensure feedback is accessible to as many people as possible.

4.2 Experience Data and Insight

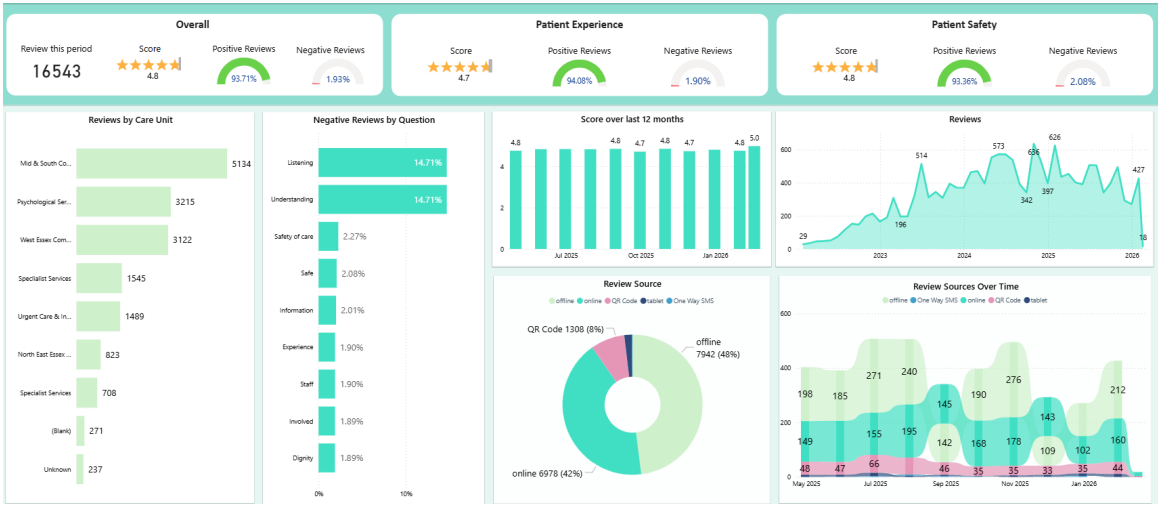
- Total responses since the launch of IWGC in January 2022 is 16,543
- Total number of responses in 25/26 (*4800), compared to 24/25 (6055) (21% decline in response rates year on year) (*estimated based on forecast responses for March 2026) (see figure 1)

Figure 1: IWGC Monthly response count April 2024 to March 2026



- Sustained high-quality patient experience:
 - Average ratings consistently **4.8** (see figure 2)
 - **94%+ positive feedback across all domains**
 - <2% negative reviews across all domains
- Feedback sources:
 - 48% offline
 - 42% online
 - Remaining 10% via QR, SMS and tablets
- Improvement areas:
 - 'Listening' and 'Understanding' both have the highest volume of negative reviews

Figure 2: IWGC Power BI snapshot FY25/26



Executive insight: *Patient experience remains consistently strong across services, providing assurance of quality. However, feedback volumes are on the decline.*

4.3 Trends

- Review volumes have declined by 21% compared to previous year
- Linked to loss of iWGC reporting and training leadership capacity

4.4 Emerging Risks

One key issue during the year has been a decline in the number of feedback responses.

This is linked to reduced capacity to:

- Promote feedback
- Support staff to collect it

Why this matters: If fewer people give feedback, the Trust has less visibility of:

- Emerging risks
- Areas for improvement

4.5 What We Are Doing About It

To address this, the Trust is:

- Increasing support to services with low response rates
- Introducing more **digital feedback methods (e.g. SMS)**
- Tracking feedback levels more closely

Some services are now:

- Actively encouraging feedback at discharge
- Using QR codes in clinical areas
- Reviewing feedback regularly in team meetings
- Response and Improvement Actions
- Introduction of targeted engagement approach
- Weekly tracking of feedback levels
- Focus on low-performing areas (e.g. North Essex)

Our Impact ambition is to ensure feedback continues to:

- Drive improvement
- Increase learning
- Provide assurance
- Demonstrate “You Said, We Did”

5. Lived Experience Workforce & Volunteering

5.1 What We Mean by Lived Experience

Lived experience refers to people using their own experience of services (as patients or carers) to help improve care.

This can include:

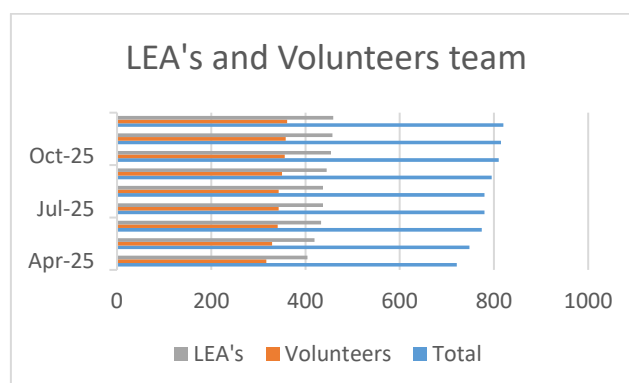
- Providing feedback or sharing their experiences to improve understanding
- Supporting service design through coproduction
- Being a valued member of key decision-making groups
- Working as peer support staff, contributing to key training programmes like Oliver MacGowan

5.2 Current Position

- * Total workforce: **820** (see figure 3)
 - LEAs: **459**
 - Volunteers: **361**
- Growth has continued but **slowed compared to previous years**
- Substantive workforce:
 - **Circa 50 whole time equivalent across all services **<1% of total workforce**
 - **Present in **<10% of services**
 - In some areas, peer support (including advocacy and mentoring) is delivered through VCSE partners such as Summit (North Essex) and Mind (West Essex). The consistently strong outcomes from these models reinforce the case for sustained investment in the Trust's substantive peer workforce.

**based on end of Q3 data **estimated based on time to care implementation and ESR*

Figure 3: LEA and Volunteers team registrations end of Q3 FY25/26



Executive insight: *Strong participation scale, but limited workforce integration*

5.3 Peer Workforce Development

- Peer roles embedded across inpatient services, including specialist and secure
- Transition to substantive model from pilot

Impact includes:

- Improved engagement with patients and families
- De-escalation of potential issues, and improved engagement with care
- Introduction of innovative approaches to recovery-focused care (see figure 4)

Research and best practice show that when lived experience roles are:

- Professionally trained
- Supported in a trauma-informed way
- Embedded in teams

They can:

- Improve patient outcomes
- Reduce conflict and incidents
- Strengthen relationships

5.4 Challenges

Key challenges include:

- Limited number of substantive roles
- Lack of clear career pathways
- Limited support structures for trauma-informed supervision

5.5 What Good Looks Like

Best practice organisations:

- Have lived experience roles at all levels (ward to board)
- Provide clear development pathways
- Embed peer workers and lived experience practitioners across services

5.6 Next Steps

The Trust will focus on:

- Expanding substantive roles
- Developing career pathways
- Embedding lived experience across more services, including aim improve trauma-informed support structure

What this means: *Peer support is proven to have significant positive impact on carer but not yet scaled system-wide*

Figure 4: Peer workers in secure services working with Tesco to support the Recovery Cafe initiative



6. Reducing Health Inequalities (PCREF & Health Equity)

6.1 What We Mean by Health Inequalities

Health inequalities are differences in:

- Access to services
- Experience of care
- Outcomes

These differences are often linked to factors such as:

- Ethnicity
- Socioeconomic status
- Geography

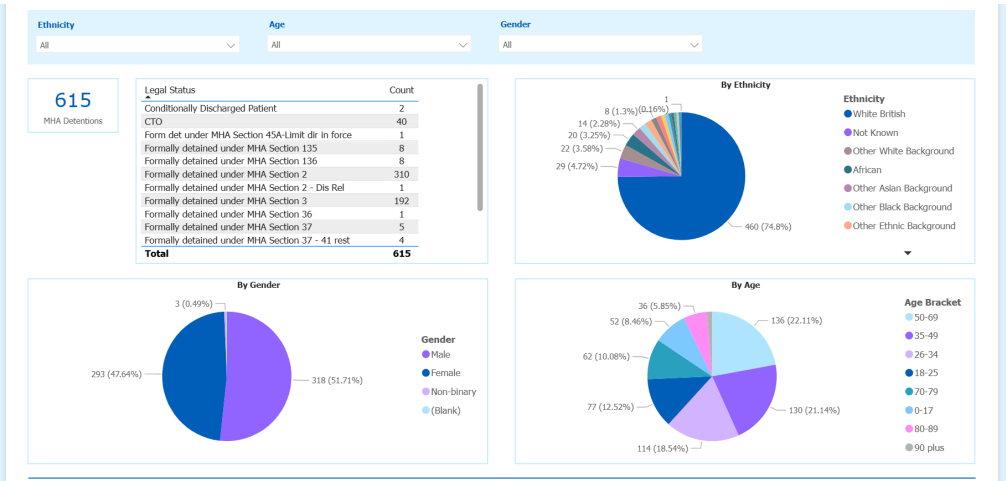
2025/26 has seen considerable progress in building infrastructure to address inequalities, particularly through the Patient and Carer Race Equality Framework (PCREF).

6.2 What We Have Done

Key actions include:

- Introducing a **data dashboard** to track inequalities (see figure 5)
- Developing **cultural awareness training**
- Launching the **COMPASS pilot**
- Improving access to perinatal services
- Embedding smoking cessation support

Figure 5: Mental Health Act Detention by ethnicity Q1 snapshot



6.3 What the Data Shows

During 2025/26:

- Around **21–24% of detentions involved people from racialised communities** which when compared to the Greater Essex population data of between 12-17% belonging to the global majority clearly identifies a disparity.
- Black patients were more likely to experience **longer stays in hospital** highlighting inequity, and indicating potential issues around cultural competency within services

What this means: There are clear differences in how diverse groups access, experience, and outcomes of care.

6.4 Best Practice Example: COMPASS

The COMPASS programme:

- Supports young men from racialised communities
- Uses outreach, mentoring and advocacy
- Focuses on reducing repeat avoidable hospital admissions

This reflects a shift from: “waiting for people to come to services” to “meeting people where they are”

6.5 Challenges

- Turning data into action at a care unit level
- Ensuring consistent delivery across services
- Building trust with communities

6.6 Next Steps

The focus for 2026/2027 will be on:

- Embedding PCREF into everyday practice, across services and at a care unit level
- Reducing disparities in detention and length of stay across inpatient services
- Strengthening community partnerships to identify and address barriers to accessing services

Figure 6: COMPASS Peer Advocacy Pilot with Start Change



7. Working in Partnership Strategy Delivery

7.1 What This Means

This enabling strategy sets out how the Trust collaborates with people and communities to:

- Improve services for people
- Build trust with our communities
- Reduce inequalities

7.2 Progress

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

7.3 Coproduction

- Embedded across organisation
- Increasing service-level ownership
- Coproduction Conference 2025 success (see figure 7)

This year the 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.

Figure 7: EPUT & ECC Coproduction Conference 2025



Impact: *Shift towards shared decision-making, shared ownership, with greater evidence of transparency*

7.4 System Leadership

- Strong external recognition
- Supporting system partners

Executive insight: *EPUT recognised as a system leader across Essex and the East of England*

8. Key Risks and Challenges

- **Capacity:** Demand exceeds resource
- **Variation:** Inconsistent delivery across services
- **Workforce:** Limited substantive roles
- **Plateau Risk:** Slowing growth

Executive insight: *Risk of inconsistency and reduced impact without intervention*

9. Priorities for 2026/27

9.1 Strengthen Infrastructure

- Reinstate leadership capacity for IWGC
- Improve digital feedback by introducing SMS functionality

9.2 Scale Workforce

- Increase substantive roles in peer and lived experience workforce
- Develop career pathways for peer and lived experience workforce

9.3 Standardise Delivery

- Set minimum expectations at a service and care unit level around lived experience roles, coproduction, and IWGC responses

9.4 Reduce Inequalities

- Target key disparities in healthcare provision, underpinned by high quality data
- Collaborate with communities to prevent the need for healthcare, and create health in the most disadvantaged

9.5 Increase Ownership

- Shift to Care Unit accountability for supporting the development of lived experience roles, and increasing feedback through IWGC

10. Conclusion

2025/26 has shown that:

- Collaborating with people and communities improves care
- Lived experience adds real value
- There is strong progress across the Trust

However, the next phase for development requires a shift towards the following:

- Consistency over growth
- Embedding over expansion
- Impact over activity

Report produced by:

Matthew Sisto, Director of Patient Experience, Partnerships, and Population Health

On behalf of:

Ann Sheridan, Executive Chief Nurse

April 2026



Essex Partnership University
NHS Foundation Trust

Complaints and Compliments

Annual Report 2025/2026

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PURPOSE

This report provides an overview of the complaints, concerns, and compliments received by the Trust between 1 April 2025 and 31 March 2026 ("2025/26"). It includes data on volumes, response times, and key themes, and highlights learning arising from both complaints and compliments.

The report also presents findings from quality reviews undertaken by our Non-Executive Directors, which provide independent assurance on the quality of complaint investigations and response letters. Finally, it reviews progress against the priorities set for the previous year and outlines our priorities for 2026/27.

SUMMARY

Essex Partnership University NHS Foundation Trust (EPUT) provides community health, mental health, and learning disability services to support people living across Luton and Bedfordshire, Essex and Suffolk. The Trust employs more than 8,000 staff, delivering services across 114 sites, as well as within people's homes and community settings.

The Complaints Team manages both the Complaints Service and the Patient Advice and Liaison Service (PALS). From 1 April 2025, the team moved into the Executive Nurse's Directorate, which also includes patient safety functions. This strengthened alignment across quality, safety and patient experience, improved joint working and supported more consistent sharing of information across related teams. It also embedded the Complaints Team within the organisation's wider governance framework, strengthening links between complaints, patient experience and organisational learning.

The Complaints Service focuses on early resolution, ensuring concerns are heard, and using feedback to improve care and experience. This includes identifying and escalating potential issues and supporting consistent learning and improvement across the organisation.

Concerns are raised through both formal and informal routes. Formal complaints are investigated and responded to by the Complaints Team, while a significant proportion are resolved informally through PALS, Member of Parliament enquiries, or directly by services. These routes allow quicker resolution of less complex issues, while also providing insight into patient experience and any matters requiring escalation.

Our approach remains complainant-led, working with individuals to agree the most appropriate route to resolution. This supports more timely responses and reflects the increasing complexity and volume of concerns being raised.

During 2025/26, demand increased alongside a higher proportion of concerns relating to access and waiting times. This has influenced both the nature of complaints received and the outcomes of investigations.

	2024/25	2025/26	+/-
Formal Complaints	249	327	+31%
PALS Concerns	603	500	-17%
MP Concerns	73	97	+33%
Locally resolved concerns	59	79	+34%
Grand Total	984	1,003	+2%

Table 1: Volume received, all types of complaints and concerns

Year Highlights

- Total complaints and concerns received: 1,003 (up by 2%)
- Formal complaints received: 327 (up by 31%)
- Formal complaints investigated: 162 (down by 26%)
- Formal complaints average response time: 70 working days (down from 85)
- Local resolutions completed: 79 (up by 34%)
- PALS concerns managed informally: 500 (down by 17%)
- Formal complaints with identified learning: 72 (44%)
- Local resolutions with identified learning: 37 (47%)
- Re-opened rate for formal complaints: 9% (down from 13%)
- Total compliments received: 1,350 (down 13%)
- Non-Executive Director reviews: 100% of investigations rated good or excellent

FORMAL COMPLAINTS

Complaints Process Overview

Complaints received directly by the Trust's Complaints Team are allocated to a Complaints Liaison Officer (CLO), who acts as the primary point of contact for the complainant. The CLO will attempt to make contact with the complainant to discuss the concerns raised, with the aim of agreeing a clear and appropriate way forward to resolve the issues.

Where appropriate, a formal complaint investigation may be recommended. This is particularly likely when:

- The concerns relate to a past event, rather than an ongoing issue requiring immediate or urgent intervention.
- The nature of the complaint is complex and cannot reasonably be addressed without a detailed investigation.

The Complaints Team conduct independent, evidence-based investigations, focused on providing a fair and impartial view of what occurred. The CLO leads the investigation process, working closely with the complainant and, where necessary, a clinical advisor from the relevant service area.

Once the investigation is complete, a Formal Response Letter is sent to the complainant. This letter outlines how the complaint was considered, the findings of the investigation, and the outcome.

Where failings in care or service have been identified, we acknowledge what went wrong, take accountability, and explain the actions taken to address the issues. The response also includes details of any lessons learned and service improvements implemented as a direct result of the complaint.

Complainants are informed of their right to refer their case to the Parliamentary and Health Service Ombudsman should they remain dissatisfied with the outcome.

During 2025/26, the Complaints Team became part of the Nursing and Clinical Governance Directorate, under the leadership of the Executive Nurse. This has strengthened links with wider quality and safety functions, including Clinical Governance, Safeguarding and Patient Safety Incident Management. Closer working relationships across these teams have improved communication, supported more joined-up responses to concerns, and strengthened the Trust's ability to identify and act on themes arising from complaints.

Complaints Received, Closed and Carried Forward

Carried forward from 2024/25	Received 2025/26	Closed 2025/26	Carried forward to 2026/27
81	327	246	162

Table 2: Complaints received, closed and carried forward

During 2025/26, the Trust received 327 formal complaints, representing a 31% increase compared to the previous year (249). This follows two consecutive years of reduction and reflects a significant change in demand and complexity.

The increase has been influenced by a number of factors. The Lampard Inquiry has had a substantial impact on operational capacity across the organisation. This includes significant demand placed on services and corporate teams to locate, retrieve and review historic records, alongside responding to detailed requests for information relating to past care and treatment. This work has required considerable resource within the Complaints Team and wider Trust.

The Inquiry has also generated increased public awareness and scrutiny, which has contributed to a rise in complaints, many of which relate to historic and complex cases. In parallel, wider system pressure across services has affected responsiveness at local level, resulting in more concerns escalating into formal complaints.

These pressures have also impacted the Complaints Team's ability to complete investigations within the year. A higher proportion of cases have been more complex and resource-intensive, resulting in fewer complaints being closed in-year compared to the number received.

As a result, the number of outstanding complaints has increased from 81 at the end of 2024/25 to 162 at the end of 2025/26, effectively doubling over the reporting period. This increase in backlog is a key area of focus for 2026/27, with priority given to reducing outstanding caseload and improving flow through the system.

A notable proportion of complaints continue to relate to ADHD services, particularly waiting times. These increased from 25 in 2024/25 to 75 in 2025/26 and remain a significant contributor to overall complaint volumes.

Response Times

Completed within agreed timescale (Target 100%)

In line with the NHS Complaints Regulations (2009), formal complaints are investigated as efficiently as possible, with complainants kept informed of progress throughout.

Each complaint is allocated to a Complaints Liaison Officer (CLO), who contacts the complainant to discuss the issues raised and agree an appropriate timescale for response based on the complexity of the case. Where this timescale cannot be met, the complainant is kept updated and a revised timeframe agreed.

In 2025/26, 98.7% of complaints were completed within the agreed timescale, maintaining a consistently high level of performance.

Completed within internal service level (Target = 90% within 60 working days)

While response times vary depending on complexity, performance is also monitored against an internal benchmark of 60 working days.

In 2025/26, 54% of the 246 closed complaints were completed within this timeframe, an improvement from 44% in the previous year.

	2024/25	2025/26
Formal Complaints Closed	268	246
Closed within 60 working days (Target 90%)	44% (119)	54% (133)
Closed within Agreed Timescale	98%	98.7%
Average Response Time (working days)	85	70

Table 3: Formal complaints response times v. targets, compared with previous year

These results show a further reduction in average response time for the third consecutive year, alongside an increased proportion of cases completed within 60 working days.

The improvement in average response time should however be considered alongside changes in case mix during the year. A significant proportion of complaints received (75 cases) related to waiting times, predominantly within ADHD assessment services. These cases are typically more straightforward to investigate and respond to, and therefore have contributed to a reduction in the overall average response time.

At the same time, the overall volume and complexity of other complaints has increased, including a higher proportion of historic and multi-faceted cases. This has resulted in greater variability in completion times across the caseload.

Despite the improvement in average performance, the Trust remains below the internal target of 90% within 60 working days. Continued pressure on services, increased demand, and the complexity of investigations continue to impact timeliness. Improving response times while maintaining the quality and robustness of investigations remains a key priority for 2026/27.

Received by Care Unit

The table below shows the number of formal complaints received by each Care Unit in 2025/26, alongside figures from the previous year.

Care Unit	2024/25	2025/26	+/-
Mid and South Essex	87	84	-3%
North Essex	12	21	+75%
West Essex	26	19	-27%
Inpatient and Urgent Care	71	91	+28%
Psychological Services	37	90	+143%
Specialist Services	12	16	+33%
Corporate / Business Units	4	6	+50%
Grand Total	249	327	+31%

Table 4: Formal complaints received by Care Unit, compared with previous year

There has been a notable increase in complaints across several Care Units, with the most significant rise seen in Psychological Services. This is attributable to increased demand and waiting time concerns within ADHD services, which has driven a substantial proportion of complaints in this area.

Inpatient and Urgent Care has also seen a marked increase, reflecting ongoing pressures within acute and crisis services.

The increase in North Essex should be considered in the context of service reconfiguration. In October 2025, urgent care services in this area transferred into the Care Unit, which has contributed to the rise in reported complaints.

Reductions in some Community Care Units suggest variation in demand and service pressures across localities, as well as differences in how concerns are managed at a local level.

Received per Patient Contacts

The table below presents the number of patient contacts across all services during 2025/26, alongside the number of formal complaints received within each Care Unit.

Patient contacts include any recorded interaction between a patient and a healthcare professional, including face-to-face appointments, telephone contacts, and virtual consultations. This provides important context, as the scale and nature of services delivered varies significantly between Care Units.

Table 5: Formal complaints shown per 1000 patient contacts, by Care Unit.

Care Unit	Formal Complaints	Patient Contacts	Complaints per 1,000 contacts
Mid and South Essex	84	833,779	0.10
North Essex	21	65,610	0.32
West Essex	19	534,706	0.04
Inpatient and Urgent Care	91	103,176	0.88
Psychological Services	90	14,147	6.36
Specialist Services	16	37,846	0.42
Corporate / Business Units	6	659	9.10
Grand Total	327	1,589,923	0.21

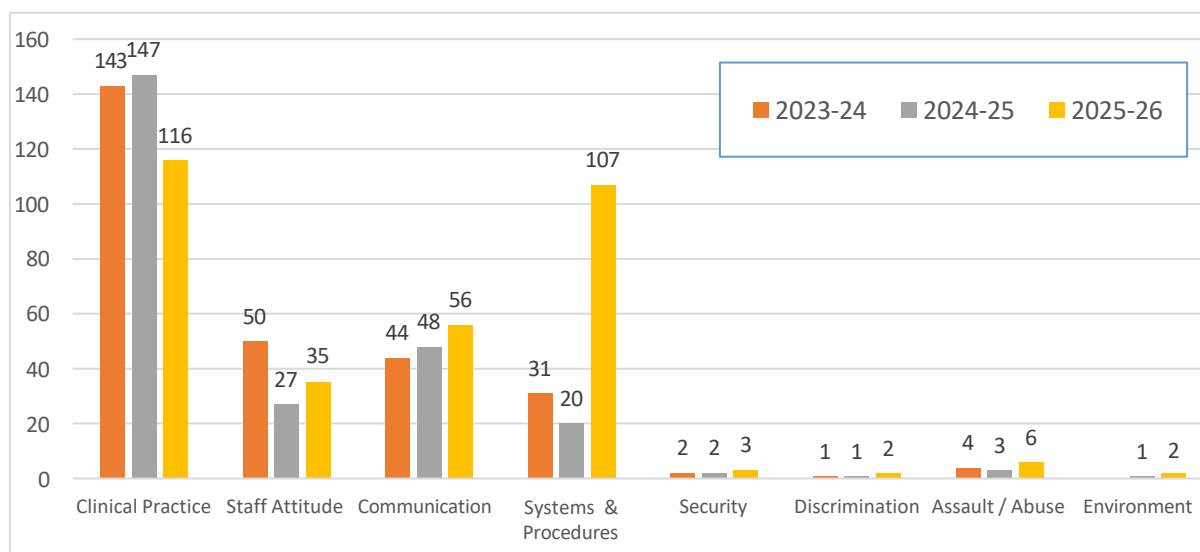
The overall rate of complaints per 1,000 patient contacts has increased from 0.14 in 2024/25 to 0.21 in 2025/26. This reflects the overall rise in complaint volumes during the year.

Rates vary significantly between Care Units, reflecting differences in service type, scale, and complexity. Higher rates in areas such as Psychological Services are influenced by relatively lower activity levels combined with a significant increase in demand, particularly in relation to ADHD services.

Complaint Themes

On the Datix Complaints Database, each complaint is assigned to one of eight predefined categories based on its primary issue. The chart below illustrates the three-year trend in formal complaints received across those categories.

Figure 1: Formal Complaints received by main category (three-year trend)



The overall increase in complaints during 2025/26 is primarily driven by a significant rise in Systems & Procedures complaints, which increased from 20 in 2024/25 to 107 in 2025/26. This represents a substantial shift in the profile of complaints and reflects growing concerns relating to access, waiting times, and service capacity.

Clinical Practice, while historically the most common category, has reduced both in volume and proportion of overall complaints. Communication complaints have increased modestly, while Staff Attitude complaints have risen slightly following two years of decline, though remain lower than historic levels.

Top Ten Sub-categories

Under each main category, a number of sub-categories provide more detailed insight into the nature of concerns raised. The top ten sub-categories accounted for 211 complaints, representing 85% of all formal complaints received in 2025/26.

Table 6: Top ten sub-categories for Formal complaints

Main Theme	Sub-category	Number Received	% of Total
Systems & Procedures	Waiting Lists/Times	75	30%
Communication	Communication breakdown with patient	33	13%
Communication	Communication breakdown with relatives	18	7%
Clinical Practice	Medication	16	6%
Clinical Practice	Diagnosis	14	6%
Clinical Practice	Referrals / Appointments	12	5%
Clinical Practice	Assessment & Treatment	12	5%
Clinical Practice	Unhappy with Treatment	11	4%
Clinical Practice	Discharge / Follow Up	11	4%
Staff Attitude	Inappropriate behaviour	10	4%
	Total	211	85%

Key Theme: Waiting Lists and Access to Services

Complaints relating to Waiting Lists/ Times represent the most significant theme in 2025/26, accounting for 30% of all complaints. Analysis shows that 70 of the 75 complaints in this category relate to ADHD services, demonstrating a clear and consistent pattern across the dataset.

Key issues identified include:

- Extended waiting times**
 Patients report waits of two to five years for assessment, with timeframes often extended without clear explanation.
- Limited transparency and communication**
 Patients report difficulty obtaining updates on waiting list position or timescales, with some advised that lists are no longer actively updated.
- Delays in treatment and review**
 Complaints highlight delays in medication initiation or follow-up after diagnosis, often perceived as avoidable.
- Impact on health and wellbeing**
 Prolonged waits are linked to deterioration in mental health and daily functioning, with some raising concerns about equity and access.
- Patients seeking alternative routes**
 Increasing numbers of patients are pursuing private assessments or Right to Choose pathways, reflecting reduced confidence in NHS waiting times.

Feedback from Psychological Services suggests that external factors have also contributed to this increase, including changes in commissioning arrangements, national publications relating to ADHD and autism, and wider media coverage of waiting times and access to treatment. These factors appear to have increased awareness and prompted more individuals to raise concerns.

Complaint Outcomes

When a formal complaint is investigated, a detailed review is undertaken to establish the facts of what occurred and assess this against expected standards, including relevant policies, guidance, and regulations.

Where a clear discrepancy is identified between the care provided and expected standards, the complaint is recorded as upheld. Where care is found to have met expected standards, the complaint is recorded as not upheld. Where findings are mixed across multiple issues, the complaint is recorded as partially upheld.

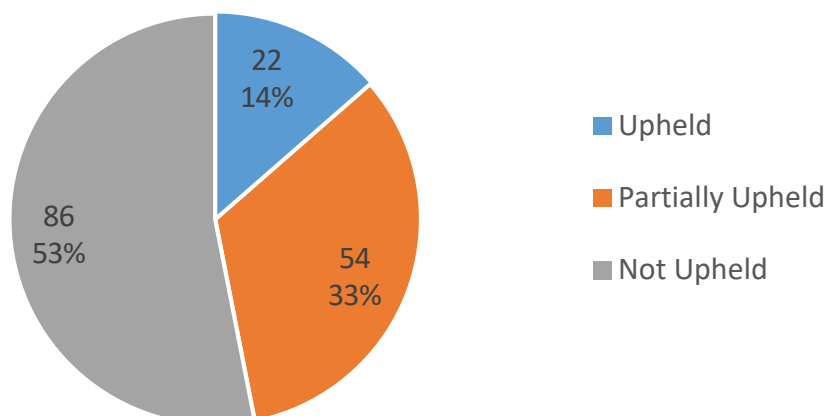
A total of 246 formal complaints were closed during 2025/26. Of these, 74 (30%) were not subject to a full formal investigation.

The primary reasons for complaints not being investigated were:

- **Lack of patient consent:** This remains the most significant factor, where consent was not received, declined, or not appropriate to seek.
- **Duplication with other processes:** In some cases, concerns were being addressed through Patient Safety Incident investigations, safeguarding processes, or other formal reviews.
- **Out of scope or incorrect organisation:** A number of complaints related to other providers or issues outside the Trust's remit.
- **Insufficient information or disengagement:** Some complaints could not proceed due to a lack of detail or engagement from the complainant.
- **Regulatory or procedural constraints:** A small number were out of time or had previously been investigated with no new information to support further review.

The outcomes of the 162 formal complaints that proceeded to full investigation in 2025/26 are shown in this pie chart:

Figure 2: Formal complaints investigations completed, by outcome



Compared to 2024/25, there has been a notable shift in the distribution of outcomes. While the proportion of upheld complaints remains consistent at 14%, there has been a reduction in partially upheld complaints (from 53% to 33%) and a corresponding increase in complaints not upheld (from 33% to 53%).

This shift is largely influenced by the increase in complaints relating to waiting times within ADHD services. In many of these cases, investigations found that while delays were significant and distressing for patients, the care provided was consistent with current service capacity and commissioning arrangements. As a result, these complaints were more likely to be recorded as not upheld.

Re-opened Complaints

We encourage complainants to contact us if they remain dissatisfied after receiving our response, so that any outstanding concerns can be reviewed and, where appropriate, addressed.

Of the 162 formal complaints that were investigated and responded to in 2025/26, 14 (9%) were subsequently re-opened. This represents a reduction compared to 2024/25, where 13% (28 of 218) of investigated complaints were re-opened.

The reasons for re-opening complaints are categorised below:

Reason for Re-opened Complaint	2025/26
Response error / misinterpretation	9
New information / evidence	3
Incomplete response	2
Total	14/ 162 (9%)

Table 7: Reasons for re-opened complaint

In contrast to previous years, the Trust has strengthened its approach to re-opened complaints to ensure clearer and more consistent application of policy criteria. Complaints are only re-opened where defined thresholds are met, including:

- receipt of new and relevant information that could reasonably affect the outcome
- identification of a clear error or misinterpretation in the original response
- evidence that the response did not fully address the issues raised

In previous years, some complaints were re-opened in circumstances where the concerns related primarily to disagreement with the outcome rather than meeting the criteria for further investigation. During 2025/26, there has been improved consistency in applying these thresholds, resulting in more robust decision-making regarding when a complaint should be re-opened.

Alongside this, improvements in the quality of initial responses have contributed to a reduction in avoidable re-openings. All re-opened complaints continue to be reviewed by senior members of the Complaints Team to ensure appropriate resolution and identification of learning.

Maintaining consistency in application of re-opening criteria, alongside continued improvement in response quality, remains an ongoing area of focus.

INFORMAL COMPLAINTS AND EARLY RESOLUTION

The Trust is committed to resolving concerns as early as possible, without the need for a formal complaints investigation where this is appropriate. Informal complaints refer to concerns that are addressed outside of the formal complaints process, often relating to current care or issues that can be resolved promptly through direct engagement with services.

Concerns may be managed through:

- **Local resolution**, where issues are raised directly with services and resolved at the point of care
- **Patient Advice and Liaison Service (PALS)**, which provides a central point of contact for patients, families, and carers to raise concerns and seek support
- **Member of Parliament (MP) enquiries**, where concerns are raised on behalf of constituents and managed in liaison with services

Where concerns cannot be resolved informally or require a detailed investigation, they are escalated to the formal complaints process with the agreement of the individual raising the issue.

MP complaints

During 2025/26, the Trust received 97 enquiries from MPs on behalf of their constituents, representing a 33% increase compared to the previous year (73).

The main themes raised through MP enquiries were:

- Waiting times for assessment
- Waiting times for treatment
- Lack of community support
- Dissatisfaction with care provided

These themes are consistent with those seen in formal complaints and PALS concerns, particularly in relation to access to services and waiting times.

The increase in MP enquiries is likely to reflect continued engagement with elected representatives and increased awareness of how to raise concerns on behalf of constituents, rather than a change in the nature of issues being raised.

Locally Resolved Complaints

All staff are encouraged to resolve concerns directly at the point they are raised wherever possible. Early resolution can provide a more immediate and positive experience for patients and reduce the need for formal escalation.

In 2025/26, 79 locally resolved concerns were recorded on Datix, representing a 34% increase compared to the previous year (59). This is the highest number of locally resolved concerns recorded to date and reflects improved recording and a continued focus on resolving issues at an early stage.

Table 8: Locally resolved complaints logged by Care Unit

Care Unit	2024/25	2025/26	-/+
Mid and South Essex	35	35	0%
North Essex	9	26	+189%
West Essex	7	5	-29%
Inpatient and Urgent Care	4	8	+100%
Specialist Services	2	3	+50%
Corporate	2	2	0%
Total	59	79	+34%

The increase is most notable in North Essex and Inpatient and Urgent Care, which may reflect both increased service pressures and improved reporting of concerns managed locally.

The most common themes in locally resolved concerns relate to:

- Communication with patients and relatives
- Medication queries
- Access to appointments and services

Communication breakdown with patients remains the most frequently recorded issue, highlighting the importance of timely, clear, and consistent communication in preventing escalation.

Overall, the increase in locally resolved concerns suggests a strengthening culture of early resolution and improved capture of issues and learning at service level.

Patient Advice and Liaison Service (PALS)

The PALS service provides confidential advice, support, and information about Trust services, acting as a first point of contact for many patients, families, and carers.

During 2025/26, PALS received 1,836 contacts representing a 7% increase compared to the previous year (1,710).

A breakdown of the types of contact is shown below.

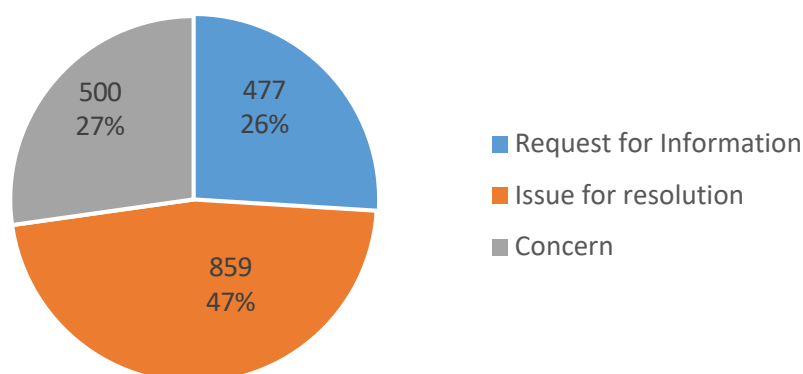


Figure 3: PALS contacts received, by type of enquiry

In addition, PALS signposted 1,545 individuals to other services or organisations for further support, an increase from 1,380 in the previous year.

The increase in overall contacts reflects continued demand for information and support, as well as the role of PALS in facilitating early resolution of concerns.

PALS Concerns

PALS concerns typically relate to current or ongoing care and are managed through direct liaison with services, with a focus on achieving prompt resolution without the need for formal investigation.

In 2025/26, 500 concerns were recorded through PALS, representing a decrease from 603 in the previous year. Despite this reduction, the number of concerns escalated to formal complaint increased to 41 (8%), compared to 25 (approximately 4%) in 2024/25.

This indicates that while overall PALS concern volumes have reduced, a higher proportion of concerns are requiring formal investigation, reflecting increased complexity and service pressures.

The top ten sub-categories accounted for 317 concerns (63%) and are shown below:

Table 9: Top 10 sub-categories for PALS concerns

Sub-category	Main Theme	Number	%
Waiting Lists	Systems & Procedures	65	13%
Unhappy with Treatment	Clinical Practice	57	11%
Medication	Clinical Practice	45	9%
Communication breakdown with patient	Communication	42	8%
Discharge / Follow Up	Clinical Practice	22	4%
Lack of Community Support	Clinical Practice	20	4%
Care planning	Clinical Practice	19	4%
Poor care on ward	Clinical Practice	17	3%
Referrals / Appointments	Clinical Practice	15	3%
Communication breakdown with relatives	Communication	15	3%
	Total	317	63%

Concerns relating to waiting lists are the most frequently reported issue and are consistent with the themes identified in formal complaints, particularly in relation to ADHD services and access to assessment and treatment.

Examples of PALS concerns

Care – Psychological Services

A patient's family member raised concerns about risk following a voicemail expressing suicidal intent. The concern was escalated immediately, reviewed by the clinical team, and managed promptly, with appropriate support put in place.

Communication – Lighthouse Paediatrics Service

A parent reported delays in communication and inaccuracies in a clinical report. The service reviewed the concerns, acknowledged the issues, and addressed them directly with the family.

Medication – ADHD Psychological Services

A patient raised concerns regarding continuity of prescribing after their GP indicated they would no longer prescribe ADHD medication. The service reviewed the case and provided guidance to ensure continuation of care.

PALS Response Times

The Trust operates an internal service level target of responding to PALS concerns within 15 working days.

In 2025/26:

- 77% of concerns were closed within 15 working days, an improvement from 69% in the previous year
- The average response time was 15.3 working days, slightly higher than 14.3 days in 2024/25

While performance against the 15-day target has improved, the increase in average response time suggests that some concerns are taking longer to resolve. This is likely to reflect the increased complexity of cases and wider service pressures.

The PALS service will continue to focus on maintaining timely responses while ensuring that concerns are resolved effectively and in a way that meets the needs of patients and their families.

PARLIAMENTARY & HEALTH SERVICES OMBUDSMAN (PHSO)

If a person remains dissatisfied after the Trust's complaints process has been completed, they have the right to refer their complaint to the Parliamentary and Health Service Ombudsman (PHSO) for independent review. This right is clearly communicated within all formal complaint responses.

The PHSO undertakes an initial assessment to determine whether a complaint should be investigated. This includes consideration of whether there is evidence that the Trust may have got something wrong, whether this has caused a significant impact, and whether the issue has already been reasonably addressed through the Trust's internal process.

Table 10: Five-year summary of PHSO referrals and investigation outcomes (2021–2026)

Year	Formal Complaints Closed	Referrals to PHSO	%	Accepted for Investigation	Investigations Completed	Outcome
2021/22	295	54	18%	0	3	3 x Partly Upheld
2022/23	380	39	10%	1	0	-
2023/24	332	64	19%	0	1	1 x Partly Upheld
2024/25	268	77	29%	0	0	-
2025/26	246	86	35%	4	3	2 x Partly Upheld 1 x Discontinued

In 2025/26, 86 complaints were referred to the PHSO. This is a continued increase from the previous year (29%), and reflects a broader upward trend. This rise should be considered in the context of increased complaint volumes and ongoing system pressures, particularly in relation to access to services.

A significant proportion of referrals did not progress to investigation. In 2025/26:

- 32 cases were not progressed as the Trust's complaints process had not been fully exhausted
- 33 cases were not accepted as they were not considered to be "properly made" (for example, where consent was not in place or the complaint was not submitted by the appropriate individual)

Four cases were accepted for investigation, one of which remains outstanding. Of the three completed, one was discontinued and two were partly upheld. These two cases are summarised below.

Summary of PHSO findings

Case 1 – Monitoring, communication and follow-up

The Ombudsman identified failings in the monitoring of a patient's condition, follow-up of prescribed treatment, and communication with the patient's family. While care had been provided and concerns were acted upon to some extent, there were missed opportunities to recognise deterioration and mitigate associated risks. These failings did not directly cause the patient's death but resulted in avoidable distress and loss of confidence for the family.

The Trust was required to provide a formal apology, a financial remedy of £800, and develop an action plan to strengthen patient monitoring, communication with families, and follow-up processes.

Case 2 – Consent, patient information and complaint handling

The Ombudsman found that appropriate consent was not obtained or documented for the use of electronic monitoring, and that patient concerns were not adequately addressed when raised. There were also shortcomings in the information provided to the patient and in the quality of the complaint response, which did not fully address the issues raised.

These failings caused avoidable distress and uncertainty. The Trust was required to provide a formal apology, a financial remedy of £925, and review its policy and practice to ensure alignment with national guidance, particularly in relation to consent, patient information, and observation practices.

Reflection

While the number of cases accepted for investigation remains low, the findings in the cases that were upheld highlight recurring themes also identified through internal complaints, particularly in relation to communication, documentation, and consent. These cases reinforce the importance of consistent application of policy, clear communication with patients and families, and robust complaint handling.

LEARNING FROM COMPLAINTS

The Trust recognises complaints as a valuable source of feedback and an important driver for service improvement. As part of the investigation process, all complaints are reviewed to identify opportunities for learning and to implement actions to reduce the risk of similar issues occurring in future.

Learning from complaints is shared through established governance routes, including:

- Monthly Learning Collaborative Partnership meetings
- Trust-wide Lessons Identified newsletters
- Quality and Safety meetings across Care Units
- Quarterly reports to Commissioners

In 2025/26, 162 formal complaint investigations were completed, with learning identified in 72 cases (44%). In addition, 79 concerns were resolved locally, of which 37 (47%) resulted in identified learning.

While many complaints still lead to identified learning, the pattern has shifted. A large proportion now relate to waiting times and access, particularly in ADHD pathways, where no specific failing is found. This reflects wider system pressures and limits the scope for traditional complaint-based learning.

EXAMPLES OF LESSONS LEARNED

A selection of examples from across the Trust is provided below to demonstrate the range of learning identified and actions taken.

1. Medication Safety and Risk Management – Poplar Ward (CAMHS), Rochford Hospital

- A patient with a known overdose risk was prescribed tablet medication, which they later concealed and used to overdose.
- The complaint was upheld. The investigation identified that prescribing decisions did not sufficiently account for known risks, and that documentation and communication were inconsistent.
- Actions taken include reinforcing admission risk review processes, improving documentation standards, and strengthening communication protocols with families (subject to consent). These measures aim to reduce the risk of similar prescribing errors and improve patient safety.

2. Compassionate Care – Palliative Care Service, Hockley Clinic

- A family raised concerns about the standard of care and staff conduct following a patient's death, including a lack of compassion and professionalism.
- The complaint was upheld. A meeting with the family confirmed that care fell below expected standards.
- Actions taken include enhanced communication training, additional training in death verification, and targeted staff development. These actions aim to improve compassionate care and ensure dignity is maintained at end of life.

3. Communication and Care Planning – Paediatric Speech and Language Therapy, Lighthouse CDC

- A parent of a non-verbal autistic child raised concerns about delays in care planning, poor communication, and failure to implement the child's EHCP.
- The complaint was partially upheld. Failings were identified in communication and timely documentation.
- Actions taken include reinforcing requirements to complete and share care plans promptly, ensuring communication preferences are followed, and reminding staff of their legal responsibilities in relation to EHCPs. These actions aim to improve clarity, consistency, and family confidence in care.

4. Documentation and Follow-up – Peter Bruff Ward, The Kings Wood Centre

- Concerns were raised about inpatient care, including documentation, communication with family, and post-discharge follow-up.
- The complaint was partially upheld. While clinical decisions were appropriate, documentation and follow-up arrangements were not consistently recorded or communicated.
- Actions taken include strengthening requirements for documenting observation levels and consent discussions, and reinforcing expectations around discharge planning and follow-up. These changes aim to improve continuity of care and transparency.

5. Access and System Pressures – Mental Health Liaison Team, The Lakes

- A complaint highlighted delays in accessing inpatient beds and therapy, alongside a missed handover that delayed referral.
- The complaint was upheld. While care provided was appropriate, system constraints and communication gaps impacted the patient's experience.
- Actions taken include reinforcing handover processes, improving referral pathways, and strengthening communication with patients and families. These actions aim to reduce delays where possible and improve patient experience during periods of high demand.

6. Governance and Policy – Specialist Mental Health Team, The Gables

- A complaint was raised regarding refusal to allow a patient's assistance dog to attend appointments.
- The complaint was partially upheld. The investigation identified a lack of clear Trust guidance, leading to inconsistent decision-making.
- A new Trust-wide policy on assistance dogs has been developed to provide clear guidance for staff. This will support consistent, lawful practice and improve patient experience.

TRIANGULATION OF COMPLAINTS, PATIENT SAFETY INCIDENTS AND CLAIMS

Complaints Linked to Patient Safety Incidents

All complaints are recorded on the Datix system and cross-referenced with any related incidents to ensure that potential links are identified and appropriately managed.

In 2025/26:

- 31 complaints were linked to incidents recorded on Datix
- 10 of these were specifically linked to Patient Safety Incidents (PSIs)

Where a complaint relates to an incident, the Complaints Team works closely with the Patient Safety Leads to ensure a coordinated approach to investigation. This avoids duplication and ensures that all aspects of the concern are fully explored.

Example case (anonymised)

A family member raised concerns regarding the care and treatment of a patient with a history of self-harm and substance misuse, who had multiple contacts with inpatient and community services prior to their death.

The investigation found that assessments, treatment, and discharge decisions were made in line with national guidance and legal frameworks. The patient was regularly reviewed, and appropriate follow-up was arranged and delivered. The patient had capacity and declined aspects of support.

Although no failings in care were identified, the case highlighted the complexity of managing co-existing mental health and substance misuse needs, particularly where patients decline support. The importance of clear documentation, communication, and coordination between services was reinforced.

This case was also subject to internal incident review processes to ensure any wider learning was identified and shared.

Legal Claims related to Complaints

In 2025/26, five new legal claims were received that related to previous complaints received regarding Trust services. These included allegations of clinical negligence, delays in diagnosis or reporting, and issues relating to equipment and care provision.

The total estimated value of these new claims is £195,200.

Four claims linked to complaints were closed during the year. These claims had been submitted in previous years. Of these:

- Damages were awarded in three cases
- The total value of damages paid was £65,000

While there has been an increase in complaint volumes during the year, there is no clear corresponding increase in the number or value of legal claims. This suggests that, despite system pressures and increased dissatisfaction in some areas, issues are generally being managed and resolved without escalation to litigation.

All claims are reviewed to identify any learning, which is shared through governance processes alongside learning from complaints and incidents.

PATIENT DEMOGRAPHICS

Patient demographic information, including ethnicity, age, and gender, is recorded on our complaints database where available. The charts below compare the demographic profile of patients who made a formal complaint in 2025/26 with the overall demographic profile of the Trust's patient population across Mental Health Services (MHS) and Community Health Services (CHS).

Ethnicity

Figure 4: Formal Complaints by ethnicity of patient

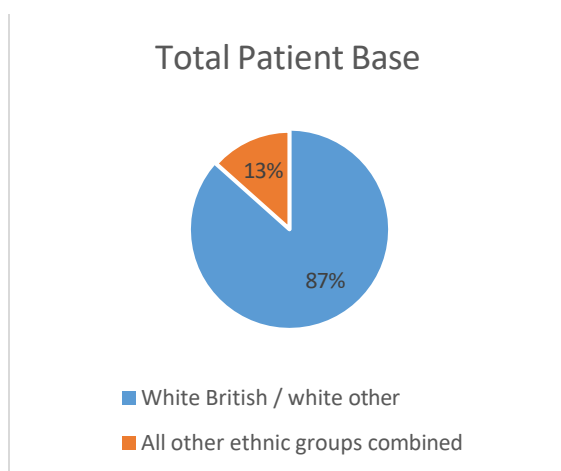
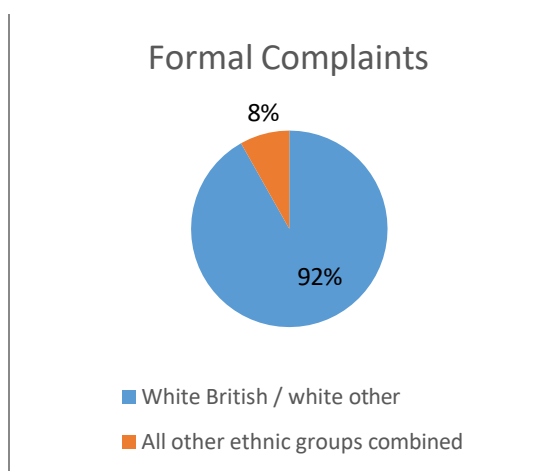


Figure 5: Total patient base by ethnicity



The ethnicity breakdown shows that:

- 87% of the total patient population identify as White or White Other, while 92% of patients who made a formal complaint were from this group.
- Patients from Black and other minority ethnic backgrounds represent 13% of the patient population but accounted for 8% of formal complaints.

What This Tells Us

- White patients are proportionately more likely to raise formal complaints compared to their representation in the overall patient population.
- Patients from minority ethnic groups remain under-represented in the complaints data.

This pattern is consistent with previous years and suggests that barriers to raising concerns may persist for some communities. These may include differences in awareness of the complaints process, confidence in engaging with services, language barriers, or wider issues relating to trust and accessibility.

Age

Figure 6: Formal Complaints by patient age group

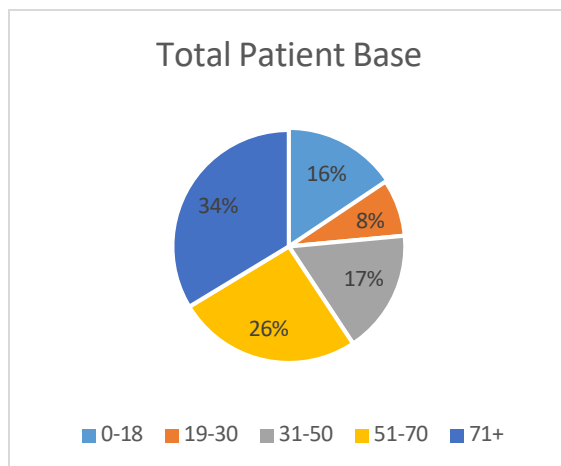
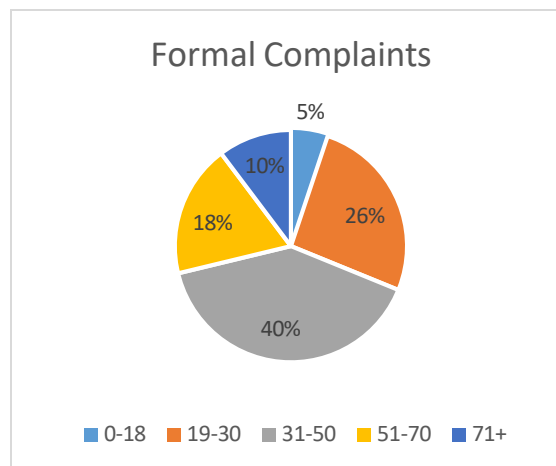


Figure 7: Total patient base by age group



The age breakdown shows that:

- 0–18 years represent 16% of the patient population but account for only 5% of formal complaints.
- 19–30 years represent 8% of the patient population but account for 26% of complaints.
- 31–50 years represent 17% of the patient population but account for 40% of complaints.

Older age groups are under-represented:

- 51–70 years make up 26% of the patient population but 18% of complaints.
- 71 years and over represent the largest proportion of the patient population (34%) but only 10% of complaints.

What this tells us

- Adults aged 19–50 are significantly more likely to raise formal complaints relative to their proportion of service use.
- Children, young people, and older adults are less likely to raise complaints, despite representing a substantial proportion of the Trust's patient population.

This suggests that working-age adults may be more confident or able to navigate the complaints process, while other groups may face practical or perceived barriers. For older adults and children, this may also reflect reliance on carers or family members to raise concerns on their behalf.

Gender

Figure 8: Formal Complaints by patient gender

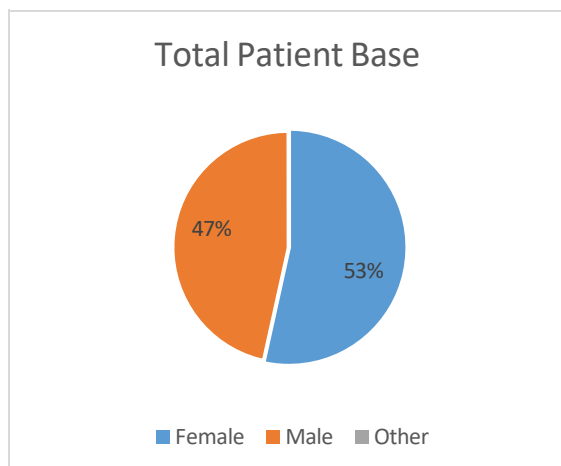
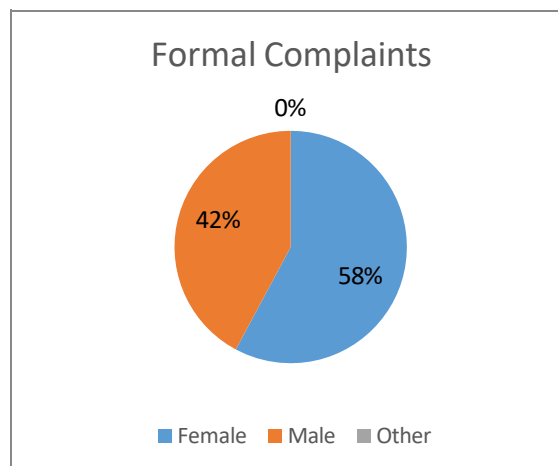


Figure 9: Total patient base by gender



The gender breakdown shows that:

- Females account for 53% of the patient population and 58% of formal complaints.
- Males represent 47% of the patient population but 42% of formal complaints.
- No formal complaints were recorded from patients identified as “Other” gender this year, although this group represents a very small proportion of the overall population (0.06%).

What this tells us

- Women remain more likely to raise formal complaints than men, relative to their proportion of the patient population.
- Men appear less likely to engage with the formal complaints process.

This may reflect differences in help-seeking behaviour, confidence in raising concerns, or perceptions about complaining.

Summary

The demographic profile of complainants in 2025/26 remains broadly consistent with previous years. Some groups are more likely to raise concerns through the formal complaints process, while others are under-represented.

This is particularly relevant in the context of this year’s data, where complaint volumes have increased significantly, largely driven by access and waiting time issues. Despite this increase, the demographic pattern has not shifted, suggesting that underlying barriers to engagement with the complaints process remain.

The Trust will continue to focus on:

- Making the complaints process visible, accessible, and inclusive
- Promoting alternative routes for raising concerns, including PALS and local resolution
- Working with advocacy services and carers to support under-represented groups
- Using insight from complaints, concerns, and patient feedback to ensure all voices are heard and acted upon

This remains an important area for ongoing improvement to ensure equitable access to raising concerns across all communities.

COMPLAINANT STORIES

Reflecting on complainant stories is valuable, because they provide greater insight and context to the complaints data. Case studies are a powerful tool that are regularly used in team meetings and coaching to bring real complaints ‘to life’ and prompt discussion, reflection and learning.

Note: All names and some other minor details have been changed in these case studies to protect patient and staff confidentiality.

Patient story 1: “We Needed to Be Involved”

David’s family raised concerns about the care he received from mental health services in the weeks leading up to his death. David had a history of mental health difficulties, including previous suicide attempts, and was known to services. He had recently been discharged from inpatient care and was being supported in the community.

Throughout this period, his family felt increasingly worried. They believed his risks were not fully understood, particularly during times when his mental health fluctuated alongside alcohol use. They also felt excluded from key discussions about his care and discharge planning, despite being closely involved in supporting him day to day.

In the weeks after discharge, David’s condition deteriorated. Tragically, he died by suicide.

For his family, the loss was devastating. They described a sense that opportunities to better understand David's needs may have been missed, and questioned whether greater involvement of the family might have helped professionals build a fuller picture of his risks.

What we learned

A detailed investigation was carried out. It found that while clinical assessments and decisions were made within expected frameworks, the involvement of David's family was not as strong as it should have been. This limited the information available to clinicians at key points in his care.

We acknowledged that greater engagement with the family may have supported a more comprehensive understanding of risk. An apology was provided to the family for this aspect of care.

In response, the Trust has strengthened its approach to family and carer involvement. This includes:

- Increasing the role of family and carer ambassadors across services
- Reinforcing expectations for involving families in care planning wherever possible
- Promoting approaches that support engagement even where formal consent is not in place

David's story highlights the importance of working in partnership with families, particularly where risks are complex and evolving. Their insight can be critical in supporting safe and effective care.

Patient story 2: "I Didn't Feel Safe"

Tom was admitted to an inpatient mental health ward during a period of acute distress. While on the ward, he experienced several incidents that left him feeling unsafe and unsupported.

He described occasions where his requests for medication were not responded to, and where he felt dismissed by staff. One incident involved a personal item linked to previous self-harm being returned to him without discussion, which caused significant distress. He also reported witnessing a restraint of another patient, which he found frightening.

Tom felt excluded from decisions about his care, particularly around discharge planning, and said that communication with staff was inconsistent. By the time he raised his complaint, his trust in the service had been significantly affected.

What we learned

The investigation found that some aspects of Tom's care were not handled appropriately. In particular, there were failings in communication, discharge planning, and how sensitive situations were managed on the ward.

We acknowledged the distress this caused and apologised for the impact on Tom's experience.

A number of changes have been implemented:

- Staff now discuss with patients before returning items associated with self-harm, with alternative options offered where appropriate
- Families and care coordinators are expected to be involved in discharge planning discussions
- Training and staff support have been strengthened to improve safety and consistency of care
- Clearer arrangements are in place to ensure continuity when care coordinators are absent

These actions aim to improve how patients feel supported and involved in their care, particularly during vulnerable periods.

Tom's experience highlights how communication, consistency, and sensitivity in day-to-day interactions can significantly influence how safe a patient feels while in our care.

FEEDBACK ON OUR COMPLAINTS SERVICE

Non-Executive Director Complaint Quality Reviews

The Trust's Non-Executive Directors (NEDs) provide quarterly independent assurance of complaint handling through review of a sample of closed cases, assessing investigation quality, response letters, and learning.

For 2025/26, 162 formal complaint investigations were completed. A 10% sample requires 16 reviews; 8 have been completed to date (approximately 5%), with a further 8 planned.

Summary of findings (Q1–Q3 reviews completed to date)

Overall investigation handling (1–4 rating)

Across the 8 completed reviews:

- 4 rated 4 (excellent)
- 4 rated 3 (good)
- 0 rated 1 or 2 overall

Average score: 3.0/4

Two reviews identified lower scores in specific elements, but overall investigations were consistently assessed as good or excellent, with strengths in complainant engagement and process completion.

Quality of response letters (1–4 rating)

- 5 rated 4 (excellent)
- 3 rated 3 (good)

Average score: 3.6/4

Reviewers highlighted clear, empathetic and well-structured responses, with appropriate explanations and apologies where required.

Key themes from NED feedback

Positive practice

- Consistently respectful and compassionate communication
- Clear, well-structured responses with appropriate apologies
- Good consideration of complainant concerns
- Evidence of learning in a number of cases

Areas for improvement

- Ensure learning is shared beyond the investigating team
- Avoid perceptions of defensiveness in a small number of responses
- Strengthen reflection of cultural and relational aspects of care

Summary

Early 2025/26 findings indicate generally good complaint handling, with particularly strong performance in the quality and tone of response letters.

Complaints Survey Results

Our complaint response letters include a QR code linking to a digital feedback survey, intended to capture service user experience of the complaints process. In 2025/26, engagement remained very low, with only 2 responses received. This is insufficient to provide a meaningful assessment of overall satisfaction or to draw reliable conclusions.

The feedback received was mixed and has been considered qualitatively rather than as performance data. The comments highlight the importance of how fairness, communication, and outcomes are perceived by complainants.

Improving response rates remains a priority for 2026/27. Actions will include:

- Reviewing how the survey is presented within response letters to improve visibility.
- Introducing a direct survey link within complaint response emails.
- The Complaints Team continuing to promote feedback at the point of closure.

The aim is to ensure feedback is accessible and provides a more reliable basis for learning and improvement.

COMPLIMENTS

A total of 1,350 compliments were received in 2025/26, a decrease from 1,545 the previous year. While this may reflect service pressures and changes in feedback capture, the volume of positive feedback remains significant and continues to provide useful insight into what matters most to patients and families.

Compliments are shared via internal communications, including newsletters and team meetings, and are used to reinforce good practice and support staff morale.

Received by Care Unit

Care Unit	Compliments
Mid and South Essex	443
North Essex	121
West Essex	192
Inpatient and Urgent Care	252
Specialist Services	236
Psychological Services	51
Corporate	55
Total	1,350

Table 11: Compliments logged by Care Unit

Learning from Compliments

Compliments provide a valuable counterbalance to complaints by highlighting what good care looks like in practice. This year's feedback consistently reflects the importance of compassion, continuity, communication, and personalised care, often during highly vulnerable moments in people's lives.

Below are selected examples from across services, with key learning drawn from each.

1. End of Life Care – Community Specialist Palliative Care (Canvey)

A family described how they were supported to care for their mother at home in line with her wishes. The team provided consistent, responsive support, including out-of-hours advice, enabling a peaceful death at home surrounded by family.

Learning from good practice:

- Respecting patient wishes through proactive planning
- Reliable 24-hour support builds confidence for families
- Compassionate communication is critical at end of life

2. Cultural Awareness and Holistic Support – Uttlesford Integrated Care Team

An occupational therapist was praised for improving independence while supporting the wider family. Care was adapted to cultural needs, including use of translation time and respect for the home environment.

Learning from good practice:

- Culturally sensitive care improves engagement
- Considering the wider family system enhances outcomes
- Taking time builds trust and understanding

3. Therapeutic Relationships in Inpatient Care – Poplar Ward (CAMHS)

A young person described how consistent kindness and emotional support from staff helped them feel safe enough to engage in their recovery.

Learning from good practice:

- Therapeutic relationships underpin recovery
- Emotional safety enables engagement and disclosure
- Consistency and presence are as important as clinical input

4. Restoring Dignity Through Listening – Complex Care Co-ordination

A relative highlighted a positive experience where the patient felt listened to, respected, and supported, contrasting with previous care elsewhere.

Learning from good practice:

- Listening without judgement improves experience
- Respectful communication restores dignity
- Small interactions significantly affect trust

5. Recovery and Hope – rTMS Service (Brentwood)

A patient described care as the best received in over a decade, highlighting kindness, consistency, and its impact on recovery.

Learning from good practice:

- Consistency of care supports recovery
- Compassionate environments rebuild trust
- Positive relationships improve engagement

6. Crisis Intervention – Mental Health Urgent Care (Basildon)

A patient reported that staff support during crisis helped maintain safety and contributed to reduced self-harm.

Learning from good practice:

- Non-judgemental support is critical in crisis
- Observation and persistence support safety
- Clear pathways to onward care aid recovery

7. Psychological Support and Continuity – Therapy For You

A patient highlighted flexible, responsive therapy that adapted to changing needs and supported complex challenges.

Learning from good practice:

- Flexibility improves access and continuity
- Adapting care enhances engagement
- Signposting strengthens holistic support

8. Multi-disciplinary Teamwork – Urgent Community Response Team

A patient praised coordinated multi-team input that enabled care at home and avoided hospital admission.

Learning from good practice:

- Effective teamwork improves outcomes
- Coordination reduces hospital admissions
- Communication supports seamless care

Key Themes from Compliments

Across feedback, consistent themes include:

- Compassion and kindness as central to experience
- Being listened to and respected as equally important as clinical care
- Continuity and reliability building trust
- Flexibility improving engagement
- Teamwork supporting safe, effective care

These themes reinforce the importance of relational care alongside clinical delivery and what matters most to patients and families.

UPDATE ON PRIORITIES SET FOR 2025/2026

Please find an update on the priorities set in last year's annual complaints report in the table below.

Priority	Status	Action Taken
Reduce the average response time for formal complaint responses by a further 10% (baseline 85 working days) through streamlining and improving process efficiency.	Complete	The average response time for formal complaints reduced to 70 working days, exceeding the target reduction set for the year.
Reduce re-opened complaints to below 8% (from 13%), focusing on quality improvements to address issues classed as "inadequate response/not fully addressed".	In progress	During 2025/26, 14 complaints were reopened (9% of closed cases), reflecting a reduction from the previous year, although the target of below 8% was not met. This improvement reflects both strengthened response quality and improved adherence to re-opening criteria, which led to a 45% reduction in complaints categorised as "inadequate response or not fully addressed".
Improve transparency and patient confidence in the complaints process.	In progress	Work has progressed to improve transparency and engagement, including clearer early communication on investigation approach, scope, and timelines. Improvements have also been made to the consistency of how outcomes and learning are communicated.
Raise under-representation of minority ethnic complainants with the Health Inequalities Steering Group to support action on equitable access to complaints.	Complete / escalated	This priority was escalated through the Patient Experience Directorate and raised with the Health Inequalities Steering Group. It will be taken forward as a key objective in the new financial year as part of wider work on equitable access to complaints.
Consolidate complaint themes and align across PALS and Complaints to improve thematic analysis.	Complete	Progress has been made in aligning the most used categories across PALS and Complaints, improving consistency and strengthening thematic analysis. While full alignment remains a significant task, the current position provides a workable framework and the priority will not be carried forward.

PRIORITIES FOR 2026/2027

1. Reduce outstanding caseload to below 100 cases

Reduce open caseload to below 100 by end of March 2027, through improved flow management, strengthened early triage, and closer oversight of ageing cases, supported by proactive escalation and closer working with services.

2. Further reduce re-opened complaints to below 7%

Further reduce reopened complaints through improved investigation quality, clearer communication of outcomes, and strengthened quality assurance prior to sign-off.

3. Review and strengthen Quality Assurance processes

Undertake a structured review of the Quality Assurance framework to ensure consistency and effectiveness, including improved feedback to investigators and systematic sharing of learning.

4. Improve triangulation of complaints with Patient Safety data

Strengthen triangulation of complaints and patient safety data by introducing regular joint thematic reviews, with at least quarterly reporting of shared safety themes identified across both datasets.

5. Increase response rates to the Complaints Satisfaction Survey

Improve survey engagement by reviewing distribution methods, clarifying purpose, and making response routes more accessible, to strengthen the quality and representativeness of feedback. Target: a minimum 8% response rate.

The Complaints Team has continued to build on progress made in previous years, delivering further improvements in response times, investigation quality, and consistency of learning. Focus on early resolution, transparency, and the quality of initial responses has contributed to improved outcomes for people using the service.

We recognise that further work is required in areas including re-opened complaints, caseload management, and engagement with feedback mechanisms. These are reflected in the priorities for the year ahead. We remain committed to using insight from complaints to drive improvement across services. The foundations in place provide a strong platform for continued development over the coming year.

Report produced by:

Claire Lawrence, Head of Complaints and PALS
Matt Sisto, Director of Patient Experience

On behalf of:
Ann Sheridan, Executive Nurse

June 2026

9.3 WINTER PLAN 2026/27

- Information Item
- Chief Operating Officer

9.4 PUBLIC SECTOR EQUALITY DUTY (PSED) 2025-2026

● Decision Item

● Chief People Officer

REFERENCES

Only PDFs are attached

 Public Sector Equality Duty (PSED) 2025-2026 07.10.2026.pdf

SUMMARY REPORT		BOARD OF DIRECTORS PART 1			7 October 2026		
Report Title:		Public Sector Equality Duty (PSED) 2025-2026					
Report Lead		Andrew McMenemy – Executive Chief People Office and Interim Deputy Chief Executive Officer					
Report Author(s):		Paul Taylor – Director of Organisational Development and Culture					
Report discussed previously at:		People Committee 27th August 2026					
Level of Assurance:		Level 1	☒	Level 2	☐	Level 3	☐

Risk Assessment of Report		
Summary of risks highlighted in this report	If the Trust does not produce accurate, timely, and credible Public Sector Equality reporting, it will fail to meet statutory requirements under the Public Sector Equality Duty. This risk undermines staff confidence and the commitment to fairness, pay equality, and the elimination of discrimination This poses a significant risk to staff experience, retention, and organisational development, as employees who feel undervalued or treated unfairly are less likely to stay or to engage positively. Poor reporting also prevents the Trust from realising the full benefits of a diverse workforce. The Trust recognises that sustaining improvements will require continued focus on inclusive leadership, staff engagement, professional behaviours and creating psychologically safe environments where all staff feel valued and able to contribute.	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	☐
	SR4 Demand/ Capacity	☐
	SR5 Statutory Public Inquiry	☐
	SR6 Cyber Attack	☐
	SR7 Capital	☐
	SR8 Use of Resources	☐
	SR9 Digital and Data	☐
	SR10 Workforce Sustainability	☒
	SR11 Staff Retention	☒
	SR12 Organisational Development	☒
	SR13 Quality Governance	☐
Does this report mitigate the Strategic risk(s)?	Yes, the associated action plan addresses the risk	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	No	
If yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	
Are you requesting approval of financial / other resources within the paper?	No	

If yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	NA
Reflection on Equalities	The report demonstrates due regard to eliminating discrimination and advancing equality of opportunity by publishing annual workforce data, narrative analysis and the actions to address inequalities.

Purpose of the Report

This report forms one of three key reports that bring together a set of required statutory reporting requirements for Equality, Diversity and Inclusion: Public Sector Equality Duty. Relating to the time period of 2025-26, it demonstrates due regard to eliminating discrimination and advancing equality of opportunity by publishing annual workforce data, narrative analysis and the actions to address inequalities.

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

Decision

☒

Discussion

☐

Information

☐

Recommendations/Action Required

The Board of Directors are asked to:

1. Note and discuss the contents of this report including performance for 2025-26 in supporting equal opportunities for staff, patients and communities with protected characteristics, insights and the areas of focus.
2. Approve the Public Sector Equality Duty report for external publication

Summary of Key Points

The 2025-26 Public Sector Equality Duty report demonstrates due regard to eliminating discrimination and advancing equality of opportunity. It presents comprehensive workforce data, key observations and a focused set of recommended actions to close gaps in representation, experience and outcomes. This report and the following themes relate to April 2025 to March 2026. The findings are consistent with the outcome of the recent CQC report and addresses the inequalities identified.

The annual report and data were presented and scrutinised by the People Committee on the 27 August 2026, and key headlines are provided for the Board of Directors:

Key report headlines:

- There has been an overall reduction in the full workforce headcount.
- A higher percentage of staff from a BME background and staff with a disability attained a role promotion.
- More staff declared their LGBTQ+ status than last year.
- Less BME staff, both bank and permanent entered formal disciplinary procedures.

Priority actions for 2026-2027

Implementing a single Trust-wide EDI plan will create further ambition and delivery on recent progress by focusing on a clear set of practical actions to reduce pay gaps and strengthen inclusion across the Trust. These will include:

- Improving disability and long-term condition data.
- Embedding fair and inclusive recruitment processes.
- Increasing senior representation across the Trust.
- Cultivating an anti-racist and anti-discriminatory culture.
- Supporting, strengthening and celebrating all staff with a protected characteristic.

- Tracking progress with the actions and the impact.

In conclusion, the report highlights that whilst there have been improvements in advancing the equality of opportunity and eliminating discrimination, this needs to improve. The 'whole Trust' commitment and actions to become an anti-racist and anti-discriminatory organisation which focusses on equity in processes and positive action for specific groups, will create an inclusive workplace where staff feel empowered to progress.

Relationship to Trust Strategic Objectives

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

Which of the Trust Values are Being Delivered

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

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

Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	☐
Data quality issues	☐
Involvement of Service Users/Healthwatch	☐
Communication and consultation with stakeholders required	☐
Service impact/health improvement gains	☐
Financial implications:	Capital £ Revenue £ Non Recurrent £ ☐
Governance implications	☐
Impact on patient safety/quality	☒
Reports evidence that providing a safe and compassionate working environment for the staff identified, has a significant impact on staff well-being and patient outcomes.	

Acronyms/Terms Used in the Report

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

Supporting Reports/ Appendices /or further reading

Public Sector Equality Duty Report (2025-2026)

Lead


Andrew McMenemy
Executive Chief People Officer and Interim Deputy Chief Executive Officer



Essex Partnership University
NHS Foundation Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PUBLIC SECTOR EQUALITY DUTY ANNUAL REPORT April 2025 - March 2026

Workforce Equality, Diversity and Inclusion

Introduction

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

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

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

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

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

This report shares gives data about our workforce, which has been collected from employee records, recruitment, and employee relations data.

Each year we are required to publish this information on our public website. The reporting period for this data is **1 April 2025 to 31 March 2026**. T

Continued Improvements

Over the last 12 months the Trust has seen some progress on a number of EDI work streams, which is combined across the People Promise themes and national EDI high impact actions. These include:

- Initial discussions for the embedding of EDI objectives into Executive member appraisals.
- Trust Behavioural framework – A co-created framework which clarifies the expected staff to staff behaviours which link with the Trust values. This has been embedded within appraisals, team away days, ward managers training, leadership development programmes and management development programmes.
- Implementation of the NHS sexual safety charter and commenced implementation of sexual safety awareness with improved experience evidenced in our most recent staff survey results
- Unprofessional Behaviours and Sexual Safety training – Linked to the Trust values and the Behaviours Framework. This encourages reporting and provides a framework for supportive “Step Up and Check in” conversations.
- Wellbeing conversations & awareness workshops created for middle managers in a management development programme.
- The continued embedding of Inclusion Ambassadors on interview panels for roles band 8a and above

to improve fairer and more equitable hiring processes.

- Menopause friendly accreditation via Henpicked delivering Menopause awareness sessions for managers and staff.
- Revised and refreshed Reasonable adjustments passport, guidance and policy for staff with disabilities.
- Continued focus on the RISE leadership programme for staff from Black and Asian backgrounds.
- The development of the Neuroinclusive Café which focusses on the strengths associated with disabilities.
- Renewed proposals for staff equality networks were approved giving stronger support, executive sponsorship and base funding to support annual work plans.
- The Trust signed up to the Anti-Racism pledge and commissioned the Kings Fund and BRAP to deliver an inquiry into the Trust's organisational culture and develop a pilot leadership development programme to address the long-standing cultural issues.
- Launched the Women in Leadership Speed Mentoring event which provides attendees the opportunity regardless of role to connect with influential women leaders from EPUT, the ICS, and the wider region.
- Commissioned Anglia Ruskin University to complete a Sexual Safety audit for the Trust. They have previously only completed this with the Police, so EPUT will be the first NHS organisation to take part.

EDI Monitoring

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

Integrating the themes from each of the 2025-26 EDI statutory reports, alongside the National Staff Survey outcomes, a Trust-wide Equality Diversity and Inclusion plan has been developed. This is aligned with the Trust-wide strategic aims and objectives and the recently published 5-year People Strategy. To monitor progress, quarterly monitoring and assurance of the plan will be submitted through the Executive Team and People Committee.

Demographic of Essex

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

The overall analysis demonstrates that the Trust's demographic profile when compared with the community profile shows us that our workforce does not fully represent the community it serves. Where there are variations, these are highlighted.

- The population of Essex (Excluding Southend or Thurrock), 1.5m in 2021, has seen an **increase of 109,713** over the last 10 years (since Census 2011) – an average annual growth rate of 0.76%
- The areas with the highest number of residents are Colchester (155.5k), Basildon (154.0k), and Chelmsford (151.0k)
- Over the last 10 years, the population of Essex has grown at a faster rate than England (0.64% growth per year). Essex's growth rate is similar to London (0.74% growth per year), though this may be in part due to the impact of the pandemic on where people were living on Census Day
- The largest ethnic group in Essex is "White", which accounts for 90.4% of Essex residents. Taken together, all other ethnic groups account for 9.6% of the Essex population.

Staff Diversity Networks

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

EPUT currently have the following 5 diversity networks:

- Spirituality and Faith
- Disability and Mental Health
- LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, +)
- Carers
- EMREN (Ethnic Minority Race Equality)

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

We also have 3 informal cafes and groups providing resources and building awareness to specific focusses

- Armed Forces Champions Group
- Neuro-Inclusive Café
- Veterans and Reservists Staff Forum

The networks meet regularly, enabling them to grow, develop staff-related activities, explore opportunities for cross-network collaboration and establish the priorities and objectives that support their members and colleagues within the Trust. They are valued representative bodies of the Trust and are members of several committees. This does not come without its challenges and increasing membership and the staff voice forms part of the Equality Action Plan which can be found at the end of the report.

Next Steps:

We will continue our journey of reducing inequity amongst our staff over the coming year and actions are set out within our Equality Action Plan which can be found at the end of the report.

Staff Survey 2025

The NHS staff survey areas are aligned to the NHS People Promise [NHS England » The Promise](#). These questions set out in the words of NHS staff the things that would most improve their working experience.

In 2025, the Trust achieved a response rate of 52%, with 3641 questionnaires returned; this was an increase from 2024. Moreover, we have also seen an increase of respondents with a long-lasting health condition or disability.

The People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher result is more positive than a lower result. These results are created by scoring questions linked to these areas of experience and grouping these results together.

The table below shows the result from the national staff survey. A higher score is better:

People Promise Year	 We are compassionate and inclusive	 We are recognised and rewarded	 We each have a voice that counts	 We are safe and healthy	 We are always learning	 We work flexibly	 We are a team	 Staff Engagement	 Morale
2023	7.55	6.37	6.98	6.45	5.96	6.84	7.20	7.17	6.28
2024	7.46	6.31	6.86	6.30	5.97	6.78	7.11	6.97	6.13
2025	7.57	6.36	6.88	6.36	6.07	6.78	7.22	7.02	6.17

We are pleased to see improvements across the People Promise elements

Improvements for 2025

The Trust understands the importance of hearing everyone's voice and experiences. Our key focus is to continue to engage with colleagues to obtain a more accurate and comprehensive understanding of our employee's needs and experiences. In doing so we will make our actions meaningful and tangible.

The response rate for 2025 was our highest ever: 52% (3,641 respondents)

Next steps 2026:

To improve momentum and experiences of our people from protected characteristics, we have shared the results along with a you said We Did campaign to showcase improvements based on feedback. The planning for the 2026 Staff Survey is progressing and is guided by a comprehensive communication and engagement plan. Following Survey closure, we will:

- Share results with key stakeholders and the Trust
- Work collaboratively with the communication team and local teams to enhance our 'You Said, We Did' campaign
- Produce additional reports to support divisional analysis of the results.
- Analysis of results and associated action plans with the relevant Staff Networks.
- Ensure that the analysis of core data is meaningful and identifies areas for improvement, the following analysis will be undertaken,
- Divisional overview by Staff Experience Team.
- Trust and divisional breakdown by core actions, disseminated to relevant managers.

We will support the Staff Experience Cafés to additionally disseminate results, have a programme of structured and area-based engagement with colleagues and continue the cycle of promoting and encouraging staff to complete the related National Quarterly Pulse survey as part of the annual staff experience cycle.

Workforce Culture

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

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

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

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

Our Workforce Breakdown

Workforce Data

As a public body, we are required to publish equality information about our workforce across all the protected characteristics.

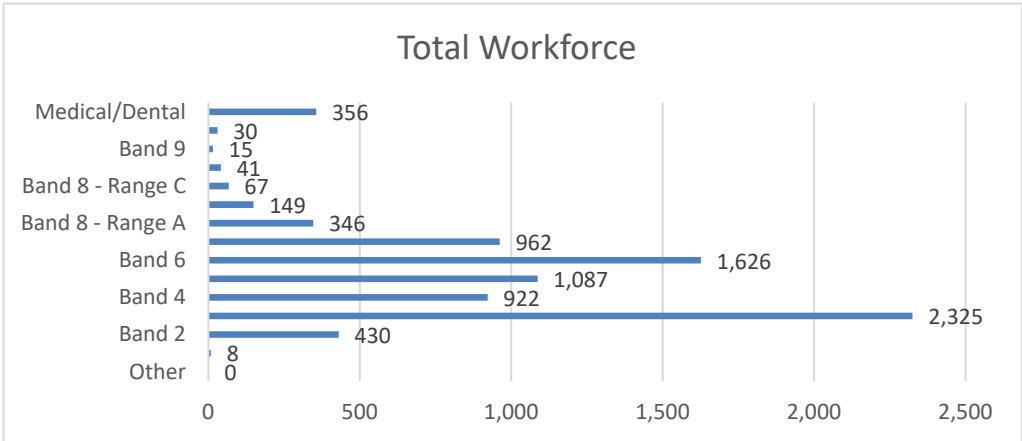
The workforce data contained within this report has been obtained from various sources:

- Electronic Staff Record (ESR)
- TRAC (recruitment records)
- Employee Relations Activity
- NHS Staff Survey Results
- WRES (Workforce Race Equality Standard)
- WDES (Workforce Disability Equality Standard)

It is important to note that within ESR, there may be gaps in data relating to certain protected characteristics where colleagues have been given the option not to disclose information in relation to those protected characteristics. This is a common dynamic across most NHS organisations.

For the 2025/2026 reporting period, the total headcount for EPUT was 8,364, a decrease of 741 staff from the last reporting period. This figure includes all permanent, fixed-term, bank workers, and leavers during this period. The table below provides a split across staffing groups and grades.

Table 1 – Total Staff Group



Staff Profile by Ethnicity

Our records show **39%** of our workforce including Bank workers is from a BME background, which is the same as the previous year's PSED report. This indicates that our workforce demographic aligns to our local population, which has a BME representation of 14.9% (Census 2021). This is positive and shows that EPUT employs a diverse workforce for the community it serves.

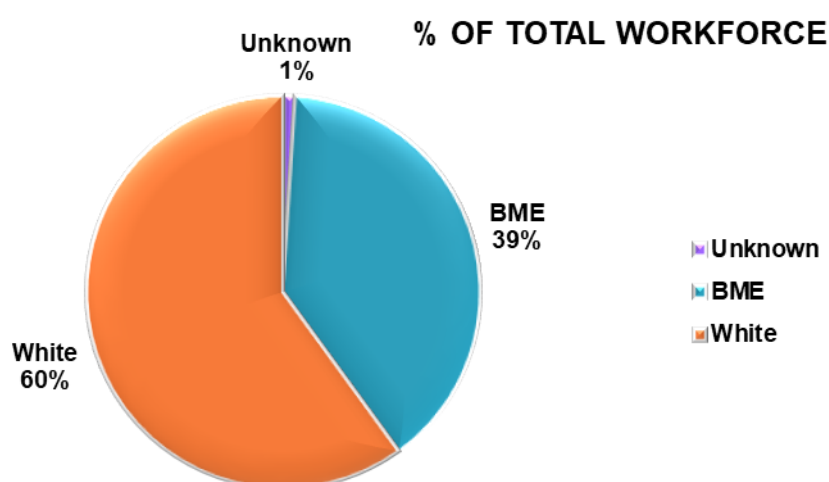
We use the definition BME (Black Minority Ethnic) as this aligns with current NHS England reporting on the Workforce Race Equality Standard.

The Trust composition of ethnicities is as follows:

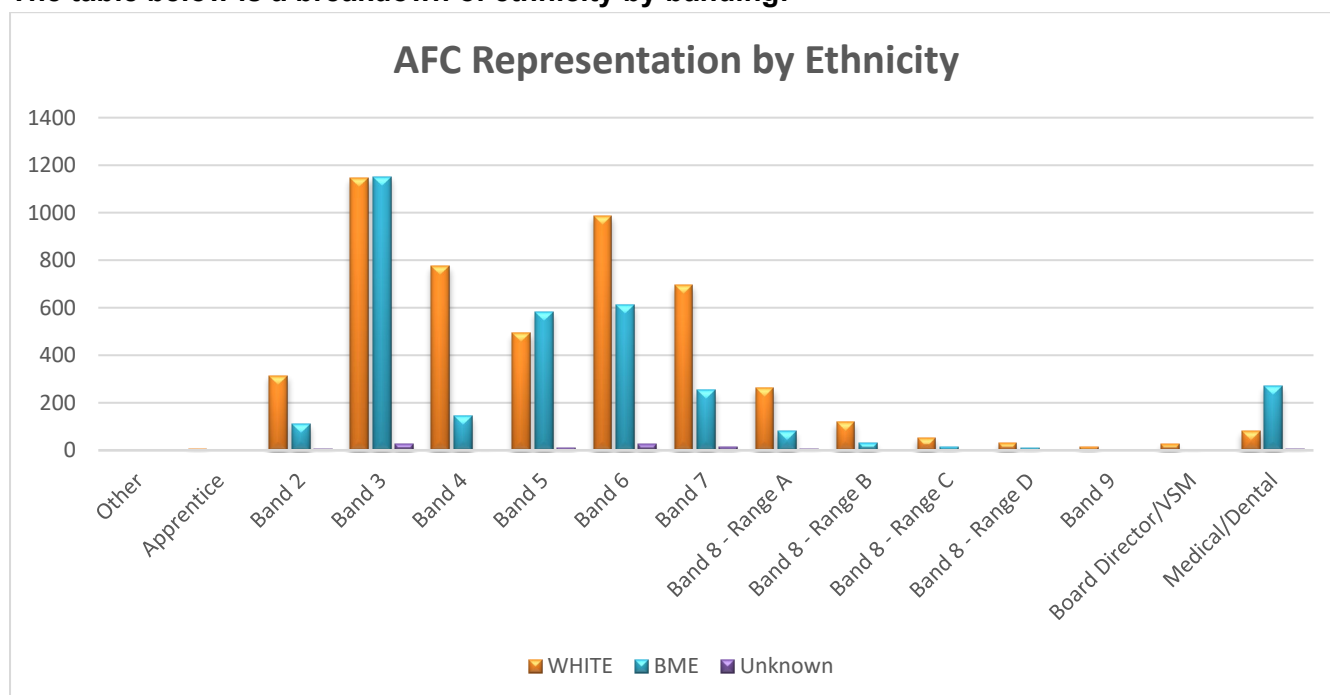
Table 2 – Ethnicity Breakdown

Code	Ethnic Origin	EPUT Workforce - 2026	Code	Ethnic Origin	EPUT Workforce - 2026
A	White - British	4,425	K	Asian or Asian British - Bangladeshi	67
B	White - Irish	66	L	Asian or Asian British – Any other Asian background	187
C	White-Any other White background	508	M	Black or Black British – Caribbean	93
D	Mixed – White & Black Caribbean	38	N	Black or Black British – African	1,810
E	Mixed – White & Black African	62	P	Black or Black British – Any other Black background	324
F	Mixed – White & Asian	34	R	Chinese	24
G	Mixed – Any other mixed background	66	S	Any other ethnic group	121
H	Asian or Asian British - Indian	367	U	Unknown / Not Stated	1
J	Asian or Asian British - Pakistani	76	Z	Unknown / Not Stated	95

The pie chart below is a breakdown of ethnicity by percentage:



The table below is a breakdown of ethnicity by banding:



There were no significant differences identified in comparison with the previous reporting period.

Workforce Race Equality Standard (WRES) Metrics 2025/2026

The WRES looks at the experience of our BAME staff compared to their white counterparts. We have seen improvements in six out of the nine WRES indicators in 2025 report, of which two are above the national average. A full breakdown of results is available in the equality and inclusion Action Plan.

Notable areas of encouraging performance include:

- An increase of 2.53 % BME staff representation from the previous year's report.
- The BME clinical workforce (non-medical) has also seen significant growth in bands 2, 3, 5, 8b and 8d.
- 4.02% increase in the percentage of BME staff believing that the organisation provides equal opportunities for career progression or promotion.
- 1.31% reduction in BME staff entering a formal disciplinary process.

Whilst we have worked hard to improve the experiences of BME staff, the WRES 2025 report highlights areas for development, including:

- 7.6% increase in the percentage of BME Staff reporting experiences of harassment, bullying or abuse from patients / service users, relatives, or the public.
- 1.3% increase in the percentage of BME staff reporting experiences of harassment, bullying or abuse from colleagues.

Whilst the Trust have seen some improvements, there remained a disparity in the negative experiences of BME staff in all indicators in comparison to their White counterparts

- Likelihood of appointment, with White staff appointed at rates of 1.39 for every 1 appointment compared to applicants from a BME background. This highlights that White staff were more likely to be appointed during this period.
- Likelihood of accessing non-mandatory training and CPD opportunities was 1.37, highlighting that BME staff access training less than their White counterparts.

We will continue to work in collaboration with our Leadership, our Ethnic Minority Race Equality Network and Organisational Development & Culture Team to drive improvement in creating an inclusive and supportive environment for our BME staff.

Steps we are taking to eliminate discrimination and improve experience:

- We have continued to roll out our new values-based recruitment procedures, encouraging hiring manager to utilise the de-bias toolkit, ensuring interviews for roles 8a and above include diverse panel members.
- We have made updates to our disciplinary policy, special leave policy, flexible working policy and grievance policy, to be more compassionate and supportive to colleagues
- The disciplinary process has been revised and a preliminary assessment form and independent triage panel have been introduced. This process supports consistency and fairness in the incident review, emphasising learning, and informal resolution and is already showing impact on the % of BME staff being referred to the formal disciplinary process
- We will refresh our approach to Reciprocal Mentoring
- Following the trust signing up our Anti-Racism pledge, we will continue to promote and rollout a zero-tolerance approach to racism in our trust, promoting the behaviour framework.
- Unacceptable behaviour and sexual safety workshops will continue to be rolled out – with focussed interventions in areas reporting negative experiences in the staff survey.
- Commence senior leaders programme in partnership with BRAP and the Kings Fund with a focus on anti-racist and anti-discriminatory leadership
- The Ethnic Minority and Race Equality Network (EMREN) has been refreshed with new Co-Chairs and is set to support the trust with these challenges.

The full WRES report can be accessed [*link will be inserted once approved for publication*]

Staff Profile by LTC/Disability

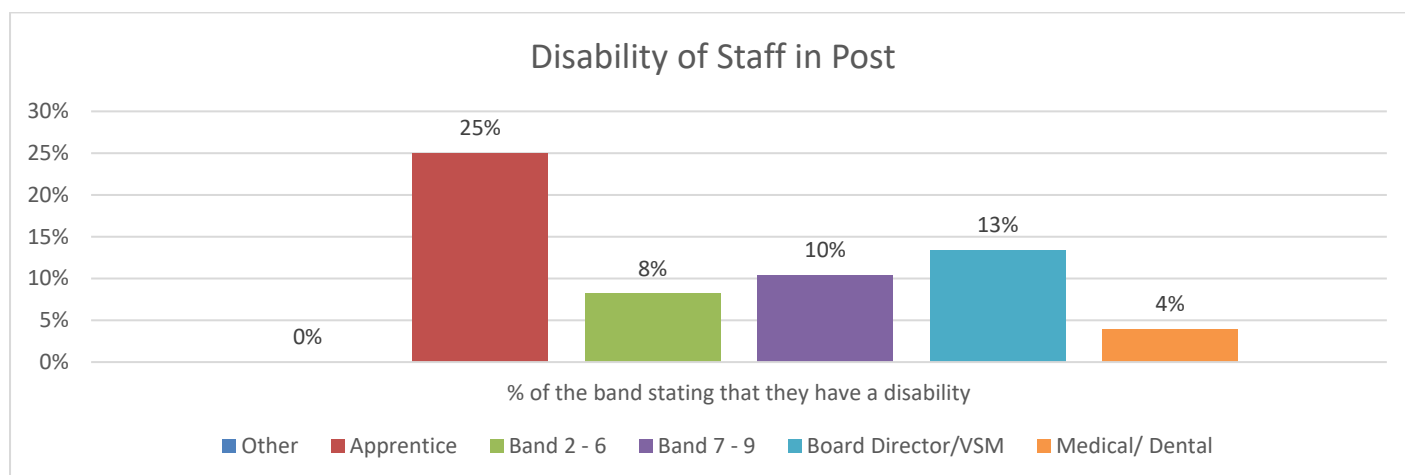
EPUT have **705 (8%)** staff who declared themselves as having a disability or long-term health condition (LTC) during this reporting period, this is slightly lower than reported in the WDES due to differing reporting time frames. This is an increase from last year and it is encouraging that staff are feeling more comfortable to declare their LTC or disability status. This reflects that EPUT is a disability confident leader and promotes an inclusive environment where everyone feels they belong.

The Trust will continue to encourage all colleagues to declare their status and reassure colleagues the benefits of doing so. This will help the Trust in providing a psychologically safe environment for its staff, as well as, improving the quality of data for this protected group. To further support achieving this we are:

- Reviewing and promoting the awareness programme on encouraging voluntary sharing of LTS or disability status for colleagues.
- Continuing to develop wellbeing discussions and updates at appraisal and 1:1 support
- Promoting the use of the ESR self-service function in which staff have the opportunity to update information relating to their protected characteristics.
- Encouraging different forms of staff support, including the new Neuroinclusive café and Staff Carer's lounge.
- Working to progress the excellent work of the Disability Staff Network.

Observations

AFC Bands 2-6 have the highest number of staff who have disclosed a disability or LTC. The percentages of colleagues sharing their disability is higher within senior roles Board/VSM (13%), which is contrary to the pattern seen across the local system.



Whilst EPUT is a disability confident leader and continually encouraging staff to disclose a LTC or disability we saw 9.5% of staff choosing not to share their disability or LTC status.

There are low numbers of Medics who declared themselves as having a disability or LTC. This can be explained by a high number of trainee doctors rotating through different Trusts, meaning that demographic data needs to be re-shared each time.

WDES – Workforce Disability Equality Standard Metrics 2025/26

EPUT has seen improvement in seven out of the thirteen WDES Metrics, with the remaining six being close to national averages. **Notable improvements were seen across the following indicators:**

- Increased representation of staff with a disability; 9.1% of staff are recorded as declaring a disability, an increase of 0.27% from the previous year
- There has been a reduction in the number of staff with a disability experiencing bullying, harassment or abuse whilst at work from managers and colleagues, which is of a similar level to non-disabled staff.
- More staff with a disability are feeling supported when not feeling well enough to work and are having adequate and reasonable adjustments made to support their everyday working experience.

Whilst there are some improvements in experience, the WDES 2025 report highlights areas for development, including:

- Non-disabled staff are 1.34 times more likely to be appointed into roles following the shortlisting process.
- Staff with a disability are 1.62 times more likely to enter a formal disciplinary process than non-disabled staff.
- Staff with a disability are experiencing more harassment, bullying or abuse from patients, service users, relatives or the public.

- There was a 1.28% reduction of staff with a disability feeling satisfied with the extent to which the organisation values their work.
- 53.4% of staff with a disability believe the organisation provides equal opportunities for career progression or promotion, a reduction of 1.64% from 2025.

To further improve the experience and treatment of staff with a disability, the Trust has taken the following measures:

- Disability and Mental Health Network meetings are attended by senior leads to ensure feedback is heard and acted upon.
- The disability Staff Network sessions are held virtually, with access to subtitles / transcribing tools to ensure they are as accessible as possible for attendees.
- Staff can raise concerns anonymously through our Freedom to Speak Up Guardians, as well as raise issues about their accessibility via our Employee Relations and Staff Experience functions.
- The Disability and Mental Health Network have clear goals for the year and can measure their own progress via SMART KPI's.

The full WDES report can be accessed at: *[link will be inserted once approved for publication]*

Health and Wellbeing

A comprehensive occupational health (OH) service is available to staff via People Asset Management Group (PAM), an outsourced provider which offers mental health, physical health and rehabilitation services.

PAM services include:

- Occupational Health assessments and guidance
- Fitness to work/practice
- Permanent/temporary injury applications
- Detailed recommendations for work related rehabilitation (for example, phased return to work, re-deployment, adjustments to duties/post)
- Ill health retirement
- Immediate response and follow-up service for staff with sharps injuries
- Pre-employment health assessments
- Fast track physiotherapy referrals
- Workplace assessments for neurodiverse colleagues supporting reasonable adjustments within the workplace.

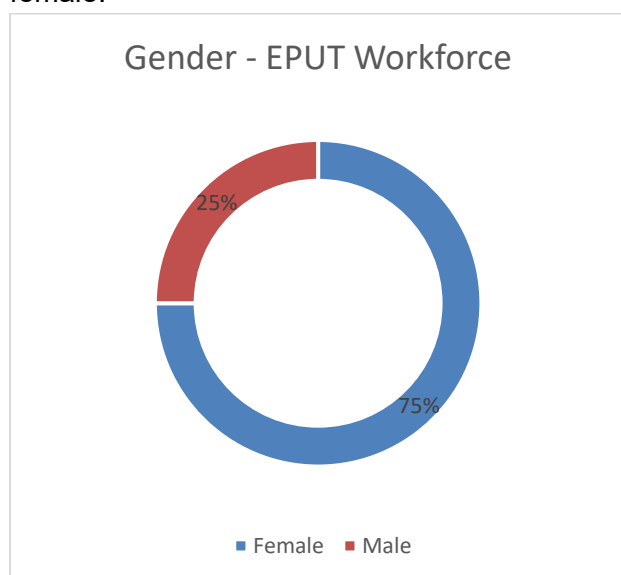
The wellbeing of our colleagues is our priority; there are several aspects in place to help, manage and support individuals, such as:

- A Trust-wide Reasonable adjustments passport scheme, with guidance for managers and staff
- Five Staff Networks (Ethnic Minority and Race Equality, LGBTQ+, Staff Carer's, Faith and Spirituality, Disability and Mental Health)
- Neuro-inclusive café for staff who are neurodivergent.
- Staff Experience Team, offering wellbeing guidance, resources, and wellbeing promotion.
- Our Here for You Service, which provides therapeutic support where difficulties are linked to the workplace. This could be stress, distress and/or trauma, which is impacting on a person's ability to be at work or carry out their duties.

- Act For You training programme and initiatives, designed to support staff in increasing personal and professional resilience.
- Facilitating local and national wellbeing initiatives/programmes relating to mental and physical wellbeing.
- Our Occupational Health service provided by PAM.
- An Employee Assistance Programme (EAP), providing 24-hour, 7 day-a-week support including a range of counselling services, self-help programmes, financial guidance, legal advice, and more
- A fast-track physiotherapy service provided through PAM.
- Health and wellbeing resources, information's and guidance for all colleagues which is available via EPUT Intranet.

Staff Profile by Gender

Our workforce is predominantly female (75%) and has remained relatively consistent over the last several years with minor declines and increases. These figures are similar to the wider NHS, which is predominantly female.



Gender			
AFC Banding	Female	Male	Total
Other	0	0	0
	0%	0%	0%
Apprentice	4	4	8
	50%	50%	100%
Band 2 - 6	4,880	1,510	6,390
	76%	24%	100%
Band 7 - 9	1,219	361	1,580
	77%	23%	100%
Board Director/VSM	19	11	30
	63%	37%	100%
Medical/Dental	186	170	356
	52%	48%	100%

The largest proportion of staff lie within AFC Bands 2-6, with a female workforce of **76%**.

Some key changes to note:

Bands 2–6:

- Remains the largest workforce group and continues to be predominantly female.
- Female representation remains stable at 76%.
- Total headcount decreased from 7,144 to 6,390 (-754 staff).

Bands 7–9:

- Gender difference remains largely unchanged.
- Female representation decreased slightly from 78% to 77%, while male representation increased from 22% to 23%.

Board Director/VSM:

- This group experienced the most significant change.
- Headcount increased from 16 to 30 staff.
- Female representation increased from 50% to 63%.
- Female numbers rose from 8 to 19, while male numbers increased from 8 to 11.

Medical/Dental:

- Moved from an equal gender split (50% female, 50% male) to a slight female majority (52% female, 48% male).
- Female numbers increased by 22 staff, compared with an increase of 3 male staff.

Apprentices:

- No change, maintaining a balanced 50:50 gender split.

Working Patterns
Pay Gap

The Trust adheres to the Government Equalities Office’s Pay Gap (GPG) reporting requirements and has an action plan, in which it sets out its remedial objectives to address any gender pay inequality. The Pay Gap report contains data and analysis relating to the gender, race and disability pay gap. This information is contained in a separate dedicated report which can be found here: *[link will be inserted once approved for publication]*

Flexible working

Over the last 3 years we have seen a significant increase in flexible working requests. Reviewing the working patterns, female colleagues are significantly more likely to work part time than their male counterparts in many cases due to caring responsibilities. Moreover, female colleagues are more likely to become and provide more hours of unpaid care than men. The staff survey responses in 2025 indicated:

- 37% from 3605 responses said ‘yes’ to ‘*Do you look after or give any help or support to family members, friends, neighbours or others because of either: long term physical or mental ill health / disability, or problems related to old age.*’
- 42% of 3604 responses answered ‘Yes’ to ‘*Do you have any children aged from 0 to 17 living at home with you or who you have regular caring responsibility for*

The implementation of the flexible working policy can often influence individuals in feeling supported and fulfilled in undertaking their role. Flexible working increases diversity and equality of opportunities for those with disabilities, caring responsibilities and provides further support during pregnancy or older colleagues who no longer wish to work full time and is a priority retention strategy for EPUT.

Table of flexible working request:

Category	2023/2024	2024/2025	2025/26
Flexible Working	301	280	317

Flexible working requests for our female workforce is significantly higher (272) than for our male (45) workforce.

The Trust currently has a Disability & Mental Health Network, which holds regular awareness sessions, sessions include flexible working and reasonable adjustments. HR support and guidance is in place for managers for maternity and paternity leave advice, health issues and flexible working.

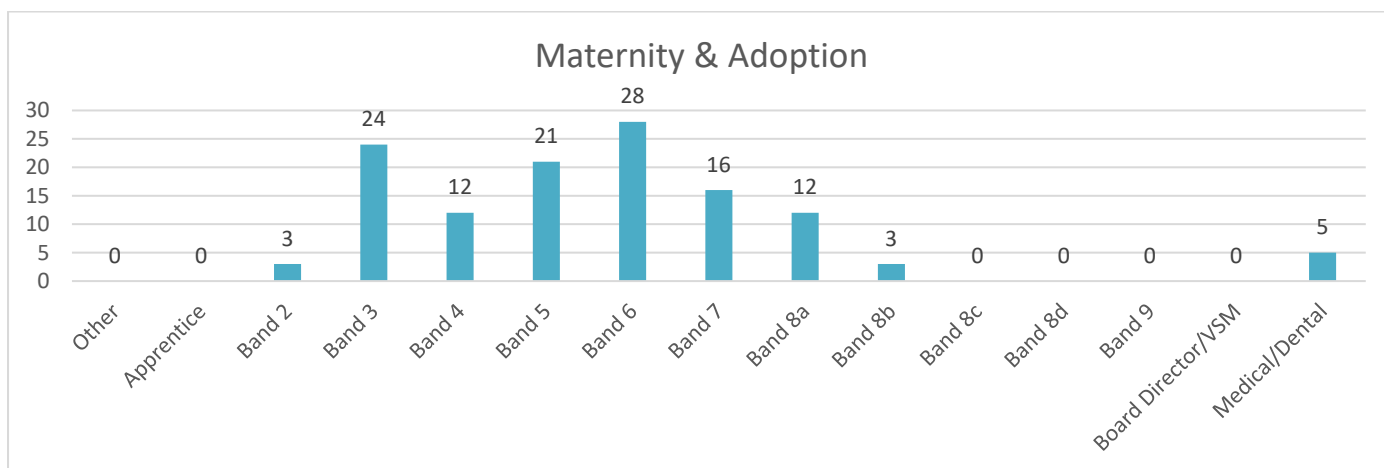
The Trust intranet is utilised to share information and resources on events and support services available. In addition, a Carer's Lounge is now in place, giving carers the opportunity to share experiences, raise awareness and share advice ensuring that our culture recognises the significance of caring in our workforce.

There is more to be done to encourage positive attitudes to flexible working whilst recognising the need for continuity of patient care and we will continue to build on the positive examples of success.

Pregnancy & Maternity

Workforce data shows 8,046 members of staff are in active assignments, of these active assignments the data show us **124 (1%) of staff have taken maternity or adoption leave**, a reduction of 1% from the previous year.

The bar chart below shows a further breakdown from the data reported within this period, showing that the highest number of those who have taken maternity or adoption are paid AFC band 3, 5 and 6.



Menopause

Our workforce breakdown of gender indicates that a significant proportion of our staff are likely to be in the age category of people experiencing perimenopause or menopause symptoms and therefore it is vital that we are providing a supportive working environment.

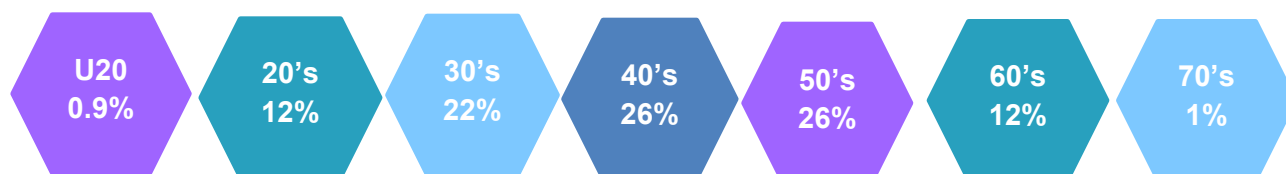
EPUT strive to ensure all staff genders have the understanding, resources and guidance available to make sure the working environment is inclusive and everyone feels they belong, EPUT have the following:

- Wellbeing hub – providing access to resources and information accessed via the staff intranet
- Menopause guidance and information on the staff internet website.
- Menopause advocates – Delivering awareness sessions for colleagues and Line managers.

Managers also are able to record menopause related absence for their staff via the health roster system. This enables the Trust record reasons behind absence and gain a better understanding of the impact of the menopause on its staff and put in place appropriate support.

Age Profiles

Workforce breakdown by Age:



With 39% of our total workforce over the age of 50, we work to offer support and sustainable career pathways to help attract and retain the younger pipeline workforce to ensure that our service users continue to receive high-quality care. This is then supported by working closely to retain our older workforce into working arrangements that not only encourage them to stay – retaining and valuing their input but also enhancing flexible working opportunities and work life balance

The Trust is actively engaging with young people in local communities by:

- Hosting recruitment drives
- Working closely with local programmes to bring employment into areas of high deprivation
- Working with local schools, colleges and universities, encouraging young adults to consider a career within the NHS.
- Promoting the benefits of the NHS apprenticeship schemes available at the Trust.
- Health Care Assistant Academy

Flexible Retirement

Within the reporting period EPUT saw 113 staff leavers due to retirement which is similar to the previous year. Recognising the contribution of our people and maximising retention of the knowledge, skills and experience of our older workforce, we strive to offer a range of flexible retirement options to support the health and wellbeing of staff. Options include:

- Step Down
- Retire and Return
- Partial Retirement
- Part time reduced hours
- Early Retirement Reduced Buy Out

Sexual Orientation

- The majority of staff declared their sexual orientation as heterosexual (85%) 7120 which is a 1% increase from the previous year's report.
- 4% of the workforce (298) declared their sexual orientation as lesbian, gay, bisexual and any other gender identified which is an increase of 2% from the previous year's report.
- 10% (806) of staff chose not to declare their sexual orientation.
- 1% of staff choose Unspecified for their sexual orientation.

Although we have seen an increase this year the Trust is conscious that the percentage of staff who shared their sexual orientation as LGBTQ+ is extremely low; this could be a result of anticipated discrimination, bullying and harassment, hate crimes and fear of being undermined.

We will be reviewing the Equality, Inclusion and Human Rights policy and procedure in collaboration with the LGBTQ+ Network in EPUT as well as the East of England Rainbow Network.

EPUT recognises there is more that can be done to support its LGBTQ+ colleagues in terms of offering reassurance, physiologically safe spaces, and further LGBTQ+ training and resources. The Trust provides resources and guidance for colleagues on the EDI hub, embedded the LGBTQ+ diversity network and developed Transgender guidelines. Our commitments this year can be found in our EDI Action Plan: *[link will be inserted once approved for publication]*

Marriage & Civil Partnership

The marital status with the highest percentage reported was married at 51% of the workforce, with single following thereafter at 35%. The data from this reporting period shows a slight increase in the following statuses: Married; with a slight decrease in the following areas; legally separated and single.

Marital Status of Staff in Post:

	Total	Percentage
Divorced	551	7%
Legally Separated	123	1%
Married	4,237	51%
Single	2,955	35%
Widowed	115	1%
Civil Partnership	140	2%
Unspecified	243	3%

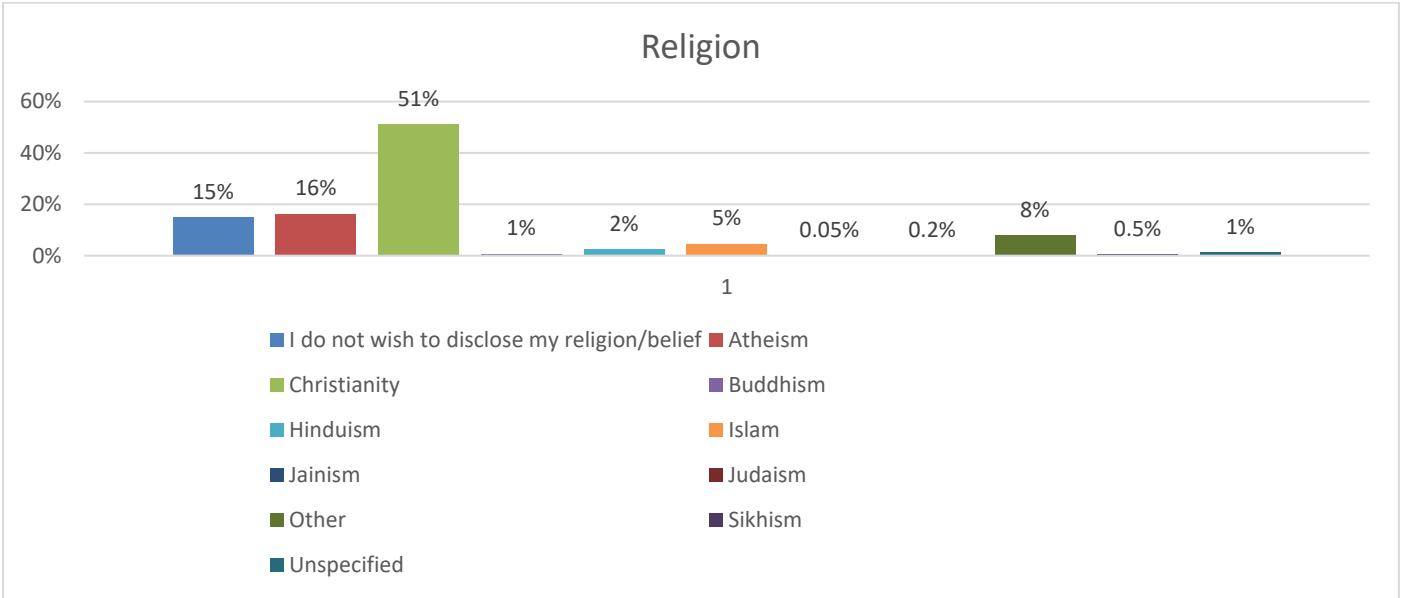
The Trust ensures all colleagues have equal opportunities and recognition, regardless of marital status, by keeping HR policies up to date which align with employment law. The Trust also encourages colleagues to update their status on ESR.

Religious Belief

Similarly to previous years, the predominant shared religious belief is **Christianity (51%)** and **Atheism (16%)**. **15%** of staff chose not to disclose their religious belief; this correlates with the current Census as

more people across the UK selected the option, ‘No Religion’ as their belief.

The chart below shows a breakdown EPUT’s religious Belief:



EPUT pays due regard to religious beliefs by promoting the Faith and Spirituality Diversity Network and celebrating religious festivals and events. The Trust encourages staff to update their religious status on ESR to support the Trust in providing equal opportunities for all faiths and non-faiths. The Interfaith and Spirituality Diversity Network works in collaboration with the Trust chaplaincy services, offering emotional, spiritual and religious guidance to all colleagues. Prayer rooms have been provided, to enable staff the space for prayer and reflection.

New Starters & Leaver Profile

The Trust has taken action to promote a more diverse workforce by embedding a fairer recruitment process, with large recruitment campaigns advertising posts in multiple job platforms to ensure a larger talent pool of candidates including a focus on our local people and communities and areas of high unemployment.

In 2025/2026 there were 1,280 new starters. The majority of new starters were employed in Band 2-6 posts.

Below gives an overview of our equality breakdown for new starters:



The demographic composition of new starters within the Trust:

Ethnicity: The total percentage of all new starters from ethnic minority backgrounds during this reporting period was 50%. This is similar to the previous reporting period.

Age: The highest percentage of new starters are those aged in their 20’s (23%), 30’s (25%) and 40’s (22%)

Gender: The workforce is predominately female which reflects in the new starters data - 74% new starters were female and 26% were male. This is a 2% increase of female new starters from the previous year.

Disability: 9% of new starters stated that they have a disability, an increase of 1% since the previous year report. There has been a slight increase year on year in the percentage of new starters disclosing a disability or LTC.

Sexual Orientation: The highest representation for sexual orientation was heterosexual (88%), followed by 7% of new starters declining to provide a response. 5% of our new starters disclosed as LGBTQ+ which is the same as the previous year.

Religious Belief: The highest representation of religious belief within new starters was Christianity (52%), followed by Atheism 20%, which reflects the figures of the overall Trusts demographics. However, there were a large number of new starters who chose not to disclose this information (11%).

Marital Status: The highest declared marital status was single.

To align with the NHS EDI High Impact Action Plan, as well as the WRES/WDES action plans, EPUT continues to strive:

- To improve the recruitment process by developing and embedding the De-Bias toolkit for hiring managers to ensure the process is fair for all.
- Inclusion Ambassadors on interview panels for 8a and above roles is mandatory to increase a fairer recruitment process.
- To promote and build awareness of the Disability Confident Scheme.
- To promote our status as a Disability Confident Leader on all job advertisements and re-accredit in 2026
- Advertise roles within a wide range of recruitment platforms and outlets

Leavers

In 2025/2026 1469 employees left the Trust with an overall turnover rate of 11%, a 9% increase from the previous reporting period.

Of the 1469 leavers, 45% of were planned (end of fixed term contracts, retirements and employee transfers) and 55% were unplanned exits (death in service, dismissal and voluntary resignation).

Leavers Breakdown:



The demographic composition of leavers for the Trust:

Ethnicity: 49% of leavers were from ethnic minority groups. Which is an increase from the previous year.

Disability: 9% of all leavers identified themselves as having a disability, an increase of 1% in comparison to the previous year.

Gender: 74% of leavers were female and 26% were male, which is proportionate to the overall workforce.

Religion: The highest percentage of leavers declared themselves as Christian (55%), which is proportionate to the overall workforce.

Sexual Orientation: 5% of leavers were LGBTQ+, an increase of 2% compared to last year.

Age: The highest percentage of leavers is aged 40+.

We will continue with our combination of the Trust's initiatives to improve staff retention & on-boarding process, improved access to career development opportunities, fewer dismissals and the refresh and development of the exit process.

Promotions

The data collected from ESR on primary job assignments shows 423 promotions which is the same as the previous reporting period. This could be as a result of no promotional vacancies or appropriate candidates for the role as well as the financially challenged position of the trust and financial recovery programmes.

The demographic composition of staff who have been promoted within the Trust:

Ethnicity: 35% of staff who were promoted were from a BME background. This is a **1% increase** in comparison to last year's report. The highest promotional band for BAME staff was Band 5 (50%) and medical staffing (80%)

Disability: 12% of the staff that were promoted declared that they had a disability, which is an increase in comparison to last year's report.

Gender Breakdown: 75% of the promotions were female, while 25% were male.

Religious Belief: The highest number of promotions came from those who declared themselves as Christian, which is representative of the underlying workforce.

Sexual Orientation: The highest proportion of staff who were promoted declared themselves as heterosexual (84%), which aligns to the overall workforce of the Trust. The percentage of LGBTQ+ staff who received a promotion was 6% which was a (1%) increase in comparison to last year.

Age: The data shows EPUT's staff promotions falls within the workforce aged group 30 - 40.

There is currently no marital status breakdown for promotions.

The Trust recognises the importance supporting staff throughout their career within EPUT and encourages career progression and development by providing the following initiatives:

- Management Development Programme
- Ward Manager Programme
- Leadership Development Programme
- RISE Programme
- Career support pathways for BME colleagues.

Employee Relations

Employee relations are the ways in which we manage our relationships at work and the management of workplace issues such as complaints or grievances and matters of behaviour and conduct.

Data in this category includes the following:

- The number of staff undergoing a disciplinary hearing
- The number of staff submitting formal grievances
- The number of staff who have been the subject of investigation and capability procedures the number of allegations made in relation to bullying and harassment (Dignity at Work)
- The number of staff whose level of sickness absence prompted formal action as detailed in the Trust's Management of Sickness & Ill Health Procedure.

The data includes all staff (permanent and bank workers) across all pay bands.

Type / Category (reporting only)	Number of cases – 2024/25	Number of cases - 2025/26
Capability	28	23
Conduct	129	103
Temporary Worker Conduct	113	59
Flexible Working	280	317
Grievance	47	50
Temporary Worker Complaint	14	8
Sickness	10	10
TOTAL	621	570

The table above shows a decrease in capability, conduct and, temporary worker cases. Cases relating to sickness absence has remained the same.

The demographic composition of staff who were involved in ER cases within the Trust:

Ethnicity: Within this reporting period:

- 57 BME staff underwent ER procedures for conduct
- 54 BME staff underwent temporary worker conduct procedures
- 84 BME staff submitted flexible working requests

Most staff who are involved in ER cases are white British (59%), with just under half of cases (41%) being attributed to workers from a BME background which in comparison is higher than the % within our workforce overall (39%). 84 flexible working applications were submitted from BME employees, with a further 233 from non-ethnic employees.

Disability: 11% of ER cases involved staff who identified as having a disability or long-term health condition.

Gender: The gender breakdown of staff involved in ER cases is 24% for men and 76% for women.

Religious: Christianity (57%) is the highest declared religion followed by “I do not wish to disclose my religion or belief” (12%) and Atheism (14%).

Sexual Orientation: 8% of staff who have been involved in ER cases have chosen not to disclose their sexual orientation.

Age: The majority of staff who were involved in ER cases were aged group 30 – 50, this is aligned with the Trust’s overall workforce as this is the largest age group within the Trust. The main areas for ER procedures falls within conduct, flexible working and Temporary worker conduct.

Equality Delivery System

The Equality Delivery System (EDS) designed by NHS England to support the NHS in making improvements on equality, diversity, wellbeing and inclusion for the benefit of patients and staff.

Our current EDS Report is published on our website [Equality Delivery System - Essex Partnership University NHS Foundation Trust](#) and will be updated and reviewed in Quarter 4 2026/2027

Next steps and Actions

This year for the first time one Equality Plan brings all workforce strands together and therefore the following areas of focus are contained within that plan which can be accessed here: *[link will be inserted once approved for publication]*

Report prepared by:	
Janice Scott Head of Staff Experience & Inclusion	Lisa Fricker Workforce/ESR and Payroll Manager

9.5 EQUALITY AND INCLUSION ANNUAL REPORT (WRES / WDES)

● Decision Item

● Chief People Officer

REFERENCES

Only PDFs are attached



Equality & Inclusion Annual Report 2026 (WRES WDES) 07.10.2026.pdf

SUMMARY REPORT		BOARD OF DIRECTORS PART 1			7 October 2026		
Report Title:		Equality & Inclusion Annual Report 2026 (including Workforce Race and Workforce Disability Equality Standards)					
Report Lead		Andrew McMenemy – Executive Chief People Officer and Interim Deputy Chief Executive Officer					
Report Author(s):		Paul Taylor – Director of Organisational Development and Culture					
Report discussed previously at:		People Committee 27th August 2026					
Level of Assurance:		Level 1	☒	Level 2	☐	Level 3	☐

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

backgrounds and staff with a disability. The associated action plan initiates mitigating the risks identified, whilst acknowledging further action at the end of this cycle of improvement.

Purpose of the Report

This report forms one of three key reports that bring together a set of required statutory reporting requirements: Equality & Inclusion Report (Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES)).

This Equality and Inclusion report details results from our Workforce Disability Equality Standards and Workforce Race Equality Standards 2025 data measuring our performance from the previous year. It provides a level of assurance on the staff experience of black and ethnic minority (BME) staff and staff with a disability, a breakdown of areas of challenge with an associated equality action plan for the next 12 months.

Decision	☒
Discussion	☒
Information	☐

Recommendations/Action Required

The Board of Directors are asked to:

1. Note and discuss the report contents and proposed actions for delivery for 2026/27
2. Approve the WRES and WDES for publication.

Summary of Key Points

The attached report provides the Board of Directors with a breakdown of our Workforce Race Equality Standards (WRES), our Workforce Disability Equality Standards and our proposed areas of action 2026/2027. The findings are consistent with the outcome of the recent CQC report and addresses the inequalities identified.

The annual report and data were presented and scrutinised by the People Committee on the 27 August 2026, and key headlines are provided for the Board of Directors as follows:

1. Main highlights from the WRES report

- 6 out of the 9 data indicators have evidenced an improvement.
- The number of black and minority ethnic staff reporting bullying and harassment and entering formal disciplinary procedures has reduced, however the numbers are still significantly higher than their White counterparts.
- Black and minority ethnic staff are still less likely to be appointed into a role or access non mandatory training and CPD than their White counterparts.
- The number of staff from a black and minority ethnic background who believe the organisation provides equal opportunities for career progression or promotion increased this year.

2. Main highlights from the WDES report

- 7 out of the 13 data metrics evidenced an improvement for staff with a disability or a Long-Term Condition (LTC).
- Higher numbers of staff with a disability report feeling supported when not feeling well enough to come in to work and have adequate reasonable adjustments in place.
- Staff with a disability report bullying and harassment and enter formal disciplinary procedures at a higher rate than non-disabled staff. They are also less likely to be appointed following shortlisting.

3. Next Steps and Equality, Diversity and Inclusion Action Plan for 26/27

Using a single Trust-wide equality, diversity and inclusion plan, we will build on recent progress by focusing on a clear set of practical actions to reduce pay gaps and strengthen inclusion across the Trust. The plan and all detail within it have been co-designed with our Ethnic Minority Race Equality Network (EMREN) and Staff Side representatives and accounts for the following drivers:

- Recommendations from the Lord Mann Review
- Feedback from the most recent well-led CQC Inspection for EDI
- The NHS England 6 High Impact Actions
- Results from the Statutory Reports and Workforce Race Equality Standards / Workforce Disability Standards,
- Strategic approach to EDI set out in EPUT People Strategy
- NHS Employers and NHS Staff Council joint recommendations
- NHS Staff Survey results including where they relate specifically to Workforce Race Equality Standards / Workforce Disability Standards.

The actions identified are the same as reported through the Public Sector Equality Duty report, with the addition of embedding fair and inclusive recruitment processes. The action plan will be reviewed and reported on quarterly basis.

In conclusion, this report highlights that whilst the Trust has made progress in advancing the equality of opportunity of black and minority ethnic staff and staff with a disability and addressing discrimination, the level and pace of change needs to consistently and cohesively improve. This first year's action plan provides a foundation for these improvements and will form the infrastructure for the aim of EPUT becoming an anti-racist and anti-discriminatory organisation.

The Board can take assurance that the Trust has complied with the requirements for Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reporting, that the findings have been scrutinised through the People Committee, and that a robust, co-designed Equality, Diversity and Inclusion Action Plan is in place to address identified disparities and support improvement in the experience, progression and inclusion of staff from ethnic minority backgrounds and staff with disabilities. Progress against the action plan will be monitored through established governance arrangements and reported on a quarterly basis.

Relationship to Trust Strategic Objectives

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

Which of the Trust Values are Being Delivered

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

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

Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	☒
The actions identified in relation to culture support the cultural work being undertaken, supporting the improvement plan developed from the CQC Well-Led Inspection.	
Data quality issues	☒

The WRES and WDES datasets are dependent upon staff declaration rates, and both national standards acknowledge limitations caused by unknown or undeclared data.

Involvement of Service Users/Healthwatch	☐
Communication and consultation with stakeholders required	☐
Service impact/health improvement gains	☐
Financial implications:	☐
Governance implications	☒

The report meets the requirement for the publication of WRES and WDES data for the Trust.

Impact on patient safety/quality	☒
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Reports evidence that providing a safe and compassionate working environment for the staff identified, has a significant impact on staff well-being and patient outcomes.

Acronyms/Terms Used in the Report

WDES	Workforce Disability Equality Standard	DCF	Data collection Framework
ESR	Electronic Staff Record	AfC	Agenda for Change

Supporting Reports/ Appendices /or further reading

Workforce Race and Disability Report and Workforce Equality Action Plan 2026

Lead



Andrew McMenemy
Executive Chief People Officer / Interim Deputy Chief Executive Officer

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Workforce Race and Disability Report and Workforce Equality Action Plan 2026

1. Introduction

The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) are annual data collection exercises undertaken by NHS organisations to drive improvements across race and disability. The information assesses the workplace experience of staff from Black and Minority Ethnic (BME) backgrounds and those with a disability which provides the trust with valuable data to help implement actions in areas where the staff report a less positive experience and promotes fair and inclusive practices so that all staff feel supported and valued.

The reports utilise the data from Electronic Staff Record (ESR) from 1st April 2025 – 31st March 2026 and the 2025 NHS Staff Survey. Where there are comparisons, these are provided for Trusts offering Mental Health, Learning Disability and Community services, as well as the National NHS average.

This report shares the findings of WRES and WDES 2026 data in some cases with comparison to previous performance and performance of Trusts of a similar type. The data has been shared with EPUT Stakeholders, including our Ethnic Minority and Race Equality Network (EMREN) and Disability and Mental Health Network (DMH Network) and the reports and associated action plan have been co-designed with those groups. It has been signed off by our People Committee and *Board of Directors*.

Our People Strategy commits to reducing inequity, promoting equality and fairness, career progression and advancement and protecting staff from harm. This report aims to provide full transparency regarding current position, share positive work and identify areas for improvement. Whilst many of the inequality issues highlighted in this report are not unique to EPUT, the experiences of our BME staff and staff with a disability are not where they should be the unintended negative impact this can have on staff is significant.

EPUT is committed to being an equal opportunities employer and to building equality, diversity and inclusion into everything that it does and has met contractual obligations to submit data for 2026 to the national teams.

Oversight and monitoring of progress is provided by the Staff Experience and Inclusion Group and equality networks who support the Trust in identifying priorities and areas of impact for staff.

2. Overview of 2026 WRES data report

Indicator	Improvement for BME staff	Highlights
1.	Yes	42.2% of BME staff work in clinical roles. The largest underrepresentation is in Bands 4 and 7-8d and an over representation in Bands 3 and 5. 14.5% of BME staff work in non-clinical roles. The largest under representation is in Bands 5, 6 and 8c and an over representation in Band 2, 8a, 8b and 8d.
2.	Slight	White applicants are 1.39 times more likely to be appointed than BME applicants following shortlisting processes.
3.	Yes	BME staff are 2.01 times more likely to enter a formal disciplinary process compared to White staff. Last year they were 3.32 times more likely, so this has reduced.
4.	Slight	White staff are 1.37 times more likely to access non-mandatory training and CPD when compared with BME staff.
5.	No	38.7% of BME staff have experienced harassment, bullying or abuse from patients/service users, relatives or the public in the last 12 months, a 7.6% increase from the previous year.

Indicator	Improvement for BME staff	Highlights
6.	No	22.7% of BME staff have experienced harassment, bullying or abuse from colleagues. This is an increase of 0.85%. There was a 1.33% reduction for white staff.
7.	Yes	54.2% BME staff believe the organisation provides equal opportunities for career progression or promotion. This is an increase of 4.02%
8.	Yes	BME staff have reported a 1.89% reduction in bullying and abuse from managers or other colleagues. 12.69% of BME staff experienced this behaviour in the past 12 months compared with 7.68% of White staff.
9.	No	BME representation at Board level has remained the same as the previous year.

The full WRES breakdown is attached at **APPENDIX A and B**

Positive areas of improvement for BME staff

Overall, the Trust has seen improvements in 6 out of the 9 WRES indicators. The areas below identify an improvement in the Trust indicators and for some, a more positive experience against comparable trusts and the national NHS average. Whilst it is noted there have been improvements, the Trust recognises the significant disparity in the staff experience and is committed to including these areas in the overall actions for improvement.

- There has been an increase in the number of BME staff within the organisation, particularly within roles in bands 8a, 8b and 8d.
- The data shows BME staff are less likely to enter a formal disciplinary process than in the previous year, yet this is still significantly higher than their White counterparts.
- BME staff report feeling more positive about the Trust providing equal opportunities around career opportunities and progression.
- There has been a reduction in the number of staff experiencing harassment, bullying or abuse from managers or colleagues, however they are still experiencing this at a significantly higher rate than their White counterparts.

Areas of challenge for BME staff

The areas below indicate BME staff continue to face challenges in their working experience with the trust.

- BME staff are still less likely to be appointed into roles following the shortlisting process, however this has seen a year-on-year increase.
- BME staff are not accessing non-mandatory training and CPD at the same level as White colleagues.
- BME staff are experiencing significantly more harassment, bullying or abuse from patients, service users, relatives, the public.

3. Overview of 2026 WDES data report

Metric	Improvement for staff with a disability	Highlights
1.	Yes	9.1% of staff including very senior managers and Executive Board members have declared a disability, which is an increase of 0.27% from the previous year.
2.	No	Non-disabled staff are applicants are 1.34 times more likely to be appointed than staff with a disability following shortlisting.
3.	Data not held	Staff with a disability are 1.62 times more likely to enter a formal capability process (excluding on the grounds of ill health) than non-disabled staff.
4ai.	No	31.4% of staff with a disability have experienced harassment, bullying or abuse from patients/service users, relatives or the public in the last 12 months, a 2.85% increase. There was a 3.94% increase for non-disabled staff.
4aii.	Yes	11.01% of staff with a disability have experienced harassment, bullying or abuse from managers compared, a reduction of 1.86%.
4aiii.	Yes	21.2% of staff with a disability have experienced harassment, bullying or abuse from colleagues, a reduction of 1.54%. There was a 0.85% increase for non-disabled staff.
4b.	Yes	64.58% of staff with a disability reported harassment, bullying or abuse from a colleague, an improvement of 1.42% from 2025.
5.	No	53.48% of staff with a disability believe the organisation provides equal opportunities for career progression or promotion, a reduction of 1.64% from 2025.
6.	Yes	18.03% of staff with a disability reported that felt pressure from their manager to come to work despite not feeling well enough to perform their duties. An improvement of 1.6% from 2025.
7.	No	There was a reduction of 1.28% of staff with a disability feeling satisfied with the extent to which their organisation values their work.
8.	Yes	76.93% of staff with a disability had adequate adjustments made to enable them to carry out their work, an improvement of 1.54%.
9a.	Same	The rate of engagement of staff with a disability remained approximately the same as 2025.
10	Yes	20% of the Total Board Membership declared as having a disability which is higher than the overall workforce - 14.29% of the voting membership and 14.29% of the Executive Board Membership.

The full WDES breakdown is attached at **APPENDIX C and D**

Areas of positive improvement for staff with a disability

Overall, the Trust has seen improvements in 7 out of the 13 WDES metrics. Similarly, staff with a disability report a more positive experience against comparable trusts and the national NHS average. Again, whilst it is noted there have been improvements, the Trust recognises the significant disparity in experience and is committed to incorporating these areas in the overall actions for improving the working environment for staff with a disability.

- More staff have felt comfortable to share their disability status and this extends to the Executive Board members who are leading by example.

- There has been a reduction in the number of staff with a disability experiencing bullying, harassment or abuse whilst at work from managers and colleagues, which is of a similar level to non-disabled staff.
- More staff with a disability are feeling supported when not feeling well enough to work and are having adequate and reasonable adjustments made to support their everyday working experience.

Areas identifying areas of challenge for staff with a disability.

The areas below indicate staff with a disability continue to face challenges in their working experience with the trust.

- Staff with a disability are still less likely to be appointed into roles following the shortlisting process.
- Staff with a disability are much more likely to enter a formal disciplinary process, this data was not reported on previously so will be monitored.
- Staff with a disability are experiencing harassment, bullying or abuse from patients, service users, relatives, the public which is a similar trajectory for non-disabled staff.
- Less staff with a disability feel the organisation provides equal opportunities for career progression or promotion and that their work is valued.

4. Achievements throughout 2025

There have been several initiatives in the last year which have centred on bettering the experience of BME staff and staff with a disability which has led to an improvement across several of the indicators and metrics for both WRES and WDES:

- The continued roll out of new values-based recruitment procedures, encouraging hiring managers to utilise the de-bias toolkit, ensuring interviews for roles 8a and above include an Inclusion ambassador.
- Updates were made to the disciplinary policy, special leave policy, flexible working policy and grievance policy, to be more compassionate and supportive to colleagues.
- The disciplinary process has been revised, and a preliminary assessment form and independent conduct concerns panel have been introduced. This process supports consistency and fairness in incident reviews, emphasising learning, and informal resolution and is already showing impact on the % of BME staff being referred to the formal disciplinary process.
- The Trust signed up to the Anti-Racism pledge and commissioned the Kings Fund and BRAP to deliver an inquiry into the Trust's organisational culture and develop a pilot leadership development programme to address the long-standing cultural issues.
- The Unacceptable Professional Behaviour and Sexual Safety training was rolled and is centred on the Behaviour framework.
- The Neuro-inclusive Café started which focusses on strengths associated with disabilities.
- Renewed proposals for staff equality networks were approved giving stronger support, executive sponsorship and base funding to support annual work plans.

5. Equality Diversity and Inclusion Action Plan

EPUT is committed to nurturing a culture of equality and inclusion, where racism, disability discrimination, and all other forms of discriminatory behaviour are not tolerated.

Whilst the Trust has made some good progress in relation to the Equality Diversity and Inclusion agenda, there remains some significant areas of challenge which will require a strong appetite for resolving. This will require improved visibility for staff on the ongoing actions and rigorous monitoring and oversight to ensure we create an open and inclusive culture where any form of discrimination, bullying or violence is not tolerated.

The Action Plan correlates with the 2026-2030 People Strategy which reflects the overall aim to be an employer of choice that nurtures and grows out workforce, delivering compassionate and inclusive care. It

provides the main areas of priority for action over the next 12 months with a number of additional actions encompassed within the work plan for Staff Experience and Staff Equality networks. The plan also aligns with the new NHS staff standards and the NHS High Impact Actions and progress will be reviewed ahead of a year 2 action plan.

6. Equality Diversity and Inclusion Action Plan 2026/27

Objective	Action	Timescale	Lead	Link to EPUT plan/strategy
Compassion				
1.Strengthen the reporting process for abusive incidents and reduce the number of incidents towards staff	Review and refresh of the Violence Abuse Prevention and Reduction (VAPR) process alongside managers including supportive reporting processes. Mapping of current processes against new Violence Prevention and Reduction Standard and NHS Staff Standard.	March 2027	Corporate Health and Safety and VAPR Service	SS SSt WDES WRES HIA CQC
	Increase staff awareness of the process of reporting a hate crime	December 2026	Corporate Health & Safety and VAPR Communications	
	Strong reintroduction of the zero-tolerance approach to abuse against staff using materials and posters such as 'not part of my job'	December 2026	Communications	
	Increase awareness of trauma-informed care and associated wellbeing offer to staff following an incident	June 2027	Head of Staff Experience Psychological Services	
	Continue delivery of the Unprofessional Behaviours and Sexual Safety training to reduce bullying improve civility and appropriate work behaviours. Produce an annual report on progress and staff experience.	March 2027	Head of Organisational Development	
2. Become an anti-racist and anti - discriminatory Trust	Alongside BRAP and the EMREN Network, develop and deliver an Anti-Racist and Cultural Awareness cascade training programme for Board members and leaders.	March 2027	Head of Staff Experience Head of Organisational Development	EDS2 PS PSED SS SSt WDES WRES KFCR
	Commence senior leaders programme in partnership with BRAP and the Kings Fund with a focus on trauma informed, anti-racist and anti-discriminatory leadership.	September 2026	OD and Culture Service	
	Review of formal capability processes to assure equity and fairness. Implement the resolution strategy for the Conduct Concerns Panels and grievances.	September 2026	Operational Human Resources	

Objective	Action	Timescale	Lead	Link to EPUT plan/strategy
	Implement the actions from the Lord Mann Review and undergo the Alumni NHS Race Observatory programme for selected NHS Trusts.	March 2027	Associate Director of OD & Culture Head of Staff Experience	
Attract				
3.Embed Fair and Inclusive Recruitment Processes	Embed a fair and inclusive recruitment process which targets improved representation and diversity.	June 2027	Resourcing/Staff Experience	EDS2 PG PS PSED SS SSt HIA WDES WRES KFCR CQC
	Review the Inclusion Ambassador role to include disability with support to effectively and appropriately question/challenge. Increase current numbers of Inclusion Ambassadors for Interview/Selection panels.	December 2026	Operational Human Resources Operational Human Resources	
	Review and refresh recruitment practices and training including the reasonable adjustment process to reflect inclusivity			
Retain				
4.Create, develop and promote clearer career development initiatives and pathways	Review and refresh staff induction and on-boarding to align with values.	September 2026	Resourcing/OD and Culture	EDS2 PS PG PSED SS SSt WDES WRES HIA KFCR
	Deliver bespoke “Speed Mentoring” events specifically to BME staff and dominant disabilities and conditions.	Quarterly 2026/2027	OD and Culture	
	Develop a reciprocal mentoring programme designed initially for BME staff and leaders	March 2027	Staff Experience	
	Set out proposals for a 6-month protected secondment programme to enhance the skills and experience of staff ahead of recruitment opportunities, initially for BME nurses but broadened to other Protected characteristics.	March 2027	Operational Human Resources	
	Intelligence led talent mapping and CPD funding initiative to support equitable access to training & learning opportunities	March 2027	Operational Human Resources/OD and Culture	

Objective	Action	Timescale	Lead	Link to EPUT plan/strategy
	Implement career coaching and review programme specifically for BME staff and staff with a disability across operational and corporate services	March 2027	OD and Culture	
5.Ensure equitable access to flexible working arrangements	Six monthly flexible working uptake and approval rate reviews by protected characteristic.	March 2027	Operational Human Resources	PS PG PSED SS SSt WDES WRES HIA
	Strengthened manager guidance on inclusive flexible working decision-making in consultation with the DMH Network	September 2026	Operational Human Resources	
	Review of workplace accessibility for staff with a disability to improve inclusivity and physical safety.	March 2027	Estates and Facilities	
Empower				
6.Support, strengthen and celebrate protected characteristics	All Executive Directors have EDI objectives in place which represent their own portfolio, network sponsorship and a commitment to reciprocal mentoring.	September 2026	Staff Experience Executive Directors	SS WDES WRES HIA PS KFCR CQC
	Strengthen the voice, visibility and influence of networks so they actively shape & co-design organisational decision-making, improve staff experience, and support a culture of belonging, inclusion and equity.	Quarterly 2026/2027	Communication Teams/ Staff Experience	
	Support and provide bespoke guidance to Staff Networks to enable delivery on their plans in line with the EDI Action plan			
	Review and deliver refreshed content of the Resilience Intelligence Strength and Excellence (RISE) programme for 2027-2028, in alignment with the BRAP and Kings Fund senior leadership programme.	Quarterly 2026/2027	Staff Experience	

Key to plan/strategy			
EDS2	Equality Delivery System 2	SS	Staff and Pulse Survey Results
HIA	NHS England High Impact Actions	SSt	Staff Standards
PG	Pay Gap	WDES	Workforce Disability Equality Standard
PS	People Strategy	WRES	Workforce Race Equality Standard
PSED	Public Sector Equality Duty	KFCR	Kings Fund Cultural Review
CQC	CQC Feedback Report 2026		

7. Agreed measures of success

The metrics identified below have been agreed as our measures of success for the duration of this action plan. They will be supported by qualitative feedback obtained through staff networks, engagement staff cafes, equality events and longer term, a workforce dashboard (including EDI)

Agreed EDI Metrics and Targets 2026/27				
Theme	Direct Measure(s)	Current position (2025-26)	Target(s) Q1 (2027/28)	National Average (2025-26)
1. Extending the role & influence of equality staff networks	National Staff Survey (q.21)	73.5%	76%	74.76%
2. Unprofessional behaviours and sexual safety	National Staff Survey (Q17b)	3.03%	2.6%	2.82%
3. Anti-racism & Cultural awareness	WRES (Metric 3)	2.01	1.50	1.11
	WRES (Metric 6)	21.91%	19%	20.22%
	National Staff Survey (Q16c.6)	62.88%	55%	51.59%
4. Violence & Abuse	WRES (Metric 6)	21.91%	19%	20.22%
	WDES (4a.iii)	21.21%	18%	18.87%
5. Gender Equality	Pay Gap Equality Report	71.8%	76%	71%
6. Disability & Neurodivergence	WDES (Metric 5)	76.93%	80%	79.05%
	National Staff Survey (Q16c.2)	10.26%	9%	14.78%

Janice Scott
Head of Experience and Inclusion
August 2026

APPENDIX A - WRES DATA

Symbol	Key
▲ ▼	Improvement / Increase
▼ ▲	Decline / Decrease
	Current data for BME staff experience at time of reporting.

Workforce Indicators (Data taken from ESR, ER and Recruitment teams, April 2025 – March 2026)		EPUT Progress				
		EPUT 2025	EPUT 2026	25 - 26 Diff.	NHS MHL D Comm Avg	NHS National Avg
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce. <i>(full breakdown in Appendix A)</i> <i>Higher % = Improvement</i>	32.1%	34.63%	▲ 2.53%	24.5%	28.7%
2	Relative likelihood of White staff being appointed from shortlisting compared to BME staff. <i>Higher = Worse, "1" being equal likelihood. Figure below 1 means that BME Staff are more likely than White staff.</i>	1.44	1.39	▼ 0.05	2.04	1.95
3	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff. <i>Lower Ratio = Better, with "1" being equal likelihood.</i>	3.32	2.01	▼ 1.31	2.31	1.63
4	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff. <i>Lower Ratio = Better, with "1" being equal likelihood. Figure below 1 means that White staff are less likely than BME Staff.</i>	1.41	1.37	▼ 0.04	0.95	0.97

Staff Survey Indicators (data taken from NHS Staff Survey 2025)		EPUT 2024	EPUT 2025	24 / 25 Diff.	Staff Survey Avg. (2025)
5	Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives, or the public in last 12 months. <i>Lower % = Improvement</i>	White 21.49%	White 22.94%	▲ 1.45%	White: 21.38%
		BME: 31.64%	BME: 38.70%	▲ 7.60%	BME: 33.83%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. <i>Lower % = Improvement</i>	White 19.97%	White 18.64%	▼ 1.33%	White 16.94%
		BME: 21.91%	BME: 22.76%	▲ 0.85%	BME: 20.22%
7	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion. <i>Higher % = Improvement</i>	White: 60.90%	White 58.53%	▼ 2.37%	White 58.40%
		BME: 50.23%	BME: 54.25%	▲ 4.02%	BME: 51.61%
8	Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in last 12 months.	White: 7.78%	White 7.68%	▼ 0.10%	White 5.80%
		BME: 	BME: 	▼ 1.89%	BME:

Staff Survey Indicators (data taken from NHS Staff Survey 2025)		EPUT 2024	EPUT 2025	24 / 25 Diff.	Staff Survey Avg. (2025)
	<i>Lower % = Improvement</i>	14.58%	12.69%		12.69%

Workforce Indicators (Data taken from April 2025 – March 2026)		EPUT Progress		
		EPUT 2025	EPUT 2026	25 – 26 Difference
9i	Percentage difference between the organisations' Board voting membership and its overall workforce	White (66.7% - 66.4%) 0.3%	White (80% - 64.3%) 16%	Wider over - represented
	<i>A score of 0 = equality of representation between membership and workforce Minus numbers caused by larger percentage in overall workforce</i>	BME (25% - 32.1%) -7.1%	BME (20% - 34.63%) -15%	Wider under - represented
9ii	Percentage difference between the organisations' Board Executive membership and its overall workforce	White (100% - 66.4%) 33.6%	White (100% - 64.3%) 36%	Wider over - represented
	<i>A score of 0 = equality of representation between membership and workforce. Minus numbers caused by larger percentage in overall workforce</i>	BME (0% - 32.1%) -32.1%	BME (0% - 34.63%) -35%	Wider under - represented

1a) Summary of Key Figures Taken from WRES DCF	WRES 2024	WRES 2025	WRES 2026
Number of White staff in overall workforce	4712	4783	4695
Number of BME staff in overall workforce	2004	2312	2529
Number of staff (ethnicity unknown on ESR)	139	107	78
Total substantive (permanent) workforce	6855	7202	7302
Number of shortlisted applicants (White)	2921	2431	1930
Number appointed (White)	657	603	573
Percentage of successful appointments (White)	22.5%	24.8%	29.7%
Number of shortlisted applicants (BME)	2379	2760	2556
Number appointed (BME)	430	474	546
Percentage of successful appointments (BME)	18.1%	17.2%	21.4%
Number of shortlisted staff (ethnicity unknown on ESR)	158	246	232
Number appointed (ethnicity unknown in ESR)	25	20	9
Percentage of successful appointments (ethnicity unknown on ESR)	15.3%	16.2%	3.9%
Number of White staff entering formal disciplinary process	23	27	36
Number of BME staff entering formal disciplinary process	34	43	39
Number of staff (ethnicity unknown on ESR) entering formal disciplinary process	0	1	3
Number of White staff accessing non-mandatory training and CPD	1023	1170	601
Number of BME staff accessing non-mandatory training and CPD	406	402	236
Number of staff (ethnicity unknown on ESR) accessing non-mandatory training and CPD	71	153	78

White Board Members	12	11	12
White Executive Board Members	8	8	7
BME Board Members	5	3	3
BME Executive Board Members	2	0	0
(Ethnicity unknown on ESR) Board Members	1	1	0
(Ethnicity unknown on ESR) Executive Board Members	0	0	0

APPENDIX B – WRES WORKFORCE DEMOGRAPHICS

1b) Non-Clinical Workforce						
NHS Banding (AfC)	2024		2025		2026	
	White	BME	White	BME	White	BME
Band 1	No Staff in Band 1 or below					
Band 2	261	61	266	66	279	81
Band 3	522	56	534	58	494	69
Band 4	364	43	368	59	362	50
Band 5	157	15	160	14	145	17
Band 6	105	20	118	24	114	15
Band 7	86	15	91	16	80	12
Band 8a	44	8	46	12	44	12
Band 8b	20	6	19	6	21	9
Band 8c	21	5	22	4	24	3
Band 8d	11	3	13	3	11	4
Band 9	6	0	8	0	9	0
VSM	22	2	21	0	19	0

1c) Clinical Workforce (of which non-medical)						
NHS Banding (AfC)	2024		2025		2026	
	White	BME	White	BME	White	BME
Band 1	Band 1 Removed from Grading System (No Staff in Band 1 or below)					
Band 2	10	3	1	1	1	0
Band 3	582	394	562	515	547	535
Band 4	420	86	418	90	396	87
Band 5	308	421	332	411	307	475
Band 6	784	367	801	481	812	554
Band 7	574	178	581	210	598	228
Band 8a	202	58	209	65	210	67
Band 8b	94	27	91	23	92	22
Band 8c	28	3	29	10	27	11
Band 8d	14	7	18	7	17	6
Band 9	3	0	4	0	5	0
VSM	2	1	2	1	2	0
1d) Clinical Workforce (of which Medical and Dental)						
Consultants	29	79	31	81	30	89
<i>Of which, Senior Medical Manager</i>	0	1	0	1	0	1
Non-Consultant, Career Grade	12	56	13	59	13	62
Trainee Grades	31	90	21	89	32	120
Other	0	0	4	2	4	1

NB: Averages from Summary Page of WRES 2025 XLS File: [NHS England » Workforce Race Equality Standard: 2025 data analysis report for NHS trusts](#) filtered to Mental Health, Learning Disability & Community NHS Trusts

APPENDIX C - WDES DATA

Workforce Metrics (Internal Data, April 2025 – March 2026)		EPUT Progress				
		EPUT 2025	EPUT 2026	25 - 26 Diff.	NHS MHLd Comm Avg	NHS National Avg
1	Percentage of staff in AfC (Agenda for Change) pay bands and very senior managers (including Executive Board members) with disabilities compared with the percentage of staff in the overall workforce. <i>(full breakdown in Appendix A)</i> <i>Higher % = Improvement</i>	Disabled 8.84%	Disabled 9.11%	▲0.27%	9.80%	7.10%
2	Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts. <i>"1" being equal likelihood. Figure below 1 means that Disabled staff are more likely in comparison.</i>	0.91	1.34	▲0.43	1.04	1.11
3	Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process. <i>(excluding entry under the grounds of ill health)</i> <i>"1" being equal likelihood, Data taken as an average across two years.</i>	-	1.62	-	This data is not published due to volatility and small numbers	

Staff Survey Metrics (data taken from NHS Staff Survey 2025)		EPUT 2024	EPUT 2025	24 / 25 Diff.	Staff Survey Avg. (2025)
4ai	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from service users, their relatives or other members of the public in last 12 months. <i>Lower % = Improvement</i>	Non-Dis 22.25%	Non-Dis 26.19%	▲3.94%	Non-Dis 22.13%
		Disabled 28.55%	Disabled 31.40%	▲2.85%	Disabled 27.24%
4aai	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers in last 12 months. <i>Lower % = Improvement</i>	Non-Dis 7.31%	Non-Dis 5.98%	▼1.33%	Non-Dis 5.74%
		Disabled 12.87%	Disabled 11.01%	▼1.86%	Disabled 11.55%
4aii	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues in last 12 months. <i>Lower % = Improvement</i>	Non-Dis 13.81%	Non-Dis 14.66%	▲0.85%	Non-Dis 11.45%
		Disabled 22.75%	Disabled 21.21%	▼1.54%	Disabled 18.87%
4b	Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. <i>Higher % = Improvement</i>	Non-Dis 64.29%	Non-Dis 67.59%	▲3.30%	Non-Dis 66.28%
		Disabled 63.16%	Disabled 64.58%	▲1.42%	Disabled 61.68%

Staff Survey Metrics (data taken from NHS Staff Survey 2025)		EPUT 2024	EPUT 2025	24 / 25 Diff.	Staff Survey Avg. (2025)
5	Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion. <i>Higher % = Improvement</i>	Non-Dis 58.99%	Non-Dis 58.42%	▼0.57%	Non-Dis 58.71%
		Disabled 55.12%	Disabled 53.48%	▼1.64%	Disabled 52.19%
6	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. <i>Lower % = Improvement</i>	Non-Dis 14.43%	Non-Dis 13.07%	▼1.36%	Non-Dis 12.09%
		Disabled 19.63%	Disabled 18.03%	▼1.60%	Disabled 18.26%
7	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work. <i>Higher % = Improvement</i>	Non-Dis 53.23%	Non-Dis 54.05%	▲0.82%	Non-Dis 52.81%
		Disabled 46.93%	Disabled 45.65%	▼1.28%	Disabled 42.47%
8	Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. <i>Higher % = Improvement</i>	75.39%	76.93%	▲1.54%	79.05%
9a	The staff engagement score for disabled staff, compared to non-disabled staff. <i>Higher % = Improvement</i>	Non-Dis 7.12	Non-Dis 7.18	▲0.06	Non-Dis 7.17
		Disabled 6.61	Disabled 6.60	▼0.01	Disabled 6.64

10	Percentage difference between the organisation's Total Board membership and its organisation's overall workforce, <i>A score of 0 = equality of representation. Minus numbers caused by larger percentage in overall workforce</i>	Non-Dis 86.67% - 79.80% 6.87%	Non-Dis 80% - 81.37% 20% -1.37%	Narrower
		Disabled 13.33% - 8.84% 4.49%	Disabled 20% - 9.11% 10.89%	Wider over - represent ed
	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, <i>A score of 0 = equality of representation. Minus numbers caused by larger percentage in overall workforce</i>	Non-Dis 91.67% - 79.80% 11.87%	Non-Dis 85.71% - 81.73% 3.98%	Narrower
		Disabled 8.33% - 8.84% -0.51%	Disabled 14.29% - 9.11% 5.18%	Wider over - represent ed
	Percentage difference between the organisation's Executive Board membership and its organisation's overall workforce,	Non-Dis 87.50% - 79.80% 7.7%	Non-Dis 85.71% - 81.73% 3.98%	Narrower

	<i>A score of 0 = equality of representation. Minus numbers caused by larger percentage in overall workforce</i>	Disabled 12.50% - 8.84% 3.66%	Disabled 14.29% - 9.11% 5.18%	Wider over - represent ed
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APPENDIX D – WDES WORKFORCE DEMOGRAPHICS

Summary of Key Figures		WDES 2024	WDES 2025	WDES 2026
Number of Non – dis staff in overall workforce		5366	5747	5942
Number of disabled staff in overall workforce		518	637	665
Number of staff in overall workforce whose status is recorded as unknown		971	818	695
Total workforce		6855	7202	7302
Number of shortlisted applicants (Non – dis)		4769	4680	3957
Number appointed (Non – dis)		958	958	1004
Percentage of successful appointments		(20%)	(20.5%)	(25.4%)
Number of shortlisted applicants (disabled)		480	488	512
Number appointed (disabled)		105	110	97
Percentage of successful appointments		(22%)	(22.5%)	(18.9%)
Number of shortlisted applicants (unknown status)		200	269	259
Number appointed (unknown status)		49	29	27
Percentage of successful appointments		(25%)	(10.8%)	(10.4%)
Number of Non – dis staff entering formal capability process (on the grounds of ill health)		0	13	14
Number of disabled staff entering formal capability process (on the grounds of ill health)		2	4	7
Number of (unknown status) staff entering formal capability process (on the grounds of ill health)		25	8	11
Non – dis Board Members		16	13	12
Non- dis Executive Board Members		9	7	6
Disabled Board Members (Exec Board)		2	2	1
Disabled Executive Board Members		1	1	1
(Unknown status) Board Members (Exec Board)		0	0	0
(Unknown status) Executive Board Members		0	0	0
Cluster (Bandings)	1b) Disabled Staff (Non-Clinical Workforce)			
	2024	2025	2026	
C1 (1-4)	96	123	130	
C2 (5-7)	33	41	34	
C3 (8a / 8b)	4	9	11	
C4 (8c +)	3	3	3	
Cluster (Bandings)	1c) Disabled Staff (Clinical Workforce)			
	2024	2025	2026	
C1 (1-4)	103	127	132	
C2 (5-7)	225	271	288	
C3 (8a / 8b)	36	46	46	
C4 (8c +)	5	6	7	
1d) Clinical Workforce (of which Medical and Dental)				
C5 (Consultants)	2	2	3	
C6 (Career Grade)	4	4	6	
C7 (Trainees)	7	5	5	

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

NB: Averages taken from Summary Page of WDES 2025 XLS File: [NHS England » Workforce Disability Equality Standard: 2025 data analysis report for NHS trusts](#) filtered to Mental Health, Learning Disability and Community NHS Trusts

9.6 GENDER, ETHNICITY AND DISABILITY PAY GAP REPORT

● Decision Item

● Chief People Officer

REFERENCES

Only PDFs are attached

 Gender, Ethnicity & Disability Pay Gap Report 07.10.26.pdf

SUMMARY REPORT		BOARD OF DIRECTORS PART 1			7 October 2026		
Report Title:		Gender, Ethnicity & Disability Pay Gap Report					
Report Lead		Andrew McMenemy – Executive Chief People Office and Interim Deputy Chief Executive Officer					
Report Author(s):		Paul Taylor – Director of Organisational Development and Culture					
Report discussed previously at:		People Committee 27 August 2026					
Level of Assurance:		Level 1	☒	Level 2	☐	Level 3	☐

Risk Assessment of Report		
Summary of risks highlighted in this report	If the Trust does not produce accurate, timely, and credible pay gap reporting, it will fail to meet statutory requirements under the Public Sector Equality Duty. More importantly, it will undermine staff confidence in the organisation's commitment to fairness, pay equality, and the elimination of discrimination. This poses a significant risk to staff experience, retention, and organisational development, as employees who feel undervalued or treated unfairly are less likely to stay or to engage positively, impacting on effective and safe patient care.	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	☐
	SR4 Demand/ Capacity	☒
	SR5 Statutory Public Inquiry	☐
	SR6 Cyber Attack	☐
	SR7 Capital	☐
	SR8 Use of Resources	☐
	SR9 Digital and Data	☐
	SR10 Workforce Sustainability	☒
	SR11 Staff Retention	☒
	SR12 Organisational Development	☒
	SR13 Quality Governance	☐
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	No	
If yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	
Are you requesting approval of financial / other resources within the paper?	No	
If yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	N/A	
Reflection on Equalities	The report identifies disparities in equality of experience and opportunities within EPUT for staff with a protected characteristic. The associated action plan initiates	

mitigate the risks identified, whilst acknowledging further action at the end of this cycle of improvement.

Purpose of the Report

This report forms one of three key reports that bring together a set of required statutory reporting requirements: Public Sector Equality Duty, Equality and Inclusion report (WRES and WDES) and Gender, Ethnicity & Disability Pay Gap.

The Gender, Ethnicity & Disability Pay Gap report is the publication of data which shows differences in pay between groups in our organisation. It sets out gaps and provides transparency with actions we are taking to address gaps over time.

Decision	☒
Discussion	☒
Information	☐

Recommendations/Action Required

The Board of Directors are asked to:

1. Note and discuss the contents of this report including the Trust's performance in supporting equal opportunities for staff with protected characteristics and areas of focus.
2. Approve for publication.

Summary of Key Points

This report identifies pay differentials across gender, race, and disability within the Trust, highlighting where gaps exist, how they have changed over time, and which pay elements and workforce structures drive those gaps. The findings are consistent with the outcome of the recent CQC report and addresses the inequalities identified. The report was discussed and signed off at People Committee on 27 August 2026.

The annual report and data were presented and scrutinised by the People Committee on the 27 August 2026, and key headlines are provided for the Board of Directors as follows:

Key headlines:

- The gender pay gap has continued to improve throughout 2026 and remains below the national average, with both the mean and median pay gap reducing.
- The main area of ongoing challenge remains representation in the highest paid roles where men continue to be proportionally overrepresented in the top pay quartile and receive higher bonus payments. This reflects the historic profile of the consultant workforce and legacy Clinical Excellence Award arrangements.
- The ethnicity pay gap continues to improve with both the mean and median pay gap reducing, however black and minority ethnic colleagues remain concentrated within the middle pay quartiles and not within the highest paid roles.
- The disability pay gap remains relatively small for staff who have declared a disability. There remains a challenge to improve staff declaring their disability which will provide a more accurate information on the pay gap and of disability representation and progression across the Trust.

The Board can take assurance that the Trust has complied with statutory Gender Pay Gap reporting requirements and has undertaken additional analysis of ethnicity and disability pay gaps in line with NHS England guidance. The report provides transparency regarding workforce pay disparities, identifies the principal factors contributing to those differences, and is supported by a Trust-wide Equality, Diversity and Inclusion Action Plan designed to promote equitable opportunity, progression and reward across the

workforce. Progress will be monitored through established governance arrangements and reported through the People Committee.

Next Steps

Implementing a single equality, diversity and inclusion plan will build on progress by focusing on practical actions to reduce pay gaps and strengthen inclusion across the Trust. Actions to address the identified pay gaps are contained within the Trust-wide Equality Diversity and Inclusion Action Plan included in the Public Sector Equality Duty (PSED) report and monitored through the People Committee.

In conclusion, the report highlights that sustaining pay gap improvements will require a 'whole Trust' commitment on inclusive leadership, staff engagement, professional behaviours and creating psychologically safe environments where all staff feel valued and able to contribute.

Relationship to Trust Strategic Objectives

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

Which of the Trust Values are Being Delivered

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

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

Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	☐
Data quality issues	☒
Declaration rates for disability remain a limitation in interpreting pay gap data and form part of the improvement programme.	
Involvement of Service Users/Healthwatch	☐
Communication and consultation with stakeholders required	☐
Service impact/health improvement gains	☐
Financial implications:	☐
Governance implications	☒
The report meets the requirement to publish pay gap information.	
Impact on patient safety/quality	☒
The Report evidence that providing a safe and compassionate working environment for the staff identified, has a significant impact on staff well-being and patient outcomes.	

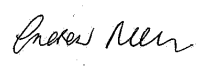
Acronyms/Terms Used in the Report

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

Supporting Reports/ Appendices /or further reading

Gender, Ethnicity & Disability Pay Gap Report

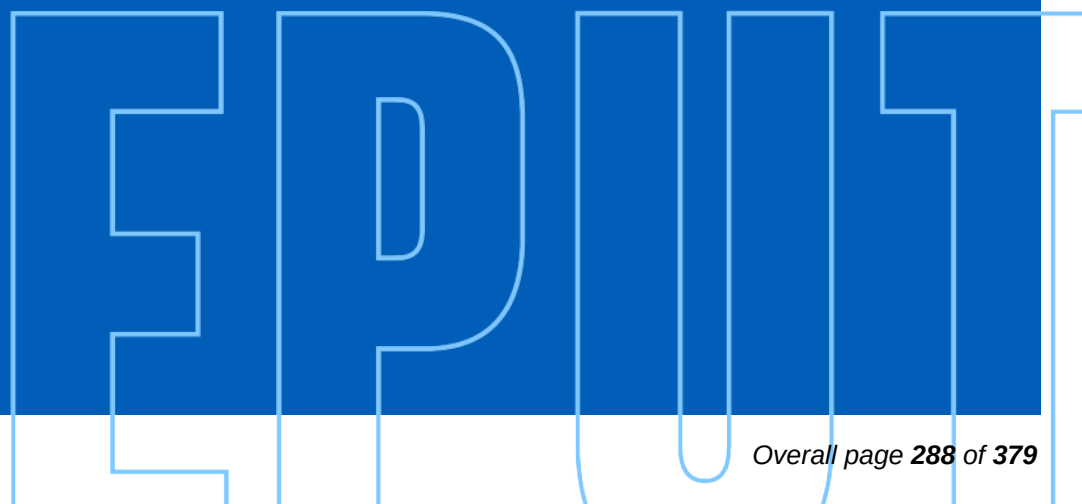
Lead



Andrew McMenemy
Executive Chief People Officer and Interim Deputy Chief Executive Officer

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

GENDER, ETHNICITY AND DISABILITY PAY GAP REPORT 2026



Purpose

This report presents gender, ethnicity and Disability pay gap data. It includes an analysis of pay differences, identifies contributing factors, and outlines commitments to addressing and closing the gap. Pay gap reporting aims to focus organisational efforts on reducing disparities, enhancing staff experience, improving retention, and fostering a workplace environment that is inclusive and rewarding for all.

The purpose of this report is to present the following pay gap information:

Gender Pay Gap (GPG)

Ethnicity Pay Gap (EPG)

Disability Pay Gap (DPG)

The report is based on a snapshot staff data as of **31 March 2026**, based on national guidelines. The data is extracted from the Electronic Staff Record (ESR).

Mean and median calculations are used for the following reasons and reviewing both measures gains a more balanced and accurate understanding of the GPG, EPG, DPG:

- Median pay provides a clearer picture of typical earnings, as it is not distorted by extremely high or low salaries.
- Mean pay shows how those very high or very low salaries influence overall averages.

The following pay gap differences are highlighted in this report:

- An hourly rate (average).
- Median hourly rate (middle value).
- Mean bonus pay.
- Median bonus pay.
- Pay Quartile (from lowest to highest).
- Proportion of staff in receipt of a Clinical Excellence Award (CEA).

Context

Essex Partnership University NHS Foundation Trust (EPUT) was established on 1 April 2017 following the merger of North Essex Partnership University NHS Foundation Trust (NEP) and South Essex Partnership University NHS Foundation Trust (SEPT). EPUT provides community health, mental health, and learning disability services to a large population across Bedfordshire, Essex, Suffolk, and Luton. We employ approximately 7,500 staff, excluding bank staff, volunteers, students, and contractors. The pay gap data offers valuable insights into the challenges related to inclusion and diversity within our entire workforce.

Like many NHS Trusts nationwide, EPUT has a predominantly female workforce. Current diversity data indicates that around 74% of employees are female, with approximately 26% male. During the period covered by this report, 60% of staff identified as White, while approximately 39% identified as from BME backgrounds. During this reporting period 8% of staff declared a disability, whilst 92% of staff did not have a disability.

A primary goal at EPUT is to promote fair and equitable career progression for all staff, of which addressing gender, ethnicity, and disability pay gaps is a key component. This report provides transparency on the current position, identify areas for improvement and supports both our statutory obligations and strategic objectives. Many of the inequality issues highlighted in this report are not unique to EPUT; they are common across the NHS and broader society. Continuing to publish data will reinforce our commitment to addressing these challenges and to foster openness as a positive step toward meaningful change.

EPUT is committed to being an equal opportunities employer and to building equality, diversity and inclusion into everything that it does.

Gender Pay, Ethnicity Pay and Disability Pay Gap Reporting

Legislation mandates that organisations with 250 or more employees provide an annual report on their gender pay gap. NHS organisations are subject to the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, which came into force on 31 March 2017. These regulations support the Public Sector Equality Duty, requiring organisations to publish their gender pay gap data each year. This includes information on both mean and median gender pay gaps, as well as mean and median gender bonus gaps, the proportion of men and women receiving bonuses, and the distribution of male and female employees across each pay quartile. Please note that only staff receiving full pay are included; therefore, figures may differ from other reports such as the PSED, WRES, or WDES.

Gender pay gap reporting illustrates the difference in average earnings between men and women within a workforce. Variations in pay gaps can be influenced by several factors, including age, length of service, and opportunities for career advancement. Recognising and addressing these factors will be key to fostering meaningful and sustainable progress. Historical gender stereotypes and role perceptions also impact pay disparities. For example, consultants on legacy contracts receive ongoing bonuses known as Clinical Excellence Awards (CLA).

It is important to emphasise that the gender pay gap differs from the concept of equal pay. Equal pay relates to ensuring that individuals performing the same or comparable work receive the same pay. Discriminatory pay differences based on gender are unlawful.

The Ethnicity Pay Gap (EPG) assesses the disparity in average remuneration between White staff and individuals from Black, Asian, and Minority Ethnic (BME) backgrounds. The Disability Pay Gap (DPG) measures the difference in average pay between disabled and non-disabled employees.

While reporting on EPG and DPG is not mandated by legislation, the NHS England Equality, Diversity, and Inclusion (EDI) Improvement Plan [EDI Improvement Plan](#) recommends that all Trusts analyse pay gap data based on protected characteristics and develop corresponding improvement strategies.

The report provides separate snapshots for the GPG, EPG, and DPG and acknowledge that various factors including flexible working arrangements, caring responsibilities, and socio-economic backgrounds may intersect with different protected characteristics, resulting in compounded disadvantage.

Scope

The pay gap is defined as the difference between the mean or median hourly rate of pay colleagues receive. The mean pay gap is the difference between average hourly earnings. This is commonly known as the average and is calculated when you add up the wages of all employees and divide the figure by the number of employees.

Gender Bonus Gap

Within the pay gap regulations, 'bonus pay' means any remuneration that is the form of money relating to profit sharing, productivity, performance, incentive or commission.

EPUT's Gender Pay Gap

This report outlines gender pay gap data. It provides an analysis of pay disparities between male and female employees, identifies contributing factors, and sets out commitments to closing the gap. The Gender Pay Gap is calculated as the difference between the average hourly earnings of men and women, as a proportion of the average hourly earnings of men.

The below table provides a snapshot of gender pay gap taken from 31 March 2026:

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	23.98	19.96
Female	21.34	19.78
Difference	2.64	0.18
Pay %	11.01	0.88

The below gender pay gap **bonus** table is taken as at the snapshot date of 31 March 2026.

Gender	Avg. Pay	Median Pay
Male	13,992.37	13,572.00
Female	6,683.75	6,031.99
Difference	7,308.62	7,540.01
Pay %	52.23	55.56

** Please see P5 for details explaining what constitutes a bonus**

Pay Quartiles by Gender

To provide an overview of gender distribution across different levels of seniority, the proportions of male and female employees are segmented into four pay quartiles: lower, lower middle, upper middle, and upper, representing ascending seniority. The distribution of men and women within these quartiles is summarised in the table below:

Quartile	Female	Male	Female %	Male %	Description
1	1356	372	78.47	21.53	Lower - Includes all employees whose standard hourly rate places them at or below the lower quartile
2	1477	516	74.11	25.89	Lower Middle - Includes all employees whose standard hourly rate places them above the lower quartile but at or below the median
3	1498	450	76.90	23.10	Upper Middle - Includes all employees whose standard hourly rate places them above the median but at or below the upper quartile
4	1358	539	71.59	28.41	Top - Includes all employees whose standard hourly rate places them above the upper quartile

Analysing the quartile distribution, although female colleagues constitute over 75% of the overall workforce, their distribution is predominantly concentrated within the first and third quartiles.

In the fourth quartile, female representation declines to 71.6%, with male representation increasing to 28.4%, compared to 21.5% in the first quartile. This suggests that while women are well-represented throughout the organisation, their presence diminishes at the most senior level. Addressing this disparity is crucial for promoting equitable career advancement and fostering greater organisational diversity

Ensuring equal pay

Legislation requires that men and women must receive equal pay for

- the same or broadly similar work
- work rated as equivalent under a job evaluation scheme or work of equal value.

Equal pay is delivered through a number of means but primarily through adopting nationally agreed terms and conditions for staff (e.g. Agenda for Change, Very Senior Manager framework).

What the data is telling us

The Gender Pay Gap (GPG) report examines key indicators, specifically the average and median pay differences:

- The GPG hourly pay gap for EPUT stands at 11.01%, with males earning an average of £23.98 per hour and females earning £21.34 per hour. When considering the median hourly rate, the gap narrows to 0.88%. **Compared to 2025, this represents a decrease of 1.25% in the average percentage and a 1.41% reduction in the median.**

This indicates that, on average, male employees are paid approximately 0.88% more than female employees within the organisation.

- The GPG bonus pay gap for EPUT is 52.23%, with males receiving an average bonus of £13,992.37 and females receiving £6,683.75. The median bonus pay has increased to 55.56%. **The average bonus pay gap has increased by 3.77%, while the median has significantly increased compared to 2025.**
- During the reporting period, 0.98% of male employees received a bonus compared to 0.13% of female employees. A contributing factor to this is the medical consultant workforce which is composed of 61.7% males and 38.3% females.

Bonus payments include components of doctors' pay. This staff group has a higher proportion of male employees, which contributes to a larger bonus pay gap compared to other staff groups within the organisation. The components of bonus pay are as follows:

- Clinical Excellence Awards (LCEAs ceased from 1st April 2024)
- Discretionary Points
- Performance-Related Pay

Over the past seventeen years, there has been substantial growth in the representation of women in medical roles, which is expected to contribute to a reduction in the gender bonus pay gap over time:

- **Female medical workforce:** A 20.9% increase, from 31.2% in 2008 to 52.1% in 2026. Currently, there are 186 females employed in medical roles.
- **Female medical consultants:** A 15.6% increase, from 22.7% in 2008 to 38.3% in 2026. This represents the highest number of female consultants employed since the commencement of monitoring.

Whilst there has been a growth in the female consultant medical workforce, the legacy of the consultants' bonus, the Clinical Excellence Award Scheme (CEA) means that there will continue to be a gender bonus pay gap because there are more male consultants than female consultants. The Trusts current medical consultant gender breakdown is detailed in the table below.

Reporting Year	Female Headcount	% of Total	Male Headcount	% of Total	% Difference between Female/Male
2022/23	36	35.60%	65	64.40%	28.80%
2023/24	36	33.00%	73	67.00%	34.00%
2024/25	44	37.93%	72	62.07%	24.14%
2025/26	44	38.30%	71	61.70%	23.40%

EPUT's Race Pay Gap

This is the third year of reporting for Ethnicity Pay Gap (EPG) data. As the presentation of ethnicity pay gap information is not yet a statutory requirement, benchmarking is not possible. The ethnicity pay gap is an emerging area of focus in this report and work will continue in collecting and analysing data to better understand the underlying factors contributing to pay disparities among different ethnic groups.

The table below provides a breakdown of staff within scope by gender and ethnicity for the reporting period 31 March 2026:

Ethnic Origin Grouping Summary	Mean Hourly Rate	Median Hourly Rate	Total Full Pay Relevant Employees
BME	22.89	20.03	2,861
White	21.40	19.33	4,627
Not Known	24.14	22.34	78
% Diff White - BME	-6.98	-3.65	38
% Diff White - Not Known	-12.83	-15.59	98

The snapshot for March 2026 shows an overall mean and median pay gap which has improved for our BME workforce.

The table below is a breakdown of pay quartile by Ethnicity:

Quartile	Asian	Black	Mixed	Other	White British	White Other	Not Stated
1. Lower	101	257	39	16	1,188	117	10
2. Lower Middle	139	709	42	11	968	109	15
3. Upper Middle	155	639	50	20	939	118	27
4. Top	266	321	45	51	1,003	185	26

The largest representation for each Ethnic Group by quartile is as follows:

- 45.21% of our BME workforce are in the 2nd quartile followed by 44.35% in the 3rd quartile.
- 75.52% of our White workforce are in the 1st quartile followed by 62.63% in the 4th quartile.

There continues to be a pay disparity between BME and White colleagues. The higher number of male BME consultants who fall within the 4th quartile causes a slight distortion to the overall pay disparity. The proposed actions to reduce inequalities between ethnicities are further detailed in the 2026 WRES Report, which is published on our website and available here: *[link will be inserted once approved for publication]*

The table below is a breakdown of pay quartile by Ethnicity Group:

Quartile	EPUT Total	BME	White
1. Lower	23%	14%	28%
2. Lower Middle	26%	31%	23%
3. Upper Middle	26%	30%	23%
4. Top	25%	24%	26%

Looking at the above table the largest representation for each Ethnic Group by quartile is as follows:

- Across EPUT total workforce is split evenly across all four quartiles with the 2nd and 3rd quartile both at 26% of the workforce.
- 31% of total BME workforce are in the 2nd quartile (901 of 2,861 BME employees) followed by 30% in the 3rd quartile (864 of 2,861 BME employees).
- 28% of white workforce are in the 1st quartile followed (1,305 of 4,627 white employees) followed by 26% in the 4th quartile (1,188 of 4,627 white employees).

The table below shows the bonus payments broken down by race as of 31st March 2026.

Ethnic Origin Grouping Summary	Employees Paid Bonus	Total Relevant Employees	Total Full Pay Relevant Employees
BME	20.00	3251.00	0.62%
White	8.00	4962.00	0.16%
Not Known	0.00	95.00	0.00%

The mean bonus pay gap was 0.45% in favour of BME colleagues. This legacy structure continues to impact equity due to senior medical pay.

Changes to Clinical Excellence Awards (CEAs) over time have created disparities in bonus pay:

- Pre-2017 consultants receive automatic annual increases (Levels 1–9).
- 2017–March 2023 consultants must reapply every three years.
- Post-March 2023 consultants are no longer eligible.
- COVID-19 pause led to equal distribution of CEA funds for two years.

It is important to note that the Trust's medical workforce has a significantly different ethnic profile to the overall workforce, with 76% of medical staff identifying as being from a Black, Asian and Minority Ethnic (BME) background. As medical roles are generally concentrated within higher pay bands and salary ranges, this workforce composition may influence the overall race pay gap figures and should be considered when interpreting the results.

No new CEAs will be awarded in the future.

EPUT's Disability Pay Gap

This is EPUTs second year of reporting disability pay data. It is an advisory requirement outlined in the NHS EDI improvement plan and represents a key milestone in efforts to understand and address disparities related to pay and representation within the Trust. This initiative reinforces the Trust's commitment to workplace accessibility, promotes equitable career progression and supports our goal of becoming an inclusive employer.

The table below shows the breakdown of staff in scope by disability for the reporting period 31st March 2026:

Disability Grouping	Mean Hourly Rate	Median Hourly Rate Grouping	Total Full Pay Relevant Employees
No	21.92	22.24	6,220
Yes	21.33	22.04	646
Prefer Not to Answer	21.69	21.98	37
Not Declared	23.38	24.11	569
Unspecified	15.25	15.17	4
% Diff No - Yes	2.69	0.90	90
% Diff No - Not Declared	-6.66	-8.44	91
% Diff No - Prefer Not to Answer	1.04	1.15	99
% Diff No - Unspecified	30.43	31.79	100

8.54% of staff have disclosed a disability, compared to the overall workforce. It is important to note that at the initial stages of the employee lifecycle, candidates may choose to disclose their long-term condition (LTC) during the application process; however, this information is not always transferred into ESR. This is due to the use of separate recruitment systems, such as TRAC online application forms. This disconnection can result in under-reporting at the onboarding stage, which subsequently impacts data accuracy and the Trust's ability to present an accurate picture in national workforce validation submissions. New starters are provided with the direction to update records within their induction and through positive encouragement from managers.

The above table indicates that further efforts are needed to encourage our highest earners to disclose whether they have a disability.

The table below is a breakdown of pay quartile by Disability:

Quartile	No	Yes	Not Declared	Prefer Not to Answer	Unspecified
1. Lower	1,415	161	132	9	1
2. Lower Middle	1,661	157	138	8	3
3. Upper Middle	1,632	172	110	6	0
4. Top	1,512	156	189	14	0

- 9.37% of our workforce with a recorded disability are in the 1st quartile followed by 8.96% in the 3rd quartile.

- 2.72% of our workforce in the 4th quartile have not declared, this is the highest number of no declaration.

It is important to highlight that the 'Not Declared' responses are most prevalent in the highest quartile. This may indicate that more experienced colleagues are not consistently reporting this information. Work is required to prioritise supporting staff to declare disability status to foster a culture of transparency and enable more accurate reporting.

The table below shows the bonus payments broken down by Disability as of 31st March 2026.

Disability Category	Employees Paid Bonus	Total Relevant Employees	%
No	22.00	6911.00	0.32
Yes - Unspecified	-	82.00	-
Learning disability/difficulty	-	166.00	-
Long-standing illness	-	181.00	-
Mental Health Condition	-	102.00	-
Physical Impairment	-	77.00	-
Prefer Not to Answer	-	44.00	-
Sensory Impairment	-	70.00	-
Other	-	83.00	-
Not Declared	6.00	664.00	0.90
Unspecified	1.00	1.00	100.00

Currently, there is no available data regarding the Clinical Excellence Awards for colleagues who identify as having a Long-Term Condition (LTC). This likely reflects a participant count of fewer than 10 and sharing such information could potentially compromise confidentiality and privacy. Therefore, we are currently unable to provide any specific details.

Office of National Statistics (ONS) - comparison to the national picture

Nationally, [The gender pay gap for workers is in favour of men for the majority of occupations](#). Occupations with the smallest gender pay gap have almost equal employment shares between men and women. It is also important to note that men and women have different personal and job characteristics, which ultimately impact their respective pay.

Across the UK, men earned on average **12.8%** more than women in 2024, according to the Office of National Statistics 23rd October 2025, meaning that EPUT's gender pay gap is below the national average.

Below is a comparison table of how EPUT's gender pay gap sits in comparison to local neighbouring NHS organisations.

The mean gender pay gap	Mean hourly rate 2025/26	Median hourly rate 2025/26
Hertfordshire Partnership University NHS Foundation Trust (HPFT)	4.31% lower than men	-5% lower than men
East London NHS Foundation Trust (ELFT)	7.48% lower than men	1.31% lower than men
EPUT	12.26% lower than men	2.29% lower than men
Norfolk And Suffolk NHS Foundation Trust	13.9% lower than men	10.39% lower than men
North East London NHS Foundation Trust (NELFT)	14.48% lower than men	7.08% lower than men
Mid and South Essex NHS Foundation Trust (MSEFT)	24.16% lower than men	7.46% lower than men
The Princess Alexandra Hospital NHS Trust	23% lower than men	16% lower than men
PROVIDE	16.03% lower than men	7.42% lower than men

Sample comparison data with neighbouring Trusts tells us:

- **EPUT is performing well in comparison with neighbouring providers.**

As part of action planning there will be work with organisations that perform well to share best practice and to learn what steps they have taken to reduce their gender pay gap.

EPUT's progress - 2026

On comparison to EPUT's gender pay gap for the year 2017, there has been a **reduction of 5.89% over the eight years to 2026**.

The mean gender pay gap for EPUT	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
The mean gender pay gap for EPUT	16.90%	15.90%	15.90%	14.30%	11.90%	13%	12.93%	12.41%	12.26%	11.01%
The median gender pay gap for EPUT	7.50%	7.40%	8.90%	8.10%	6.50%	6.20%	7.31%	3.90%	2.29%	0.88%
The mean gender bonus gap for EPUT	34.40%	31.20%	25.20%	33.60%	47.00%	59.50%	56.01%	55.31%	48.46%	52.23%

When comparing EPUT's gender pay gap nationally, EPUT is **below the national average of 12.8%** (2025, www.gov.uk).

Next steps - 2026

A single Equality, Diversity and Inclusion (EDI) delivery plan will provide greater opportunity and support for marginalised groups across EPUT and further reduce the pay gap across gender, race and disability: *[link will be inserted once approved for publication]*

Report prepared by:	
Janice Scott Head of Staff Experience & Inclusion	Lisa Fricker Workforce/ESR and Payroll Manager

On Behalf of:
Andrew McMenemy
Chief People Officer

August 2026

9.7 CQC WELL LED REPORT AND RESPONSE PLAN

● Information Item

● Chief Executive

REFERENCES

Only PDFs are attached

 CQC Well-Led Response and Response Plan 07.10.2026.pdf

SUMMARY REPORT		BOARD OF DIRECTORS PART 1			7 October 2026		
Report Title:		CQC Well Led Report and Response Plan					
Report Lead		Denver Greenhalgh, Executive Director for Corporate Governance					
Report Author(s):		Denver Greenhalgh, Executive Director for Corporate Governance					
Report discussed previously at:		Board seminar session held 2 September 2026					
Level of Assurance:		Level 1	☒	Level 2	☐	Level 3	☐

Risk Assessment of Report		
Summary of risks highlighted in this report	Delays in addressing CQC Well-Led breaches could lead to sustained governance weaknesses, regulatory escalation, reputational damage, and a reduced ability to deliver safe, effective and well-governed services	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	☐
	SR4 Demand/ Capacity	☐
	SR5 Statutory Public Inquiry	☐
	SR6 Cyber Attack	☐
	SR7 Capital	☐
	SR8 Use of Resources	☐
	SR9 Digital and Data	☐
	SR10 Workforce Sustainability	☐
	SR11 Staff Retention	☐
	SR12 Organisational Development	☒
	SR13 Quality Governance	☒
Does this report mitigate the Strategic risk(s)?	Link with SR13 Quality Governance and SR12 organisation culture.	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	No – as links directly to existing BAF risks SR13 and SR12.	
If yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	NA	
Describe what measures will you use to monitor mitigation of the risk	Monitoring and progress reports	
Are you requesting approval of financial / other resources within the paper?	No	
If yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.		
Reflection on Equalities	There is no direct equality impact arising from this report; however, delivery of the actions will support improvements in organisational culture and workforce inclusion, with potential positive benefits for equality, diversity and inclusion outcomes.	

Purpose of the Report

This report provides the outcome of the CQC Well-Led Inspection and the Trust response.

Decision	☐
Discussion	☐
Information	☒

Recommendations/Action Required

The Board of Directors is asked to:

1. Receive and note the CQC Well Led Inspection report published 27 August 2026
2. The Trust response submitted by the Executive Team on the 25 September 2026

Summary of Key Points

Trust level (well-led) assessment which included an onsite visit, 12 staff focus groups and observation of a board meeting in January 2026. Assessed all the quality statements in the well-led domain followed assessments of 3 of the trusts frontline assessment service groups (ASGs): long stay or rehabilitation mental health wards for working age adults, child and adolescent mental health wards and community health inpatient services. Also visited 1 acute ward for adults of working age. Link to full report: <https://www.cqc.org.uk/provider/R1L>

The inspection cited 4 breaches of regulations, with a summary of findings detailed within the report:

- 1) 12 (Safe care and treatment) - The trust must ensure that systems and processes are in place to effectively assess, monitor and learn from incidents in a timely way (Regulation 12(1)).
- 2) 17 (Good governance) - The trust must ensure they have a robust process for implementing and monitoring improvement processes. Such as breaches identified in assessment service group reports in a timely and effective way. (Regulation 17(1)).
- 3) 17 (Good governance) - The trust must ensure they have a robust process in place for improving the culture of the organisation and improving the experience of staff. This includes supporting people to speak up about concerns and improving the experience of people with a disability and people from all ethnic groups. (Regulation 17(1)).
- 4) 17 (Good governance) - The trust must ensure that the governance systems are effective and reviewed to enable the identification of issues affecting the quality of care being delivered. (Regulation 17(1)).

The report was discussed at a full Board seminar held on the 2 September 2026, with the response plan developed by the Executive Team. The response plan was submitted to the CQC on the 25 September 2026 and is attached for formal receipt by the Board.

The actions outlined within the response plan are associated with existing work flows and will be aligned to the appropriate Board Committee for oversight to point of completion and sustained impact, reporting to the Board via the Committee Chairs reports on a bimonthly basis.

Relationship to Trust Strategic Objectives

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

Which of the Trust Values are Being Delivered

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	☒
The report details regulatory breaches.	
Data quality issues	☐
Involvement of Service Users/Healthwatch	☐
Communication and consultation with stakeholders required	☐
Service impact/health improvement gains	☐
Financial implications:	☐
Governance implications	☒
Findings relate to organisational culture and clinical governance.	
Impact on patient safety/quality	☐

Acronyms/Terms Used in the Report			
PCREF	Patient and Carer Race Equality Framework	FTSU	Freedom to Speak Up
CQC	Care Quality Commission	QAF	Quality Assurance Framework
EDI	Equality Diversity and Inclusion	WRES	Workforce Race Equality Standard
IA	Internal Audit	WDES	Workforce Disability Equality Standard
SRO	Senior Responsible Officer		

Supporting Reports/ Appendices /or further reading
CQC Well Led Summary
CQC Well Led Response Plan (v1.0 dated 25 September 2026)

Lead
 Denver Greenhalgh Executive Director for Corporate Governance

CQC Well Lead Inspection Report (August 2026)

Visit Dates: 24 – 26 March 2026



Rating Requires improvement

Inspection Details	Trust level (well-led) assessment which included an onsite visit, 12 staff focus groups and observation of a board meeting in January 2026. Assessed all the quality statements in the well-led domain followed assessments of 3 of the trusts frontline assessment service groups (ASGs): long stay or rehabilitation mental health wards for working age adults, child and adolescent mental health wards and community health inpatient services. Also visited 1 acute ward for adults of working age.		
Regulation Breaches	Inspection found 4 breaches of regulations: • 12 (Safe care and treatment) - The trust must ensure that systems and processes are in place to effectively assess, monitor and learn from incidents in a timely way (Regulation 12(1)). • 17 (Good governance) - The trust must ensure they have a robust process for implementing and monitoring improvement processes. Such as breaches identified in assessment service group reports in a timely and effective way. (Regulation 17(1)). • 17 (Good governance) - The trust must ensure they have a robust process in place for improving the culture of the organisation and improving the experience of staff. This includes supporting people to speak up about concerns and improving the experience of people with a disability and people from all ethnic groups. (Regulation 17(1)). • 17 (Good governance) - The trust must ensure that the governance systems are effective and reviewed to enable the identification of issues affecting the quality of care being delivered. (Regulation 17(1)).		
Next Steps	• Display updated posters in all public areas		
✓ Areas of Good Practice	Areas for Improvement		
• The board was collegiate, well formed and able to function cohesively with respectful challenge. • Non-Executive Directors and Governors reported an open, transparent culture at Board level with appropriate challenge and learning from mistakes • Effort had been made to ensure the Trust was a valued system partner. • Strong collaborations existed with universities, local authorities, primary care, acute trusts, and community partners • There were good financial management arrangements and ambitions for the next financial year. • Clear vision, values, and strategic plan (2023-2028) established and developed through engagement with staff, service users, carers and partners. • There were ambitious and innovative plans in place for the future, particularly around understanding the culture and implementing a first of its kind system wide electronic patient record. • The Trust achieved Disability Confident Leader Status. • Comprehensive Green Plan in place.	• Further work was needed to improve the culture of the Trust with some staff saying that some managers did not tackle behaviours that failed to represent the values of the organisation. • Recognition of the work underway to improve the leadership development programme and support managers to promote a positive culture, at the time of the inspection this had not been implemented. • Arrangements were in place to cover for the impending departure of the Chief Executive, ad they noted that these would need to be kept under review to ensure they are robust and effective. • There was a need for a clearly defined strategic approach to equality, diversity and inclusion (EDI), with improvement work required to improve the experience of people with a disability and people from all ethnic groups equally. The patient and carer race equality framework (PCREF) was noted to be at an early stage. • Oversight of the care being delivered on the frontline and the assurance received by board required improving, making reference to assessments of Ardleigh Ward and Ipswich Road. • Noted that learning in the organisation happened but was inconsistent. Incident reviews backlog existed, with themes and trends in that needed to be addressed to reduce likelihood of reoccurrence.		
Overall page 303 of 379			

Report on actions you plan to take to meet Health and Social Care Act 2008, its associated regulations, or any other relevant legislation.

Please see the covering letter for the date by when you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	Provider ID R1L
Our reference	Well Led Assessment AP18817
Location or provider name and ID	Essex Partnership University NHS Foundation Trust

Regulation 12 (1) a of the Health and Social Care Act (Regulated Activities) Regulations 2014

How the regulation was not being met:

Regulation 12: Safe care and treatment: The trust must ensure that systems and processes are in place to effectively assess, monitor and learn from incidents in a timely way.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	Who is responsible	What resources (if any) are needed to implement the change(s) and are these resources available?	Date actions will be complete
Set the incident backlog baseline and a monthly reduction trajectory for every care unit, with weekly Executive Team oversight of progress, exceptions and recovery action, to have in place a single accurate and risk stratified account of overdue incidents.	SRO - Executive Nurse Supported by: Care Unit Deputy Directors of Quality and Safety	Weekly backlog trajectory reported to the Executive Team (showing backlog reduction against baseline and trajectory, stratified by harm level and age)	Director of Safety Quality Committee Oversight	Dedicated time for reviews and implementation (within existing resources) Additional or redeployed incident review capacity may be required for more complex investigations.	In place

Implement the Trust incident management improvement plan, prioritising incidents by harm, age and risk, to reduce the overdue backlog in accordance with approved care unit trajectories and ensure incidents are reviewed within agreed timescales.	SRO - Executive Nurse Supported by: Director of Safety Director of Risk & Compliance Deputy Directors of Quality & Safety	Monthly backlog trajectory and incident management performance KPIs (showing number and percentage overdue, age profile, demonstrating improvement on baseline and achievement of standards) reported to Accountability Framework meetings.	Director of Safety Accountability Framework Meetings Quality Committee Oversight	Dedicated time for reviews and implementation (within existing resources) Additional or redeployed incident review capacity may be required for more complex investigations.	In place
Review and strengthen incident management framework covering triage, review, investigation, action tracking, and closure controls, with defined timescales, escalation thresholds, quality standards and evidence requirements, so incidents are consistently managed and actions show impact.	SRO – Executive Nurse Supported by: Director of Safety Director of Risk & Compliance Deputy Directors of Quality & Safety Data and Performance Team	Number and percentage of severe, fatal and other high-risk incidents outside agreed timescales. Percentage of sampled reviews meeting quality standards and actions closed with verified evidence of improvements and sustained achievement for an agreed period before closure. Recurrence rate for selected priority themes and evidence of changed practice. IA of incident management controls, reporting to the Audit Committee.	Director of Safety Quality Committee Oversight Audit Committee (IA)	Dedicated time for reviews and implementation (within existing resources) Inclusion on the IA plan for 2027/28	Jan '27 for framework Oct '26 for report Six month refinement and effectiveness review July '27 Q4 '27/28 for IA
Design, approve and implement an incident -assurance report for Executive Team and Quality Committee, covering backlog, timeliness, incident severity, PSIIIs, overdue actions, recurrent themes, emergent risks and evidence of impact, enabling timely challenge, escalation and remedial action.					
Design, approve and implement a Quality Intelligence Framework, to work through the Learning Oversight Sub-Committee, which combines clinical, workforce, experience, safety and regulatory intelligence into a consistent process for identifying recurrent themes, emerging risks, required action and evidence of impact. The intended outcome is earlier identification and escalation of material concerns and demonstrable spread of learning across relevant services.	SRO – Executive Nurse Supported by: Director of Safety Director of Risk & Compliance Directors of Nursing Data and Performance Team Functional Lessons Analyst & Head of Shared Learning	Quality Intelligence Framework in place, supported by information / data flows. Monitoring of data sources submitting complete and timely data. Analysis of data / information on a quarterly basis, reporting to LOSC quarterly. Material themes with an implementation plan and evidence	Director of Safety Quality Committee Oversight Audit Committee (IA)	Use of existing data sources. Analytic capacity and consistent participation from all data owners (within current resources)	Dec '26 for framework First integrated quarterly report Jan '27 Six month refinement and effectiveness

		of spread across applicable services areas. Reduction in recurrence for selected priority themes. Tracking and escalation of themes remaining unresolved over successive quarters. IA of Quality Intelligence Framework (alongside the incident management controls), reporting to the Audit Committee.			review June '27 Q4 '27/28 for IA
Produce and submit a quarterly integrated thematic learning report to the LOSC and Quality Committee. The report will identify recurrent and emerging themes, actions taken, evidence of effectiveness, gaps in spread or sustainability, residual risks and further action required. The intended outcome is that recurrent themes and assurance gaps are identified promptly and addressed through accountable, trust-wide learning.		Material themes with an implementation plan and evidence of spread across applicable services areas. Reduction in recurrence for selected priority themes. Tracking and escalation of themes remaining unresolved over successive quarters. IA of Quality Intelligence Framework (alongside the incident management controls), reporting to the Audit Committee.			

How will people who use the service(s) be affected by you not meeting this regulation until this date?

There is a risk that recurring themes and associated incidents may not be identified and addressed promptly. Until the regulation is met, this risk will be mitigated through ongoing clinical risk assessments and the provision of effective clinical care.

Regulation 17 (1) a of the Health and Social Care Act (Regulated Activities) Regulations 2014

How the regulation was not being met:

Regulation 17: Good governance: The trust must ensure they have a robust process for implementing and monitoring improvement processes. Such as breaches identified in assessment service group reports in a timely and effective way.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	Who is responsible	What resources (if any) are needed to implement the change(s) and are these resources available?	Date actions will be complete
Review and strengthen the Quality Assurance Framework (noting revised NHSE guidance Sep '26) and align internal compliance reviews, quality visits, risk, incidents, complaints, workforce, FTSU, patient/carer feedback and regulatory intelligence so serious concerns are identified, escalated earlier and actions monitored to completion with evidence of embedding.	SRO – Executive Nurse and Executive Director of Corporate Governance Supported by: Director of Safety Directors of Nursing Executive Chief Medical Officer Head of Compliance and EPRR	Improvement actions are clearly owned, tracked and monitored to completion. Reduction in recurrence of regulatory breaches. Significant concerns identified locally are appropriately escalated through the governance framework. Service-level inspection / visit findings are visible to the Executive and Board Committees where appropriate. IA follow-up confirms the redesign arrangements are embedded and operating effectively.	Director of Risk and Compliance Executive Team Quality Committee Audit Committee	Subject matter expert time (within existing resources) IA plan 2027/28	Apr '27
Assess the QAF system through deep dives and traceability exercises from frontline issues to Board oversight, including known regulatory examples and a sample of current high-risk services.	SRO – Executive Nurse and Executive Director of Corporate Governance Supported by: Head of Compliance and EPRR	Quarterly ward-to-Board traceability tests and targeted deep dives demonstrate improved quality assurance. IA follow-up confirms the redesign arrangements are embedded and operating effectively.	Executive Director of Corporate Governance	Within existing resources of the Compliance Team	Quarterly deep dive from Apr '27

Regulation 17 (1) a of the Health and Social Care Act (Regulated Activities) Regulations 2014

How the regulation was not being met:

Regulation 17: Good governance: The trust must ensure they have a robust process in place for improving the culture of the organisation and improving the experience of staff. This includes supporting people to speak up about concerns and improving the experience of people with a disability and people from all ethnic groups.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	Who is responsible	What resources (if any) are needed to implement the change(s) and are these resources available?	Date actions will be complete
Deliver the response to the EPUT Cultural Review, with clear executive accountability, and routine staff feedback.	SRO – Executive Chief People Officer and Deputy CEO Supported by: Executive Team Director of Organisational Development and Culture Director of Education, Learning and Development	Culture review actions delivered to milestone, with impact reported to Board.	Director of Organisational Development and Culture People Committee	Resources for the Cultural Review response, leadership programme and EDI plan are reported as approved.	Sep '27 Year 1 Output
Deliver the leadership development programme to agreed priority leadership groups and introduce post-programme assessment at 12 months to determine whether participants demonstrate sustained improvement in inclusive leadership, accountability, psychological safety and compassionate leadership. Findings will improve subsequent cohorts and address areas where behaviour change is not demonstrated.		Staff Survey and quarterly pulse measures: confidence to speak up, confidence leaders will act, psychological safety, bullying/harassment, and leadership visibility to show positive movement in people promise scores. Leadership programme evaluation tests behaviour and service impact at 12 months, not participation alone.	Director of Education, Learning and Development People Committee		Jul '27 Cohort 1 & 2 evaluation
Approve and implement integrated WRES, WDES and EDI action plans with validated baselines, defined improvement trajectories, accountable owners and quarterly review. The intended outcome is a demonstrable and sustained reduction in identified workforce-experience disparities.		A functioning ambassador/listening network with coverage, training, and activity measures attendance and impact. WRES/WDES indicators and local workforce data show narrowing disparities from baseline; recruitment, disciplinary and development decisions are audited.	Director of Organisational Development and Culture People Committee		Apr '27
Review and implement a structured programme of executive and senior leadership visits and quarterly leadership forums, with agreed coverage, recorded themes, named actions,			Director of Communications and Engagement		Nov '26

feedback to participating staff and escalation of unresolved safety or cultural concerns. The intended outcome is improved leadership visibility and increased staff confidence that issues raised result in action.		Induction programme evaluation at 12 months.	People Committee		
Enhance and implement a quarterly Trust-wide staff-recognition programme with transparent criteria, equitable access and monitoring across services and staff groups. The intended outcome is improved recognition of positive contribution and a more inclusive staff experience			Director of Organisational Development and Culture People Committee		Apr '27
Implement revised Corporate Induction for all eligible new starters, explicitly covering Trust values, expected behaviours, speaking-up routes, inclusion and patient-safety responsibilities. The intended outcome is that new staff understand expected standards and how to raise and respond to concerns.			Director of Education, Learning and Development People Committee		Sep '27
Approve and implement a sustainable Freedom to Speak Up model covering Guardian capacity, case-management standards, acknowledgement and resolution timescales, backlog recovery, confidential and anonymous routes, feedback to people raising concerns, local routes, an ambassador or listening network, and arrangements to prevent, identify and respond to potential detriment. The intended outcome is that staff can raise concerns safely, receive a timely and transparent response, and have confidence that concerns lead to appropriate action without adverse treatment.	SRO – Executive Director of Corporate Governance	FTSU case volume and age, compliance with acknowledgement and resolution standards, feedback to people speaking up, repeat concerns, alleged detriment, and independent case audit. Reduction in people speaking up anonymously (against baseline). Staff Survey and quarterly pulse measures: confidence to speak up, confidence leaders will act, and leadership visibility to show positive movement in people promise scores.	Executive Director of Corporate Governance Executive Team People Committee	Within existing resources	Apr '27

Regulation 17 (1) a of the Health and Social Care Act (Regulated Activities) Regulations 2014

How the regulation was not being met:

Regulation 17: Good governance: The trust must ensure that the governance systems are effective and reviewed to enable the identification of issues affecting the quality of care being delivered.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	Who is responsible	What resources (if any) are needed to implement the change(s) and are these resources available?	Date actions will be complete
Undertake an end-to-end review of governance and assurance from ward/team to Board, including committee and sub-group architecture, terms of reference, decision rights, escalation, information flows, duplication, gaps, and the effectiveness of the Accountability Framework and supporting leadership structure.	SRO – Executive Director of Corporate Governance Supported by: Director of Risk and Compliance Assistant Trust Secretary Directors or Operations Director of Organisational Development and Culture	Approved Governance Manual, committee architecture, scheme of escalation and terms of reference in place (and leaders' knowledge assured). Reduction in duplicate reports and agenda items and clearer ownership of actions and risks.	Executive Director of Corporate Governance	Potential requirement for external partner to support compliance team.	Apr '27
Use the review to produce a simplified governance operating model with explicit ownership at service, care unit, executive and Board levels, supported by a governance manual, committee map, and assurance standards.			Executive Team Quality Committee Executive Director of Corporate Governance Executive Team Board	Intranet page design (within existing resources) Data and Informatic support for review of data flows.	Jul '27

How will people who use the service(s) be affected by you not meeting this regulation until this date?

Service users and staff may lose confidence in the service and its delivery, with potential reputational damage, if identified concerns are not addressed promptly.

Completed by: (please print name(s) in full)	All Executive Directors
Position(s):	All Executive Directors
Date:	25 September 2026

10.1 COMMITTEE CHAIRS REPORT

 Information Item

 Chairs

REFERENCES

Only PDFs are attached

 Committee Chairs Report 07.10.2026.pdf

SUMMARY REPORT		BOARD OF DIRECTORS PART 1				7 October 2026	
Report Title:		Committee Chairs Report					
Report Lead		Chairs of Standing Committees					
Report Author(s):		Chairs of Standing Committees					
Report discussed previously at:		N/A					
Level of Assurance:		Level 1	☐	Level 2	☒	Level 3	☐

Risk Assessment of Report		
Summary of risks highlighted in this report	Report provides summary of items and risks discussed associated with the BAF risks within the remit of each Committee.	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	☒
	SR4 Demand/ Capacity	☒
	SR5 Statutory Public Inquiry	☐
	SR6 Cyber Attack	☒
	SR7 Capital	☒
	SR8 Use of Resources	☒
	SR9 Digital and Data	☒
	SR10 Workforce Sustainability	☒
	SR11 Staff Retention	☒
	SR12 Organisational Development	☒
	SR13 Quality Governance	☒
Does this report mitigate the Strategic risk(s)?	No – provides summary of discussion / assurance received.	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	
Are you requesting approval of financial / other resources within the paper?	No	
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.		
Reflection on Equalities	The Standing Committees consider a range of items which impact on equalities and each have been summarised within the relevant Committee summary.	

Purpose of the Report		
This report provides a summary of key assurance and issues identified by the Board Standing Committees.	Decision	☐
	Discussion	☐
	Information	☒

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the report and assurance provided.

Summary of Key Points

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

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

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

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

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

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

Relationship to Trust Strategic Objectives

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

Which of the Trust Values are Being Delivered

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

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

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

Acronyms/Terms Used in the Report

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Supporting Reports/ Appendices /or further reading

Committee Chairs Report

Lead

Chairs of the Standing Committees

2. FINANCE & PERFORMANCE COMMITTEE

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

Committee meeting held: 24 September 2026

Information

EPUT Mid-Year Provider Review Meeting

- The Committee received an update following a meeting with NHSE on 7 September 2026 to discuss the mid-point review of the Trust's 2026/27 Annual Plan.

Finance & Efficiency Planning

- The Committee received a report providing a deep dive on finance and efficiency planning for 2026/27 and preparation for 2027/28.
- The report included a refresh on the basis of the opening 2026/27 Operating Plan, embedded efficiency requirements, current performance against the programme, indicative forecast and potential financial gaps, mitigations, and next steps including TEG actions.
- It was noted that the level of non-recurrent efficiency delivery in 2026/27 would increase previously planning efficiency levels in 2027/28 and potentially impact a breakeven plan.

Premises Assurance Model (PAM) Self-Assessment 2025/26

- On 27 August 2026, the Committee supported a recommendation for the PAM Self-Assessment 2025/26 to be presented to the Board of Directors for their approval to submit to NHSE by their deadline of 13 September 2026 (subject to further information and assurance being provided to Board members prior to the meeting).
- On 24 September 2026, it was confirmed that the document had been submitted within the deadline, and updates on action plan progress will be provided to the Committee on a quarterly basis.

Treasury & Cash Management Policy – Three Yearly Review

- The Committee received a report providing the Treasury and Cash Management Policy for review and comment.
- The policy was approved and it will now be submitted to the Policy Oversight & Ratification Group for formal approval.

Deconstruction of Block Contracts

- The Committee received a report providing an update on deconstruction of block contracts. The report identified a difference in current contracts and a contract under-activity price of £43.3m
- The Committee noted that the annual return had been submitted by the national deadline of 17 September and the outcomes were awaited.
- Key variances had been outlined in the report, and a new risk will be added to the Corporate Risk Register.

SIG Independent Review of Mental Health System Pathways

- The Committee received a report providing details on the Southend, Essex & Thurrock Executive Mental Health Strategic Implementation Group's (SIG) proposed arrangements for a whole system review of mental health pathways.

Cont...

2. FINANCE & PERFORMANCE COMMITTEE

Assurance

Performance Report

- The Committee received a report providing:
 - A summary of performance for Month 5 2026/27.
 - A deep dive into Crisis 111 60-second responses.
 - A presentation on Community Health Services.

Financial Report

- The Committee received a report providing Month 5 2026/27 financial results.
- The year to date deficit was £8.4m, which was £4.5m adverse to plan, with an adverse movement of £1.7m in month.
- The Cash balance at the end of Month 5 was £9.4m above plan, including the cash benefit of £2.7m relating to asset disposals.
- The Month 5 Capital spend was £6.4m, a £0.3m underspend. This position was offset by £1.7m disposal proceeds.

Estates & Facilities Report

- The Committee received an update providing an update and assurance on key estates issues including backlog maintenance, catering contracts, grounds and gardens, the capital programme and operational estates.

Board Assurance Framework

- The Committee received an update on risks relating to the Committee on the Board Assurance Framework Strategic & Corporate Risk Register.
- Risks relating to data quality and deconstruction of block contracts were in the process of being added to the Corporate Risk Register.

Action

No Actions for the Board.

Alert

Winter Planning 2026/27

- On 27 August 2026, a report outlining the proposed approach to winter planning for 2026/27 was received and discussed by the Committee, which supported a recommendation that the Board of Directors give delegated authority for the Committee to approve the finalised plans for submission by their deadline of 30 September 2026.
- On 24 September 2026, the finalised plans were received and discussed by the Committee. These were approved for submission, subject to no further changes being identified following the ICB system test on 25 September 2026.

2. PEOPLE COMMITTEE

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

Committee meeting held: 27 August 2026

Assurance

- **Workforce Key Performance Indicators:** Discussed workforce indicators, such as agency/bank and staff in post against plan, sickness absence, appraisal, turnover & mandatory training. The Committee agreed for further analysis to be undertaken to understand the relationship and impact between the individual indicators and well as additional benchmarking.
- **Education Strategy:** Noting progress and refresh of the delivery plan. The Committee agreed for an employee-journey assessment of education and training is completed to understand the experience of career progression in the Trust. (BAF Risk SR12 Control – People and Education Strategy)
- **National Staff Survey:** Noting progress against pre-survey actions to promote engagement with the survey. The Committee cross-checked this against the outcome of the cultural review, ensuring the actions taken from previous feedback were demonstrated before any further feedback is requested. (BAF Risk SR11 Assurance – Staff Survey People Promise outcomes)
- **Project Plan Band 5 Nurse Job Evaluation:** Noting the plan remained on track and had received positive assurance following the completion of a self-assessment audit.
- **Safer Staffing:** The Committee received and discussed a Stage 2 Safer Staffing Business Case, building on the recommendations approved through the Mental Health Inpatient Bi-Annual Safer Staffing and Annual Workforce Review by the Board in February 2026. The Committee noted the Business Case was to be approved by the Finance and Performance Committee, with the role of the People Committee to review and consider the workforce implications. (BAF Risk SR10 Control – Operational Plans).

- **People Strategy Implementation Plan:** The Committee received an update on the implementation plan for the People Strategy, noting a number of completed actions, in progress actions and two items in recovery relating to the leadership behavioural framework and three-year leadership development succession plans. The Committee was assured that funding for actions was in place. (BAF Risks 10,11,12)
- **Staff Flu Vaccination Plan 2026:** A three-route flu vaccination plan to increase eligible frontline staff uptake by 16% to above 45%, using care-unit clinics, roving peer vaccinators, and vouchers for community staff. This supported the Winter Plan and included clear success measures. (BAF Risk SR4 Control – Business Continuity Plans as part of Winter Planning)
- **Cultural Review:** The Committee received and discussed the outcome of the cultural review, noting the key headlines and proposing next steps including development of plans and stakeholder engagement. (BAF Risk SR12 – Diagnostic)
- **Employee Relations Report:** Noting positive / negative indicators and action required to address these areas. The Committee identified some areas of concern to receive further oversight by the Quality Committee.

Action

The Committee received and recommended the following items for approval by the Board of Directors in October:

- Gender, Race and Disability Pay Gap Report
- Equality and Inclusion Annual Report
- Public Sector Equality Duty Report

2. PEOPLE COMMITTEE

Alert

The Committee identified a new EDI risk for the Board Assurance Framework which will be taken through the Risk Framework for inclusion on the Corporate Risk Register.

Information

- **Reducing Restrictive Practice – Observations/Temporary Staffing:** The Committee received a presentation from Hertfordshire Partnership University NHS Foundation Trust on reducing restrictive practice, enhanced observations and reliance on temporary staffing, discussing a proposal on how the Trust could develop a similar quality-led workforce improvement programme in this area.

3. QUALITY COMMITTEE

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

Committee meeting held: 10 September 2026

Assurance

- **Emergency Planning, Preparation and Response (EPPR):** The Committee received assurance that no significant emergency planning risks or activity had arisen during Quarter 1 and that business continuity incidents had been managed effectively. Business continuity plan compliance had improved to more than 95%, with the outstanding plans being progressed. Assurance was qualified pending further evidence on trained command capacity and mitigation of outstanding Gold Command training requirements.
- **Reducing Restrictive Practices:** Patient feedback remained positive. More than 1,000 reviews had been received, with an overall reported experience score of 4.8 out of 5. Feedback particularly recognised compassionate and respectful staff, personalised care and patients feeling listened to. Areas for improvement included waiting times, communication between services, follow-up arrangements and clarity for patients about their care and next steps. Further assurance is required on whether the available feedback is sufficiently representative, particularly given the difference between feedback obtained through I Want Great Care and that reported through Healthwatch. (BAF Risk SR13 – control patient incident response plan and Quality of Care Priority)
- **Learning Disability Improvement Standards:** The Committee received assurance that 12 of the 14 national learning disability improvement standards had been assessed as complete, with the remaining two partially complete. Embedded foundations included reasonable adjustments, patient flagging, learning from deaths, restrictive practice monitoring and Oliver McGowan mandatory training. The Committee requested stronger validation of compliance with the Accessible Information Standard, including testing with people with lived experience. (BAF Risk SR13 – Control clinical governance structure)

- **Winter Plan:** The Committee received the draft Winter Plan, noting the Committee role to provide assurance regarding the Trust's preparedness for winter pressures, with the overall plan being approved by the Finance and Performance Committee for submission. The plan had received input from all care units and would be considered as part of the Essex challenge and stress testing exercise in September. It incorporated lessons from the previous winter. Additional assurance was provided regarding increased fit-testing capacity, strengthened compliance monitoring and a revised staff vaccination programme. (BAF Risk SR4 – control business continuity plans)
- **Deep Dive presentation on 'Reduction in Self-Harm Incidents' from the CAMHS Service:** The Committee received positive assurance from the CAMHS deep dive. A consistent, trauma-informed and data-led approach is being used to understand the function of self-harm, reduce dependency, develop coping strategies and manage risk safely. Case studies demonstrated the contribution of clinical leadership, multidisciplinary working, family involvement and consistency of care planning. The Committee considered this to be an example of continuous quality improvement, with potential for wider application through the Fundamentals of Care programme and therapeutic engagement across the Trust. Further thematic analysis will be needed to demonstrate how the learning is being spread and whether comparable benefits are being achieved elsewhere. (BAF Risk SR13 – learning partnership).
- **CQC and Prevention of Future Death (PFD):** Noting the progress made against the overall improvement plan and the continued focus on ensuring the sustainability of improvements. (BAF Risk SR13 Control – Clinical governance structure)

3. QUALITY COMMITTEE

Assurance (Continued)

- **Working with Neurodivergence:** Positive progress was reported through improved Oliver McGowan training compliance, the launch of the Neurodivergence Hub, development of a staff experience quality improvement project, and implementation of the SPACE framework. ADHD-related deaths have also been incorporated into enhanced mortality governance arrangements. The Committee's assurance is presently based mainly on programme development and training activity. Future reporting will need to demonstrate the effect on clinical practice, patient experience, restrictive practice, self-harm, ligature incidents and wider safety outcomes. (BAF Risk SR13 Control - Clinical governance structure / Quality of Care Priority)
- **Infection Prevention and Control (IPC) Annual Report:** Assurance was received that the Trust was fully compliant with six of the ten assessment criteria within the National Code of Board Assurance Framework and partially compliant with the remaining four, with improvement plans in place. Training compliance had improved to 90% for Level 1 and above 80% for Level 2. Mandatory reporting requirements for healthcare-associated infections were being met, with reported cases subject to review and learning processes. The Committee also received assurance that no cases of Legionnaires' disease had been reported, and that enhanced water testing, filter controls and Water Safety Committee oversight were in place pending permanent remedial work. This assurance remains qualified because the implications of partial framework compliance, antimicrobial stewardship arrangements, fit-testing delivery and winter preparedness require further scrutiny at the point of reporting to the Committee. (BAF Risk SR 13 – Control Lead roles and subject matter experts / clinical governance structure / mandatory training).

Information

- **Fundamentals of Care:** The Committee noted the proposed Fundamentals of Care Group Terms of Reference which will strengthen the triangulation of quality intelligence and provide a clear mechanism for translating learning from safety, workforce, patient experience and quality improvement activities into demonstrable improvements in patient care.
- **Quality Scorecard:** The Committee received a first presentation of the Quality Scorecard, which will replace the existing Quality of Care Performance Dashboard. The new scorecard combines regional and local measures across the domains of safety, effectiveness and experience, with the aim of improving triangulation, strengthening oversight of performance and providing clearer improvement trajectories for areas of concern. The Committee requested a smaller set of key indicators, clear escalation thresholds, trend information, consistent reporting periods, benchmarking where possible, transparency over data gaps and stronger links between improvement programmes and intended outcomes. The Committee acknowledged this as a work in progress and agreed the would be utilised to develop a further iteration of the scorecard for further review.
- **Population Health and Health Inequalities:** Noting the establishment of a steering group and identification of priorities to take forward.
- **Board Assurance Framework:** The Committee identified areas for update for the Board Assurance Framework:
 - Patient flow pressures associated with suitable onward placements
 - Neurodivergence and ADHD waiting times
 - Infection Prevention and Control partial compliance against National Code Framework, antimicrobial stewardship and fit-testing arrangements
 - SR6 Cyber resilience testing
 - Gold command capacity
 - Reduction in the number of Lived Experience Ambassador
 - Winter pressures as part of the business continuity for flow and capacity in our services.

3. QUALITY COMMITTEE

Alert

- **Ardleigh Ward:** The Board is alerted to the continued intensive support for Ardleigh Ward, including neurodiversity expertise. A regional review identified positive staff-patient interactions but also highlighted the concentration and complexity of patient need, lengthy admissions, and the psychological impact on staff. Immediate measures have included temporary closure to admissions to reduce pressure, clinical review of patients who may be discharged or transferred, and engagement with local authority partners regarding suitable onward placements. The intensive support is ongoing with joint medical, nursing and operational accountability. The next update is expected to include defined outcomes, and measurable evidence of impact.
- **Deprivation of Liberty Safeguards** – The Board is alerted to a recent ruling affecting Deprivation of Liberty Safeguards, which may have implications for capacity assessments and use of the Mental Health Act. Work was underway to understand the clinical and operational consequences. Potential workforce and financial implications were identified, and the Committee supported clinical, ethical and academic engagement to inform the Trust's position.

Action

The Committee reviewed and recommended the following annual reports for approval by the Board of Directors:

- Infection, Prevention and Control (IPC) Annual Report
- Mental Health Act Annual Report

These are included as separate agenda items for the Board meeting on the 7 October 2026.

10.2 INFECTION, PREVENTION AND CONTROL (IPC) ANNUAL REPORT

● Decision Item

● Chief Nurse

REFERENCES

Only PDFs are attached

 Infection, Prevention and Control (IPC) Annual Report 07.10.2026.pdf

SUMMARY REPORT		BOARD OF DIRECTORS PART 1			7 October 2026		
Report Title:		Infection Prevention and Control Annual Report					
Report Lead		Ann Sheridan, Executive Nurse					
Report Author(s):		Angela Wade Director of Nursing and Infection Prevention and Control.					
Report discussed previously at:		Quality of Care Group and Quality Committee					
Level of Assurance:		Level 1	☐	Level 2	☒	Level 3	☐

Risk Assessment of Report		
Summary of risks highlighted in this report	Trust achievement 85% of the Infection Prevention and Control (IPC) Code of Practice with 15% partially achieved	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	☐
	SR4 Demand/ Capacity	☐
	SR5 Statutory Public Inquiry	☐
	SR6 Cyber Attack	☐
	SR7 Capital	☐
	SR8 Use of Resources	☒
	SR9 Digital and Data	☐
	SR10 Workforce Sustainability	☐
	SR11 Staff Retention	☐
	SR12 Organisational Development	☐
	SR13 Quality Governance	☒
Does this report mitigate the Strategic risk(s)?	Yes, as part of the Trust clinical governance framework by ensuring resources both human and consumable are supported with best practice and discharge the Trusts statutory requirements set within Health and Social Care Act 2008 Code of Practice.	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	Infection Prevention and Control training, clinical practice and quality control audits at service level. The Infection Prevention and Control Team provide subject matter advice and guidance, alongside audit of clinical practice. The Infection Prevention and Control (IPC) Code of Practice Board Assurance Framework, monitored through quality governance to Quality Committee bi-annually.	
Are you requesting approval of financial / other resources within the paper?	No	
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	N/A	

Reflection on Equalities	The report demonstrates a commitment to equitable access to safe care through trust-wide infection prevention and control arrangements, staff training, and targeted support.
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Purpose of the Report		
This report provides assurance on the effectiveness of the Trust's Infection Prevention and Control arrangements during 2025/26 and level of compliance with the Health and Social Care Act 2008 Code of Practice. Following assurance review the Quality Committee recommends the Infection Prevention and Control Annual Report for approval by the Board of Directors.	Decision	☒
	Discussion	☐
	Information	☐

Recommendations/Action Required
The Board of Directors is asked to: Note the contents of the report and the assurance provided through the Quality Committee of the Trust's infection prevention and control arrangements, achievements and improvement priorities.

Summary of Key Points
Key headlines in the annual report: - The Trust achieved compliance in 46 of 54 (85%) Infection Prevention and Control (IPC) Code of Practice elements, demonstrating a modest improvement on the previous year. - Specialist infection prevention and control support, audit activity, outbreak management, staff education and National Code Board Assurance Framework monitoring have continued to provide assurance regarding the prevention and control of infection across the organisation. - Reportable healthcare-associated infections remained low, with one MRSA bacteraemia case, five Clostridioides difficile cases and no gram-negative bloodstream infections reported during the year. - Key areas requiring continued attention include mandatory infection prevention and control training compliance, environmental and water management programmes, antimicrobial stewardship arrangements, and ongoing audit compliance. Action plans are in place to address these areas. - The report highlights significant achievements including management of outbreaks, annual IPC audits, collaboration with Estates and Facilities on environmental improvements, fit-testing programme, and continued learning and sharing of best practice across the Trust and wider system.

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

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	☐
Data quality issues	☐
Involvement of Service Users/Healthwatch	☐
Communication and consultation with stakeholders required	☐
Service impact/health improvement gains	☐
Financial implications:	☐
Governance implications	☐
Impact on patient safety/quality	☒
Infection, Prevention and Control has an impact on patient safety and the quality of services provided.	

Acronyms/Terms Used in the Report			
IPC	Infection prevention and control	ICB	Integrated care board
IPCG	Infection Prevention and Control Steering Group	NIPCM	NHS England National Infection Prevention and Control manual
DDQS	Deputy Directors of Quality and Safety	WRA	Water Risk Assessments
DIPC	Director of Infection prevention and control	AMS	Antimicrobial stewardship
AMR	Antimicrobial resistance	QAV	Quality Assurance Visits

Supporting Reports/ Appendices /or further reading
Infection Prevention and Control Annual Report 2025/26

Lead
 Ann Sheridan Executive Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Infection Prevention and Control ANNUAL REPORT 2025-2026

EPUIT

CONTENTS

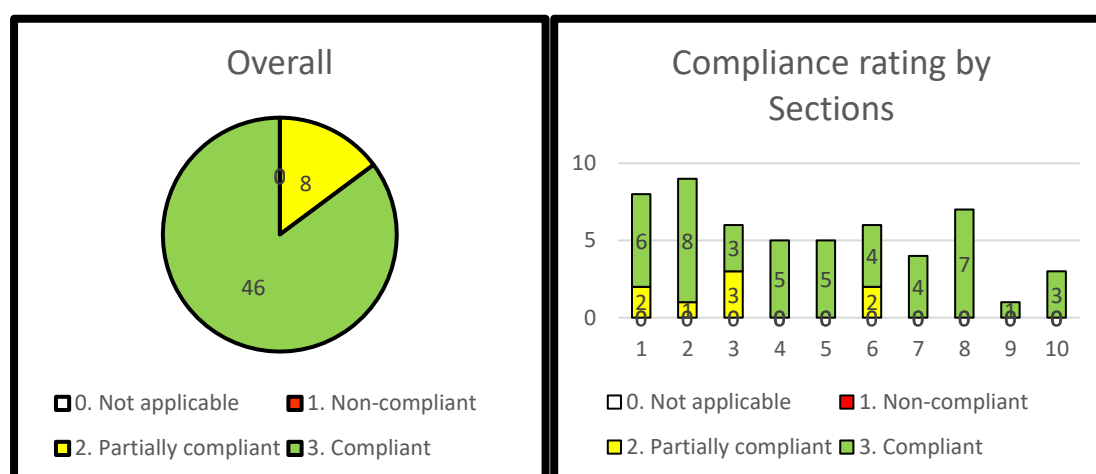
P3	Executive Summary
P5	Criterion 1 - Systems to manage and monitor the prevention and control of infection
P7	Criterion 2 - The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
P10	Criterion 3 - Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance
P11	Criterion 4 - The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further care in a timely fashion
P12	Criterion 5 - There is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment to reduce the risk of transmission of infection to others
P14	Criterion 6 - systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
P17	Criterion 7 - The provision of, or ability to secure, adequate isolation facilities
P17	Criterion 8 - The ability to secure adequate access to laboratory services as appropriate
P17	Criterion 9 - Have and adhere to policies designed for the individual's care that will help to prevent and control infections
P18	Criterion 10 - A system or process in place to manage staff health and well-being and organisational obligation to manage infection prevention and control
P20	Appendix 1: IPC team achievement summary

EXECUTIVE SUMMARY

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

The aim of the IPC service is to ensure that all our patients are provided with care in a clean, safe environment by staff members who are competent and engaged with IPC practices. With specialist IPC advice provision to all organisational areas including clinical and non-clinical colleagues.

The report outlines the achievements and activities in relation to IPC across the organisation during the year; giving focus to the National Code of Practice Board Assurance Framework (NHS England, 2025). The IPC Board Assurance Framework has been reviewed and updated quarterly and reported through the Quality of Care Group bi-annually.



The Trust is fully compliant in 46 of the 54 (85%) elements of the IPC Code of Practice Criteria. This is a slight increase from last year of 2%. The areas assessed as partially compliant, are summarised as follows:

- Criteria 1:** Partial compliance in 2/8 - Systems to manage and monitor the prevention and control of infection: Yearly mandatory training is red at 59%, two yearly is also red at 79%. This is in part due to a change of frequency of courses. **Actions to move to Green** - Mandatory training compliance and any quality and safety impact is monitored in care groups. Accountability Framework meetings chaired by the Executive team will work with care groups to ensure compliance and mitigation of risks. Care unit quality and safety meetings to have continued oversight and monitor improvement against mandatory IPC training targets, along with any triangulated insights for patient safety impact. IPC team also continue to work with the Communications team to ensure Trustwide messaging to support IPC practice and mandatory training requirements is sent to address the deficit.

- **Criteria 2:** Partial compliance in 1/8 - The provision and maintenance of a clean and appropriate environment: **Action to move to green** - A plan is in place to continue the environment maintenance programme. Clinical and cleaning services working and auditing in accordance with environmental cleaning standards. Additionally, water maintenance programmes and routine testing identified areas that required urgent work due to legionella being present in the water systems. This work is in the process of being completed and mitigations have been introduced. These include, amongst other things the fitting of filters to affected outlets and increased flushing of little used outlets.
- **Criteria 3:** Partial compliance in 3/6 - Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance: **Action to move to green** - Whilst systems and processes are agreed, the antimicrobial meetings have not taken place therefore there will be a review of the Terms of Reference and membership to support attendance. Currently, the Trust does not have an antimicrobial specialist pharmacist, which has been raised through pharmacy services for achieving compliance.
- **Criteria 6:** Partial compliance in 2/6 - Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection: **Action to move to green** - in accordance with actions detailed in Criteria 1 relating to mandatory training, IPC audits generate action plans and areas that fall below expected standards are re-visited and IPC specialist nurses support to make improvements.

Mandatory reportable health care associated infection

All cases have been fully investigated and scrutinised by the IPC team, working with the clinical teams involved, and completion of the post infection review process to identify any learning for the Trust.

Since April 2025:

- **Clostridioides Difficile** 5 single cases.
- **MRSA bacteraemia** 1 single case.
- **Gram negative blood stream infections** 0 cases.

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

Assurance of compliance with the Hygiene Code is provided by the undertaking of an audit programme each year. This programme is comprised of two elements: annual audits by the IPC team members and self-audit carried out by clinical teams on a quarterly basis via the Tendable platform. Key elements such as the environment, hand hygiene, environmental and equipment cleaning, and mattresses are all audited.

A quarterly Infection Prevention and Control Steering Group (IPCG) meeting is

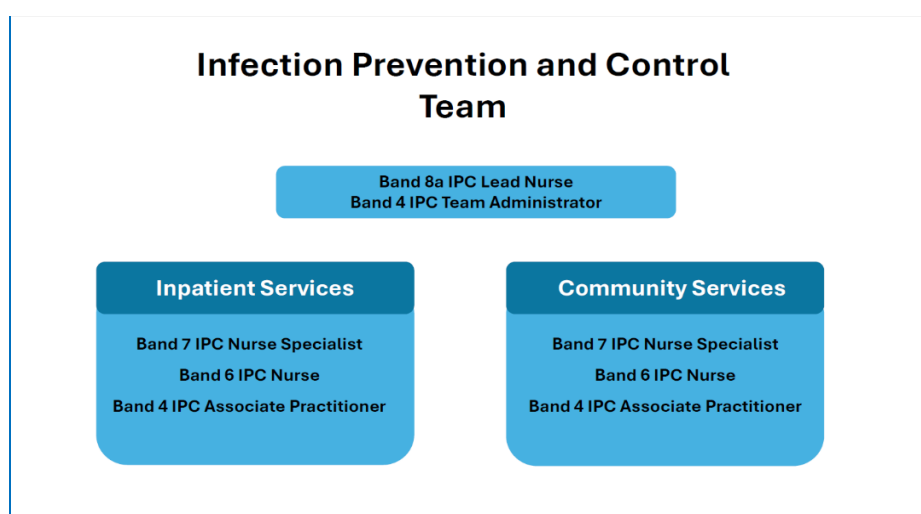
held as a part of the wider clinical governance structures within the organisation, which includes engagement of key system stakeholders. The group reviews the local IPC Risk Register in relation to the National Code of Practice Board Assurance Framework.

REPORT

Criterion 1

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

The Trust has acknowledged the key role that the IPC team play in the provision of safe care for patients and reduction of risk to staff. Changes to the IPC team structure followed a consultation and introduces dedicated teams for inpatient services and community services. This change is designed to strengthen support and ensure more tailored IPC guidance across services. The changes have been in place since January 2026 and are as follows:



The IPC team members will continue to work in collaboration with the Deputy Directors of Quality and Safety (DDQS) for the care units. A good understanding of the services provided has been established and positive working relationships with the staff continue. The aim is to increase staff engagement and therefore, the quality of care delivered.

Expert clinical advice is provided by a Consultant Microbiologist via a Service Level Agreement. This individual works in a local acute trust and provides support both to the organisation and on an individual basis when required.

The quarterly IPCG is chaired by the DIPC or Lead Nurse for IPC. Representatives from key Trust and system partner stakeholders attend and participate. The group members include clinical, occupational health and estates and facilities colleagues. The meeting is also attended by all three commissioning boards. Recent changes

to commissioning boards' boundaries mean that moving forward we will be working alongside the Essex ICB in the coming year, rather than three separate ICBs. The IPCG meeting provides oversight and assessment of IPC assurance across the Trust.

1.1 IPC Information Training and Supervision

The IPC team deliver IPC induction training as part of the Trust Corporate Induction Programme. The session is based on the NHS England National Infection Prevention and Control Manual (NIPCM) and incorporates standard infection control practices.

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

As of the end of March 2026, the Trust Training Department has reported compliance with IPC mandatory training as follows. Figures have dropped significantly this year, and this is in part due to a change in frequency in the courses:

1 Yearly mandatory training compliance (level 2)	2 Yearly mandatory training compliance (level 1)
59%	75%

Action to move the compliance includes the monitoring of mandatory training compliance and any quality and safety impact in care groups, Accountability Framework meetings chaired by the Executive team who will work with care groups to ensure compliance and mitigation of risks. Care unit quality and safety meetings will continue to have oversight and monitor improvement against mandatory IPC training targets, along with any triangulated insights for patient safety impact. The IPC team also continue to work with the communications to ensure Trust-wide messaging to support IPC practice and mandatory training requirements sent to address the deficit.

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

The IPC newsletter is available on the Intranet focusing on education relating to topics e.g. back to basics and chickenpox. The newsletter also provides an opportunity to promote IPC events, share good IPC practice from clinical areas and share learning points from IPC incidents or site visits. It is circulated via the Trust's weekly communications quarterly to reach as many staff as possible. An example of the newsletter can be seen by clicking on the link below.

[IPC Newsletter - sharps July & August 25.pdf](#)

Criterion 2

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

2.1 Water Management

Water Risk Assessments

A risk-based approach to Water Risk Assessments (WRAs) has been implemented across the Trust, enabling assessment frequency to be aligned to building risk profiles, including clinical activity and infrastructure. All WRAs due during 2025/26 have an agreed completion programme in place, with a new three-year contract for assessments and sampling being procured.

Thermostatic Mixing Valves (TMVs)

The Trust maintains a comprehensive planned preventative maintenance programme for over 3,000 TMVs in accordance with HTM 04-01 and ACOP L8 requirements. Six-monthly fail-safe testing has been completed, with annual strip-down and disinfection programmes continuing as planned.

Water Training

A structured water safety training programme is in place for relevant staff groups, including awareness training, duty to manage training, and domestic staff training delivered through local cascade arrangements, with completion schedules extending into 2026/27.

Water Quality Management

Targeted improvement programmes remain in place at several sites where water sampling has identified elevated counts. Water sampling is undertaken when new works are proposed or there is a failure in established control measures. Samples are sent to an external laboratory and on receipt of results which indicate bacteriological load, a Water Committee is immediately convened with estates, clinical, IPC and consultant microbiologist colleagues.

Multi-disciplinary Water Committee meetings oversee mitigation measures including enhanced flushing regimes, tap/outlet filter application, descaling programmes, infrastructure improvements, and regular monitoring. The use of filters on taps in patient settings, completely removes risk to patients. When these are applied the multi-disciplinary Water Committee work in partnership to ensure monitoring, replacement and the communication with staff, patients and carers to provide awareness and understanding in the care setting. Recent sampling demonstrates improving compliance across a number of sites.

Governance and Compliance

The Trust Water Policy and Standard Operating Procedure were reviewed and updated in 2024, with the next review scheduled for June 2027. Water management arrangements continue to comply with HTM 04-01, ACOP L8 and

associated HSE guidance. Performance and compliance are monitored through the Water Quality Group and regular contractor review meetings.

Ventilation

The Ventilation Safety Group continues to provide oversight of ventilation compliance and maintenance. Key developments include appointment of a permanent Authorised Engineer, implementation of competency training programmes, rollout of guidance for portable air-conditioning units, and targeted capital investment in ventilation systems.

2.2 Estates Programmes

During 2025/26, the Trust continued to invest in its estate to improve patient safety, infection prevention, environmental standards and service quality.

Key completed projects included:

- The Lakes ECT Suite refurbishment
- Anti-barricade bedroom door upgrades at The Lakes
- Ipswich Road kitchen refurbishment
- Derwent Centre Window Replacement Programme
- Specialist Services Bed Configuration Project

Major projects progressing through 2025/26 included:

- Basildon Mental Health Unit kitchen refurbishment
- Landermere Centre dementia-friendly improvements
- CAMHS seclusion room upgrades
- Mental Health Emergency Department Diversion Schemes at the Emerald Centre and Derwent Centre



2.3 Facilities

Facilities services continue to provide assurance that Trust environments remain safe, compliant and supportive of high-quality patient care. Services include cleaning, catering, waste management, laundry services, grounds maintenance, and pest control.

Cleaning Services

Cleaning services are delivered in line with the National Standards of Healthcare Cleanliness. Performance is monitored through a structured audit programme, supported by ward-based cleanliness ratings and cleaning efficacy audits.

2025/26 Audit Performance

Functional Risk Category	North	South	West	Trust Average
Category 2	96%	98%	97%	97.0%
Category 3	96%	96%	95%	95.7%
Category 4	94%	96%	97%	95.7%

Cleaning performance remains consistently above internal thresholds, demonstrating strong compliance and assurance across all regions.

Catering Services

Catering services continued to deliver safe, high-quality food provision in accordance with the National Standards for Healthcare Food and Drink.

Compliance is supported through mandatory training, routine food safety audits and unannounced inspections.

Key assurances include:

- Sustained 5-star Environmental Health Officer ratings across inspected sites
- Food audit compliance consistently exceeding the Trust target of 90%
- Ongoing supplier performance reviews and food safety monitoring

Waste Management

Waste segregation performance improved during 2025/26, with recycling rates increasing to 25.3%, exceeding the national minimum target. Improved clinical waste segregation and revised collection arrangements have contributed to greater efficiency and a sustained budget underspend.

The Waste Management Policy and supporting Standing Operating Procedures were approved and implemented during the year, strengthening governance and compliance arrangements.

2.4 Risks and Mitigation

Workforce Capacity and Service Resilience Risk

There remains a risk that workforce pressures, particularly during periods of increased sickness absence, may impact the resilience and consistency of facilities service delivery, specifically within domestic services.

- **Impact:** Potential disruption to cleaning schedules may affect environmental cleanliness standards and increase the risk of infection transmission if not effectively managed.

- **Controls and Assurance:** Dynamic resource allocation, responsive cleaning models, and alignment with IPC guidance ensure service continuity is maintained.

Infection Prevention and Control (IPC) Compliance Risk

There is an ongoing risk that changes in national IPC guidance, outbreak situations, or variations in adherence to cleaning standards could impact compliance with the National Standards of Healthcare Cleanliness.

- **Impact:** Failure to maintain compliance may increase the risk of healthcare-associated infections and negatively affect patient safety and experience.
- **Controls and Assurance:** A structured audit programme aligned to functional risk categories, cleaning efficacy audits, and visible ward-based assurance ratings provide strong oversight and enable timely intervention.

Food Safety and Catering Compliance Risk

There is a risk that food safety standards could be compromised if training, monitoring, or operational controls are not consistently applied across all sites.

- **Impact:** Potential failure in food safety compliance may result in patient harm, regulatory non-compliance, and reputational damage to the Trust.
- **Controls and Assurance:** Mandatory training programmes, unannounced spot checks, sustained 5-star EHO ratings, and food audit compliance exceeding Trust thresholds provide robust assurance.

Supply Chain and Supplier Performance Risk

There is a risk that reliance on external suppliers for catering and facilities services may impact service continuity, quality, or value if supplier performance is not effectively managed.

- **Impact:** Disruption to supply chains or reduced supplier performance could affect food provision, service standards, and overall patient experience.
- **Controls and Assurance:** Quarterly supplier performance reviews, ongoing procurement activity, and active monitoring of national alerts mitigate this risk and support continuous improvement.

Governance, Engagement and Ownership Risk

There is a risk that variability in engagement and ownership across clinical and operational teams may impact consistent adherence to Facilities standards and processes.

- **Impact:** Inconsistent application of standards may lead to reduced compliance, variability in service quality, and gaps in assurance.
- **Controls and Assurance:** Ongoing engagement with clinical teams, targeted training and awareness initiatives, and monitoring through governance forums support improved accountability and performance.

The Trust can provide assurance that effective systems and controls are in place to maintain safe, clean, and compliant environments. Strong performance in

cleaning, catering, water safety, and waste management is supported by robust governance arrangements. Continued focus on workforce resilience and service improvement will further strengthen assurance during 2026/27.

Criterion 3

Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Antimicrobial stewardship (AMS) refers to an organisational or healthcare system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness

The loss of antimicrobial effectiveness (antimicrobial resistance (AMR)), evolves naturally, but this process is accelerated by the inappropriate or incorrect use of antimicrobials. With this in mind antibiotics should never be prescribed or supplied for viral infections.

As part of the Code of Practice (which supports compliance with the Health and Social Care Act (2008)), antimicrobial prescribing continues to be audited within the organisation on an annual basis. The annual audit results are incorporated, along with antimicrobial stewardship, into the education packages delivered to both prescribers and nursing staff during mandatory medicines management training courses. An antimicrobial bulletin was also curated and is available on the Trust Intranet for easy reference.

All prescriptions of antimicrobials within the organisation are governed by national and local prescribing guidelines, which advocate the use of specific antimicrobials for a specified period of time. Non-formulary antimicrobials are only available following advice from consultant microbiology colleagues in the local acute trusts. These are not dispensed by pharmacy unless assurances are received that the prescription has been discussed and agreed. All prescriptions for inpatient settings are clinically screened by a pharmacist for:

- Appropriateness including route, dose, duration and frequency, taking into account patient co-morbidities
- Selection of antimicrobials according to guidelines for specific clinical indications and any sensitivities based on microbiological samples
- Length of treatment and potential switches from IV to oral (only applicable in community health service settings)

Effective antimicrobial stewardship requires a coordinated and communicative approach from doctors, pharmacists and other healthcare professionals to ensure patients receive the right drug in the right dosage for the optimal duration.

Criterion 4

The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.

Patient information leaflets on MRSA, Clostridioides difficile, Norovirus, hand hygiene and general advice for patients and visitors are available for trust wide

use. They ensure that those we care for have access to appropriate information relating to some common infections and how to assist in preventing their transmission.

Information relating to antimicrobial use is available from the national source www.nhs.uk Specific information is also provided with each prescription in the form of the patient information leaflet.

Criterion 5

That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

5.1 IPC Clinical Guideline Reviews Undertaken and Ratified in 2025-2026

All IPC policies are reviewed on a three yearly basis or when national guidance changes. Since April 2025, the following guidelines have been reviewed and updated:

- IPCG1: Section 3: Infection Prevention and Control in Clinical Practice
- IPCG1: Section 5: MRSA
- IPCG1: Section 7: Tuberculosis
- IPCG1: Section 8: Infestations
- IPCG1: Section 9: Prevention and management of sharps injuries
- IPCG1: Section 10: Pets and pests
- IPCG1: Section 11: Mattresses
- IPCG1: Section 12: M Pox

5.2 Cases of Reportable Health Care Associated Infection

The number of cases of MRSA bacteraemia remains low with one single case since April 2025. Five single cases of *Clostridioides Difficile* were identified during the same reporting period and zero gram negative blood stream infections. All cases were fully supported and scrutinised by the IPC team with the clinical team involved and a post infection review process to identify any learning as follows:

Clostridioides difficile – <i>C. difficile</i> incidence is assessed as cases detected after 3 days of admission (these are considered to be attributable to an infection acquired in a healthcare setting). The system of reviewing cases determines whether cases were associated with or without breaches of local protocols, the latter being deemed unavoidable.	5
MRSA bacteraemia – MRSA incidence is assessed as cases detected more than 48 hours after admission, which are considered to be attributable to an infection acquired in hospital, or cases where MRSA is considered to be a contaminant.	1
Gram-negative blood stream infections – E.coli bloodstream infections represented 55% of all gram-negative blood stream infections. Approximately three-quarters of these cases occur before patients are admitted to hospital, and the Trust continues to contribute to a system-wide plan to support improvements across the health economy.	0

5.2 MRSA and CPE Screening

All patients who are admitted to inpatient units and community services caseloads are risk assessed for MRSA and if deemed high risk are screened. Swabs are taken from the nose and groin, wound sites, indwelling devices sites and a Catheter Specimen of Urine (CSU) is obtained for those with indwelling catheters.

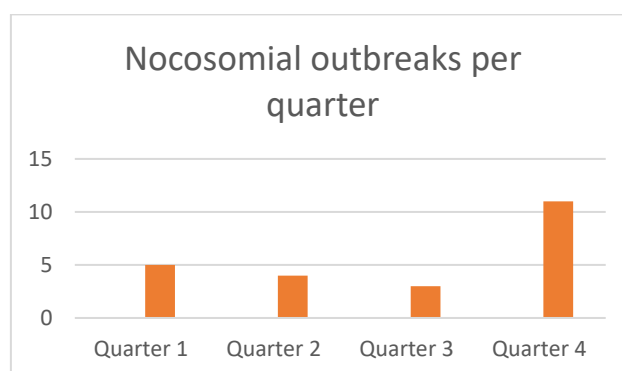
CPE screening is carried out when a risk assessment dictates it is required.

5.3 Candidozyma Auris

In the coming year, IPC will develop guidelines related to screening of Candidozyma Auris following the risk profile outlined by UKHSA. This includes patients who have been hospitalised outside of the UK in the previous year or who are admitted from an affected unit in the UK.

5.4 Outbreak Management

The definition of outbreak is two or more connected cases of infectious disease in either patients, staff or visitors. In the period of this report, it has been evident that the prevalence rate of outbreaks within EPUT have mirrored what is being seen in the community. A higher number of outbreaks was seen in quarter 4, 11 in total. 8 of these were attributable to diarrhoea and vomiting with 3 confirmed norovirus. The remainder were due to respiratory conditions including influenza and COVID 19.



The IPC team have continued to ensure that all outbreaks have been reported in line with local and regional requirements. Lessons learned have been identified and shared with teams involved and via the Trust governance meetings and learning culture partnership. These lessons include communication breakdowns either within teams or with IPC, not fully implementing barrier nursing and incorrect use of PPE (over use). Link champion training will be provided in all areas over the coming year with the focus on being back to basics of IPC. Outbreak management will be a core theme on the day.

Criterion 6

Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

IPC responsibilities are included in all Trust job descriptions as detailed below.

The post holder is accountable and responsible for the prevention of healthcare associated infections by complying with all IPC policies and procedures in line with legislation (Health Act 2006; Code of Practice for the Prevention and Control of Healthcare Associated Infections).

All staff are encouraged to professionally challenge colleagues and be challenged themselves if they are not compliant with IPC policies. Additional training for staff is provided by the IPC team ad-hoc within the workplace as a need is identified in order to support best practice.

As per criterion 1; all new starters attend Trust Induction where an IPC session is delivered by the IPC team, and all staff are to complete their online mandatory training whether they be clinical or non-clinical. The Trust provided staff with the National Skills for Health E-learning Module, which is updated as national changes in practice occur; ensuring the programme is current. The frequency that the courses need to be completed changed in October 2025.

All staff can access IPC contact details, guidance and information on the staff Intranet, where IPC has its own page. All policies are available on the Sophia platform.

The IPC team celebrated Global Hand Hygiene Day in May 2025 and Infection Prevention and Control week 2025 with increased site visits to staff from all specialties including those who support clinical colleagues.

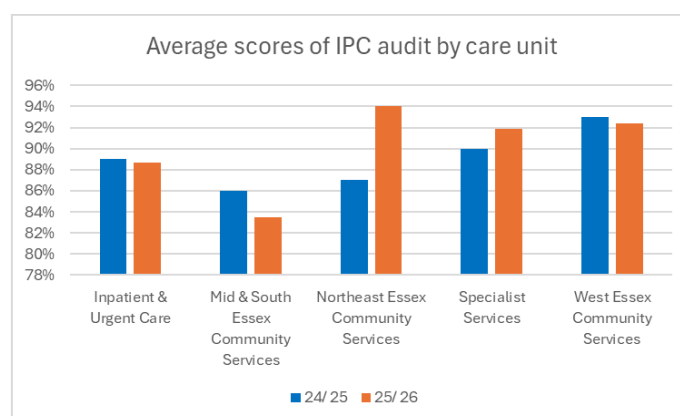
6.1 Audit Programme

As explained earlier in the report, environmental audits are carried out on an annual basis by the IPC team in all clinical areas. Re-visits are planned where areas fail to meet the required standard. Any deficits highlighted are reassessed and this helps to ensure the process is effectively followed through and managed.

The audit is based on the Infection Control Nurses Association (ICNA, 2004) audit tool, which has been amended to take into account mental health settings, and is carried out using the ICAT electronic auditing platform. This is an extremely stringent and thorough audit that assesses every room in each clinical area, thus providing a comprehensive and in-depth view of cleanliness, status of fixtures, fittings, furniture and infection control procedures and processes. An action plan is generated upon the completion of the audit which helps clinical areas address the deficits identified in the audits. The following table shows how many audits have been completed over the course of the year and the average scores. IPC team are working with teams to ensure standards are lifted and are re-visiting areas that fall below the expected standard.

Care Unit	No. of Audits	Average Score
Inpatient & Urgent Care	33	88.7%
Mid & South Essex Community Services	35	83.5%
Northeast Essex Community Services	3	94%
Specialist Services	25	91.9%
West Essex Community Services	28	92.4%
TOTAL	124	90.1%

Comparison of the last two years can be seen below for each care unit. This shows a decline in three of the five care units over the year and improvement in the remaining two. North East Essex community services, however, have demonstrated significant improvement during this time. Overall, the target of over 85% compliance has been reached in each care unit apart from Mid and South Essex community services:



Actions to move to Green: The enhanced cleaning audits are addressed by the action plan and any training identified by the current themes are incorporated into both formal and informal training sessions. The IPC team have continued to provide additional support in between formal audits by way of ad-hoc site visits.

Auditing sites which are shared with other provider organisations, and those that are leased from external landlords remains challenging. The IPC team encourage communication and partnership working with the other providers and building landlords in order to address areas for improvement. Additionally, close working with EPUT estates and facilities teams as well as care unit colleagues has helped to identify areas of concern and support resolution.

6.2 Quality Assurance Visits (QAVs)

Internal QAVs are undertaken by a team of colleagues led by the Compliance team, supported with audit and action planning information supplied by the IPC team. These visits not only assist in further escalation of certain environmental concerns but also highlight some of the good clinical practices seen.

6.3 Self-Audit Within Inpatient Wards

Quarterly inpatient IPC audits are carried out on the Tendable electronic auditing platform. Self-auditing in this manner captures current IPC practices as well as environmental standards.

The audit includes elements such as hand hygiene and mattress auditing. Over the year, the average score achieved is 98.8% The completion of ward manager and matron audits also on the Tendable platform provides further assurance.

Audit results are now shared on the Trust Quality and Safety Dashboard. The development of the IPC dashboard (in collaboration with the Performance team) has been halted temporarily due to the Nova Programme.

The aim of IPC dashboard will be to include both the inpatient team self-audits and IPC team environmental audit initially, with progression to a dashboard that also includes HCAI data. The performance team will continue the progression once the Nova Programme is complete.

6.4 Fit Testing for FFP3 Masks

The Health and Safety Act (1974) guidelines dictate that relevant staff should be fit tested every 2 years to ensure that staff are protected effectively. Fit testing of FFP3 masks is an essential element of long-term preparedness, not only for future pandemic, but also for use with patients who are suspected or known to have diseases of high consequence and other infections transmitted by respiratory routes such as influenza, measles, and chicken pox.



The IPC team continue to provide some level of fit testing for the fitting of masks for relevant staff as part of the wider work stream using a porta count machine which provides a quantitative test; and in 2024/2025, provided external accredited training for 22 staff within the care units to encourage active support of the programme. Unfortunately, very few of these 22 staff have gone on to undertake fit testing in their work environments in this reporting period due to workload capacity, therefore, the IPC team continue to be the primary testing resource.

Between April 2025 and March 2026, the following number of staff have been tested by IPC practitioners: 804 staff were seen of whom 571 passed, and 184 failed (all those who failed have either had risk assessments completed or been re-booked for further testing). A further 49 staff did not attend their booked appointment (in the period from October 2025 to March 2026).

In the coming year, the aim is to report on compliance with the addition of a care unit denominator to enable accurate data production. Work has been undertaken to establish the eligible workforce, and this will continue into 2026-2027, and plans to include this information within the Electronic Staff Record will be implemented to improve data accuracy, monitoring and compliance.

The IPC team recruited a Fit Tester who joined the team in April 2025 to assist in the development of fit testing as an ongoing project as well as providing practical fit testing and support for those colleagues already trained. This role has now changed following the reconfiguration of the IPC team as outlined above, and the individual will have other duties to fulfill as well as fit testing.

Criterion 7

The provision or ability to secure adequate isolation facilities.

EPUT's inpatient accommodation comprises the use of bays and single side rooms, many of which are en-suite, but not all, with the remainder having shared bathroom facilities. Therefore, patients who require isolation can be cared for within our services. Individual risk assessments should be carried out by the clinical team to ensure a safe approach is taken in situations where patients require isolation due to infectious reasons. This risk is frequently reviewed to ensure any isolation period does not extend any longer than necessary.

A further point to note is that the Trust's inpatient services have communal social, activity and eating areas allowing patients to participate in active rehabilitation. However, if a patient is required to isolate due to infection, provision is made for them as individuals.

Ward or bay closure decisions may be made as part of outbreak management. The IPC team will lead outbreak meetings and specify that wards will not admit patients during the emerging and critical stages of an outbreak of infection. However, it is acknowledged that for a variety of clinical reasons the risk of not admitting would be greater than the risk of transmission of infection. In these instances, a clinical risk assessment is to be carried out and fully documented by the clinical team with support of the IPC team if required.

Criterion 8

The ability to secure adequate access to laboratory support as appropriate.

Contracts are in place with accredited pathology services provided by the acute NHS trusts across the wide geographical area that EPUT covers. Additionally, the organisation has a contract for sessional support from a consultant microbiologist who is employed by one of the local acute trusts.

Criterion 9

That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.

An overarching IPC policy is accessible to all staff via the Sophia platform; it includes the following subject matters by way of individual guidelines:

- Common Infectious Diseases
- Standard Precautions
- Infection Control in Clinical Practice
- Communicable Diseases and Outbreak Control
- Prevention and Management of MRSA
- Prevention and Management of *Clostridioides Difficile*
- Prevention and Management of Tuberculosis
- Prevention and Management of Infestations

- Prevention and Management of Sharps Injuries and Contamination Incidents
- Pets and Pests
- Care and Decontamination of Mattresses
- M Pox

Each policy/guideline is subject to review on a three yearly cycle or as national guidance changes. The policy and guidelines are informed by the National Infection Prevention and Control Manual for England.

All policy/guideline reviews include comment from expert colleagues who form the Infection Prevention and Control Group; following this update all policies and guidelines are taken for final approval to the Quality Senate.

Criterion 10

That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

10.1 Occupational Health (OH) Services

The Trust's employee OH service is contracted via an external provider. The current provider's contract commenced in June 2024.

Staff can access their services and advice using a range of methods including via telephone, posters, guidance on the staff Intranet page. Line managers are provided with information to help signpost staff to these services, as well as access to make referrals and view reports for their team members via the OH portal.

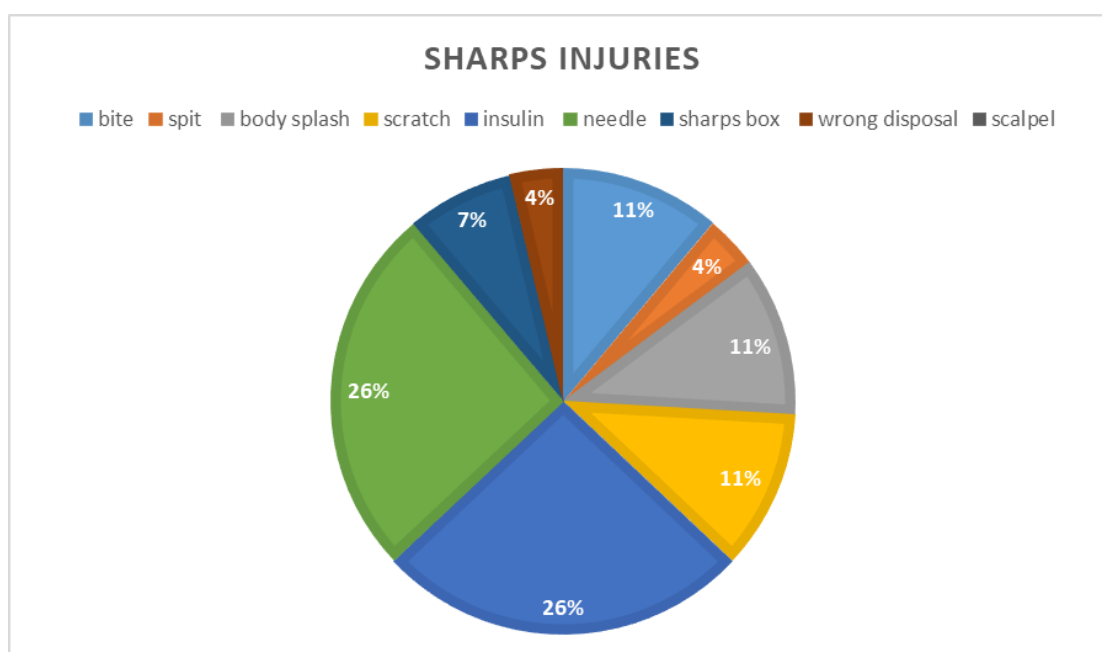
OH policies and procedures can be accessed on the Trust intranet and via the Sophia platform. The Trust's Human Resources team work together with OH in relation to the organisation's Sickness Policy.

The IPC team provide general principles relating to staff becoming unwell during the delivery of the Trust Induction Programme. These principles are also covered in the National Mandatory Training Skills for Health E-learning Module that all staff undertake.

Sharps Injuries

OH lead on risk assessments and providing expert advice for staff sustaining sharps injuries, calling on the IPC team if required. A 24 hour help line number is provided for staff to call, should they sustain a sharps or bodily fluid contamination injury.

A monthly review of inoculation injuries has been undertaken by the IPC team and OH provider to assist in the identification of lessons learned and training opportunities. The following pie chart highlights sharps and body splash injuries:



10.2 Staff Swabbing During Outbreaks of Infection

The Trust continues to use the services of an external contractor as part of the ICB contract for the swabbing of staff in outbreaks of infection such as Group A strep, as these services are not currently provided by the current OH service provider.

Immunisations

OH service collects and keep records of staff immunisations as part of the New Joiner Risk Based Screening Assessment. Any immunisation recommendations made by them align with the National Green Book. Although a regular review of immunisation status is not currently undertaken, if staff members change their role whilst working with the organisation, immunisation status is checked again at that point by OH services.

Patients who were being cared for as inpatients during the winter season were offered influenza vaccination as well as those who met the criteria for COVID-19 vaccination.

All staff are offered a free influenza vaccination each year. These vaccinations were provided by the OH services with assistance from peer vaccinators.

Appendix 1

Key Infection Prevention and Control Achievements in the Organisation

- Provision of expert advice and leadership on the management of nosocomial outbreaks of infection within the organisation
- Quarterly review and submission of the National Board Assurance Framework
- Maintained levels of support in relation to all related IPC issues/queries
- Supportive site visits for clinical and non-clinical staff and provided bespoke responses to team IPC needs
- Carried out yearly IPC audits as per the annual audit programme in order to assist teams in identifying and actioning areas of good practice and improvement in accordance with evidence based best practice and National Technical Memorandum Standards
- Collaboration with the Trust Estates teams in refurbishment and change of use projects, providing advice to align with the National Health Technical Memorandums to ensure health care standards are met when changes of use or refurbishment projects are in the planning stages
- Attendance at and provision of expert IPC advice at the Trust Water and Ventilation Safety Committees
- Collaboration between IPC, Estates and clinical teams in the safe management of water quality issues linked to positive legionella results
- Collaboration with ICB specialists in urinary catheter care in order to support reduction in gram negative infections as well as work towards evidence based best practices across the system
- Active member of the Harm Free Care Group focusing on the physical health of patients within our care
- Provision of shadowing opportunities for staff and students
- Ongoing collaboration with estates colleagues to review clinical hand wash sink provision within the organisation, in order to meet current Health Technical Memorandum Standards
- Continued Community Collaborative Band 6 Network Forum for IPC nurses across the geography of Mid and South Essex
- Delivery of the Trust induction programme for staff
- Provision of adhoc training sessions in the workplace for staff
- Production of a quarterly IPC newsletter providing updates, education and lessons learned whilst out in the clinical departments
- Provided expert IPC advice to EPUT teams working with migrant populations across the geography of the Trust
- Review of IPC guidelines
- Provision of fit testing for FPF3 masks for relevant staff on behalf of the organisation as part of wider role
- Collaborative working with Trust performance team to establish IPC Dashboard

***Essex Partnership University NHS
Foundation Trust***

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Essex SS11 7XX***

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10.3 MENTAL HEALTH ACT ANNUAL REPORT

● Information Item

● Chief Nurse

REFERENCES

Only PDFs are attached

 Mental Health Act Annual Report 07.10.2026.pdf

SUMMARY REPORT		BOARD OF DIRECTORS PART 1			7 October 2026		
Report Title:		Mental Health Act Annual Report					
Report Lead		Ann Sheridan – Executive Nurse					
Report Author(s):		Tendayi Musundire – Deputy Director of Nursing for Safeguarding and MHA					
Report discussed previously at:		Quality of Care Group Quality Committee					
Level of Assurance:		Level 1	☐	Level 2	☒	Level 3	☐

Risk Assessment of Report		
Summary of risks highlighted in this report	None - Although there are no risks to highlight in this report, there have been some improvements identified that form part of the MHA workplan for 2026/2027, particularly in regards improved communication, data management and best practice improvements.	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	☐
	SR4 Demand/ Capacity	☐
	SR5 Statutory Public Inquiry	☐
	SR6 Cyber Attack	☐
	SR7 Capital	☐
	SR8 Use of Resources	☐
	SR9 Digital and Data	☐
	SR10 Workforce Sustainability	☐
	SR11 Staff Retention	☐
	SR12 Organisational Development	☐
	SR13 Quality Governance	☒
Does this report mitigate the Strategic risk(s)?	Yes - MHA work plan in place and active	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	
Are you requesting approval of financial / other resources within the paper?	No	
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	N/A	
Reflection on Equalities	The report has identified an overall positive impact on equality through patients' rights processes and preparations for access to Tribunal hearings. Poor practices such as unclear access to advocacy services, documentation quality and communication are being mitigated through training, policy reviews, auditing and improvements to digital process improvements.	

Purpose of the Report

This report provides an overview of the Trusts' Mental Health Act activities during 2025/26 and details of governance frameworks, operational perspective and compliance efforts. It also identifies areas for improvement and planned actions to strengthen legal compliance, best practice and patient experience.

Decision	☐
Discussion	☐
Information	☒

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Points

The Mental Health Act (MHA) team continues to support the compliance of the Act by maintaining and continuously improving strong MHA processes including providing legal advice and expertise to clinical staff, monitoring auditing compliance and incidents and ensuring robust scrutiny arrangements.

There is a continued focus on patient rights and experience, with ongoing work has focussed on access for patients to fair and speedy hearings, advocacy referrals and consent processes.

The Trust supports the reforms through policy review, digital transformation initiatives and workforce development.

Relationship to Trust Strategic Objectives

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

Which of the Trust Values are Being Delivered

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

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

Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	☒
Supports CQC standards and EPUT priorities through strong governance, legal compliance, and continuous quality improvement.	
Data quality issues	☐
Involvement of Service Users/Healthwatch	☐
Communication and consultation with stakeholders required	☒
Consultations with key Trust stakeholders, such as Datix managers, governance and auditing managers, modern matrons and ward managers as well as the MHA team.	
Service impact/health improvement gains	☒
For strengthened compliance, improved patient experience outcomes and information, better data quality.	
Financial implications:	☐
Governance implications	☒
The report supports the MHA responsibilities, provides assurance on legal and regulatory compliance and is submitted through the Board for approval.	

Impact on patient safety/quality



The MHA work plan aims to improve patient safety and compliance through increased compliance the relevant provisions of the MHA, namely patient lawful detention, strengthening information, improved access to reviews of detention.

Acronyms/Terms Used in the Report

MHA	Mental Health Act	CQC	Care Quality Commission
IMHA	Independent Mental Health Advocate	NOVA	EPUT electronic patient record
CTO	Community Treatment Order	MHAA	Mental Health Act Administrator

Supporting Reports/ Appendices /or further reading

Mental Health Act Annual Report

Lead

Ann Sheridan

**Ann Sheridan
Executive Nurse**



Essex Partnership University
NHS Foundation Trust

MENTAL HEALTH ACT ANNUAL REPORT

This Annual Report provides a comprehensive overview of the Essex Partnership University NHS Foundation Trust's Mental Health Act (MHA) activities. It details the governance framework, operational review, and compliance efforts related to the MHA.

2025/26

EPUT

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Mental Health Act Annual Report

1. Foreword

By Ann Sheridan, Executive Nurse

I am pleased to present our Mental Health Act Annual Report for 2025/26. Once again, it has been a busy year for us as we have continued to prioritise high quality, safe and compassionate care for everyone who comes into contact with our services. For many of our patients, the Act does not feature in their treatment, but for those where it does, our use of it and the associated legislative framework shapes their experience and ultimately the outcome of their treatment.



In late 2025, the Mental Health Bill was agreed and passed by Parliament, paving the way for some of the most significant changes in mental health provision and the use of the Act in many years. The Bill was designed to modernise the Act and took into account the 2017 independent review. Key changes centre around increasing patients' individual rights and ensuring that the Act is used proportionately, always taking into account both the relative risk patients pose to themselves and others and also their prospect of benefiting from treatment provided under section. At EPUT, we welcome the changes, especially those which relate to patients with learning disabilities and/or neurodivergence and the introduction of the nominated person role to replace the current default to the patient's nearest relative. The changes will take time to be evaluated and embedded across all relevant services, but we stand ready to work with our partners locally, regionally and nationally to support the implementation.

Closer to home, we have now fully rolled out our Time to Care inpatient programme which is changing the way we staff and run our inpatient wards, bringing a greater emphasis on therapeutic engagement with patients and reducing length of stay by focusing on ensuring people are only treated in inpatient settings where this has a clear benefit to their treatment and recovery. We are now reviewing and redesigning our community mental health services, using a similar approach. Training for our staff therefore remains key to how we use the Act in our day to day engagement with patients and their loved ones, and I am pleased to report that training rates remain high for both registered and unregistered staff.

At the same time, we have continued to support the valuable external scrutiny afforded to us through inspections of our use of the Act by the Care Quality Commission. Though generally positive, the inspections did find room for improvement and these priorities are now being taken forward in our ongoing planning.

Looking forward to 2026/27, maintaining our level of training and awareness of the Act and its use will remain a key priority, alongside working to implement the changes resulting from the Mental Health Bill and our own strategic aims and objectives.

2. Executive Summary

This ninth Annual Report for EPUT's Mental Health Act & Safeguarding Sub-Committee outlines its operating framework, reviews activities and outcomes from 2025/26, and summarises upcoming developments and challenges for 2026/27.

The Board believes strong governance is vital for achieving strategic objectives, ensuring service safety, enhancing user and carer experience, and protecting stakeholder interests. Effective governance starts with the Board and influences all organisational practices, policies, and procedures.

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

This report reviews the operation of the Mental Health Act (MHA) for the year 1st April 2025 to 31st March 2026. It summarises efforts to ensure lawful and safe use of the Mental Health Act 1983 in the Trust, offers Board assurance, and addresses risks effectively.

The Mental Health Act team continues to monitor Mental Health Act activity across the Trust, Consent to Treatment (CTT) compliance, use of emergency treatment provisions, information to service users and access to courts and tribunal service. Whilst there is some fluctuation in data, it remains consistent with previous years.

Between 1st April 2025 and 31st March 2026, the Care Quality Commission (CQC) conducted fifteen inspections in relation to the Mental Health Act across the Trust. The results of these inspections were predominantly positive, reflecting well on the Trust's compliance with statutory requirements and its commitment to service quality.

While most feedback highlighted strengths in practice, the CQC also identified several recurring themes and learning points. These areas were reviewed by the Trust and action was taken to address the concerns raised. The Trust's response demonstrates its commitment to continuous improvement and the effective implementation of recommendations arising from external scrutiny.

Surpassing the Trust's target compliance figure of 85% for Mental Health Act mandatory training, actual performance reached 93%, covering both registered and unregistered staff. This achievement underscores the organisation's commitment to equipping its workforce with essential knowledge and skills, thereby supporting safe and lawful practice under the Mental Health Act. The MHA team facilitates regular training and, during the reporting period, delivered sessions to hundreds of staff, ensuring a comprehensive understanding of key legislative requirements and practical responsibilities. Such strong compliance contributes positively to the Trust's overall risk mitigation strategy, particularly regarding timeliness and admission

delays, and bolsters resilience within the team and working relationships across departments. Ongoing efforts are focused on streamlining processes, enhancing communication, and addressing workload pressures to maintain up-to-date records in the electronic patient record system, thereby safeguarding both patient rights and organisational performance.

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

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

This report provides assurance on compliance with the Mental Health Act 1983 and Code of Practice.

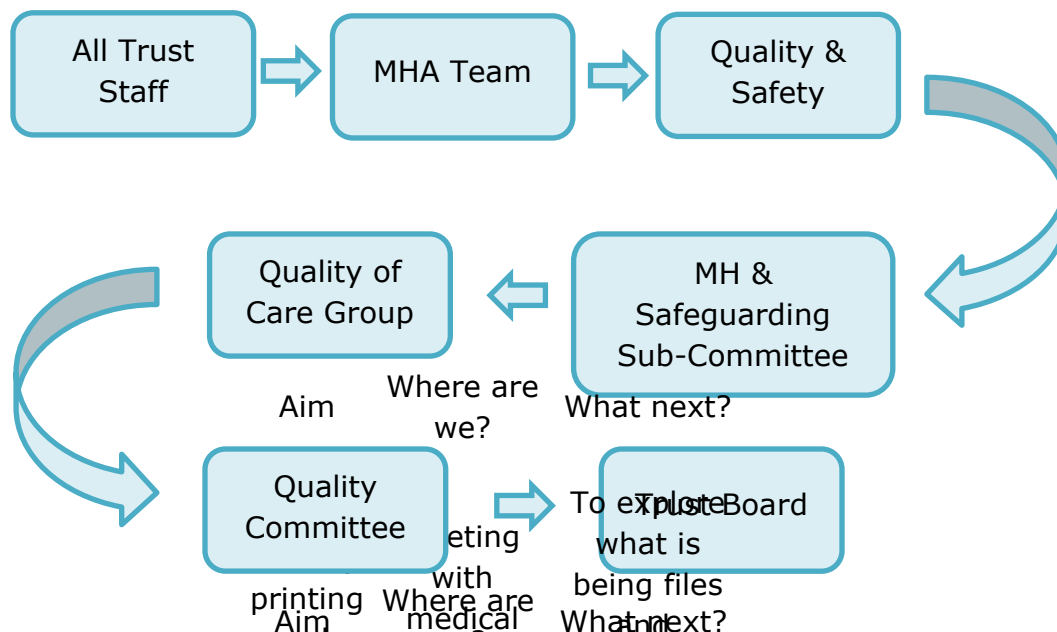
The following escalation table is designed to provide a clear overview of key risks faced by the Trust during the reporting period, alongside their ratings and the mitigation strategies implemented. Its purpose is to ensure transparent communication of risk management measures, highlight areas requiring urgent attention, and support ongoing efforts to strengthen resilience within teams and improve working relationships. By outlining challenges such as timeliness of admissions, reliance on emergency powers, documentation errors, and communication gaps, the table demonstrates the Trust's commitment to continuous improvement and organizational performance.

Risk	Rating	Mitigation
Timeliness & admission Delays	High	Process review; tracking systems; training; prioritisation matrix
Heavy reliance on emergency powers	High	Process review; systems digitisation
Documentation Errors	High	Auditing; incident reporting; digital tools
Workforce capacity	Medium	Team resilience exercise; redistribution; explore recruitment

3. Governance and Assurance Framework

The Trust regularly updates its Board and committees on Mental Health Act activity, trends, and quality through strong reporting systems.

Meeting/Group	Lead/Reporter	MHA Attendance	Content & Purpose
Trust Board	Deputy Director for MHA and safeguarding	Annual	Strategy & EPUT plan Risks/Issues
Quality Committee	Deputy Director for MHA and safeguarding	Quarterly	
Quality of Care Group	Deputy Director for MHA and safeguarding	Quarterly	Quality analysis
MH & Safeguarding Sub-Committee	MHA Lead	Bi-Monthly	Themes & Trends Risk escalations



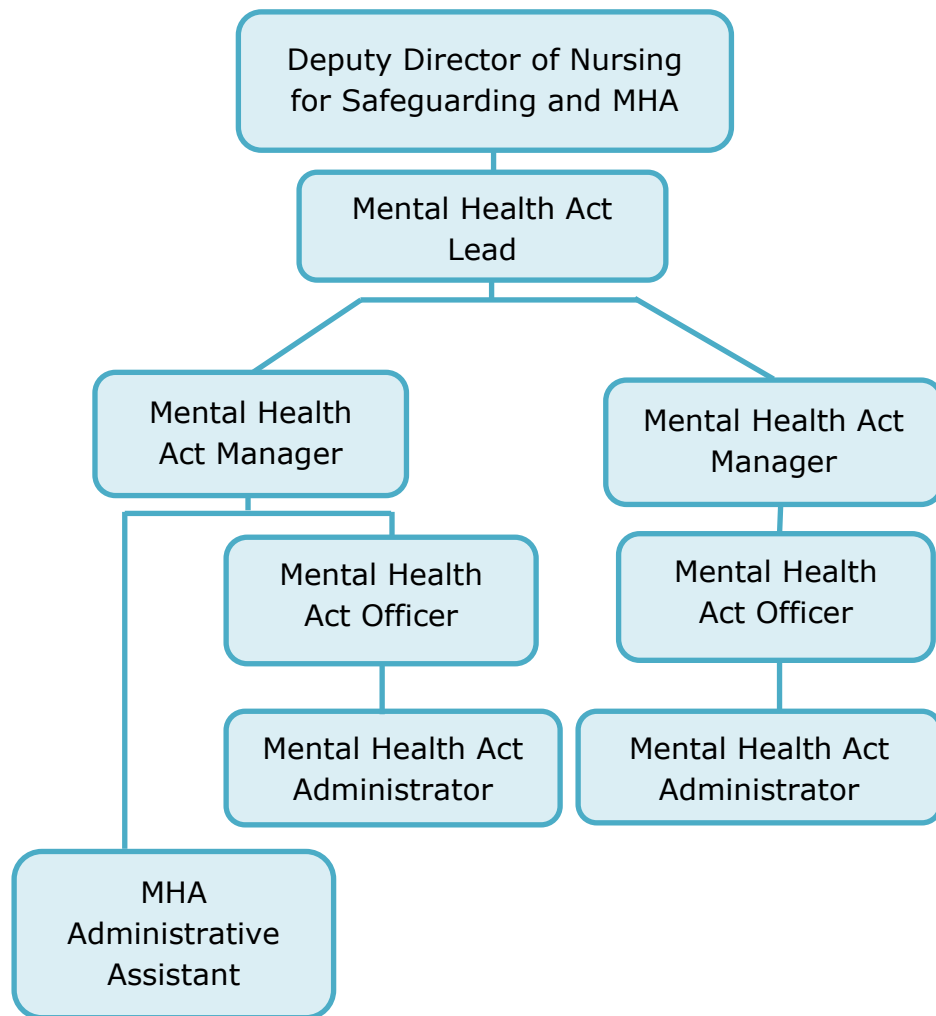
The Mental Health Act (MHA) has always been an essential component of the governance framework and quality monitoring. The MHA team continues to strengthen compliance through this targeted actions focused on improving documentation, audit performance with statutory filing processes. This includes addressing gaps identified in Tenable audits, medical records, and providing targeted support to wards that are not achieving full compliance. The team is also prioritising the timely completion of consent to treatment requirements, reducing outstanding SPOB cases, and ensuring robust legal authorisation for all patients.

Alongside this, the introduction of the new MHA leadership role presents an opportunity to undertake a comprehensive review of current processes, systems, and service delivery. This provides a platform to streamline workflows, enhance efficiency, and improve overall compliance with the Act. There is a clear opportunity to modernise and digitalise MHA administration, reduce duplication, and strengthen governance arrangements.

By embedding learning from audits, CQC investigation and operational pressures, the service can move towards a more proactive, standardised, and efficient model, ultimately improving both staff experience and patient outcomes while ensuring legal robustness.

Increasing representation of Mental Health Legislation in governance forums provide subject matter expertise for leadership governance forums across the organisation.

To stop 2nd Scrutiny
Continue until further notice
Sheet to Explore options
1) Continue with current process; Explore



4. MHA Activity and Data Insight

Detention Activity Overview

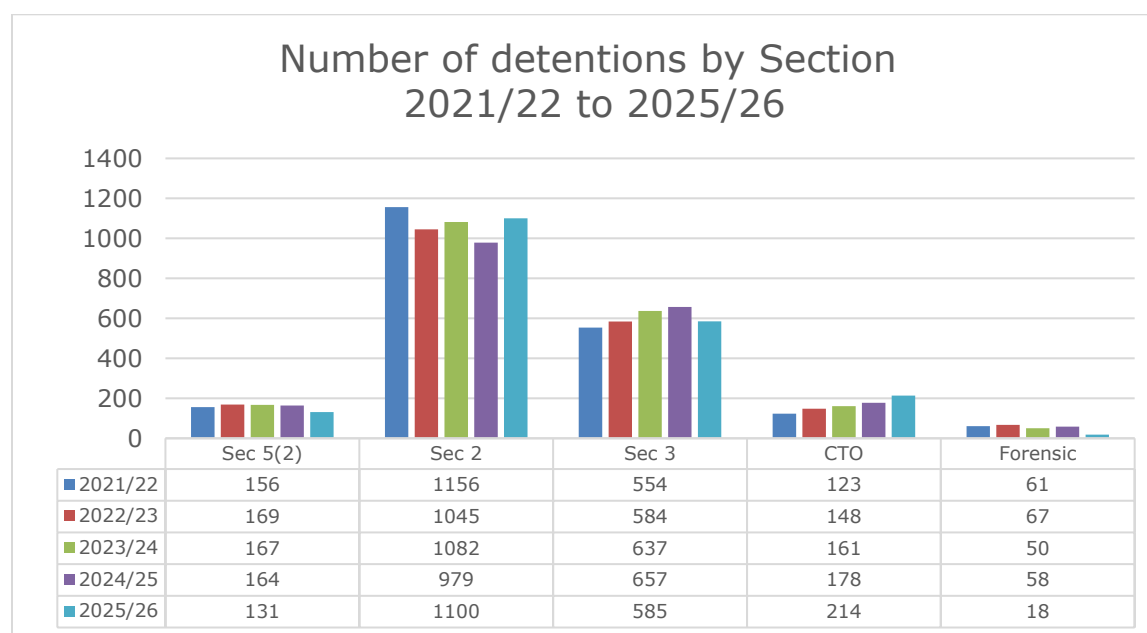
The Mental Health Act (MHA) detention activity continues to be a focal point for governance and quality monitoring. Recent efforts by the MHA team have centered on strengthening compliance, streamlining statutory processes, and modernising administration. The introduction of new leadership roles is expected to enhance efficiency and legal robustness.

Trends in Detention Activity

Over the past year, detention activity has shown both seasonal and operational fluctuations. The majority of detentions occur under Section 2 (assessment), followed by Section 3 (treatment) and Section 5(2) (holding powers). A review of audit data reveals a gradual shift towards more proactive, standardised approaches, with a notable reduction in duplicated processes and improved governance arrangements.

The service is embedding learnings from CQC themes and operational pressures to further drive these improvements.

- Section 2 detentions remain the most common, reflecting national trends.
- Section 3 detentions are increasing, indicating longer-term treatment needs.
- Section 5(2) detentions fluctuate in response to patient needs and the increased likelihood of informal admissions, reflecting a preference for the least restrictive approaches.



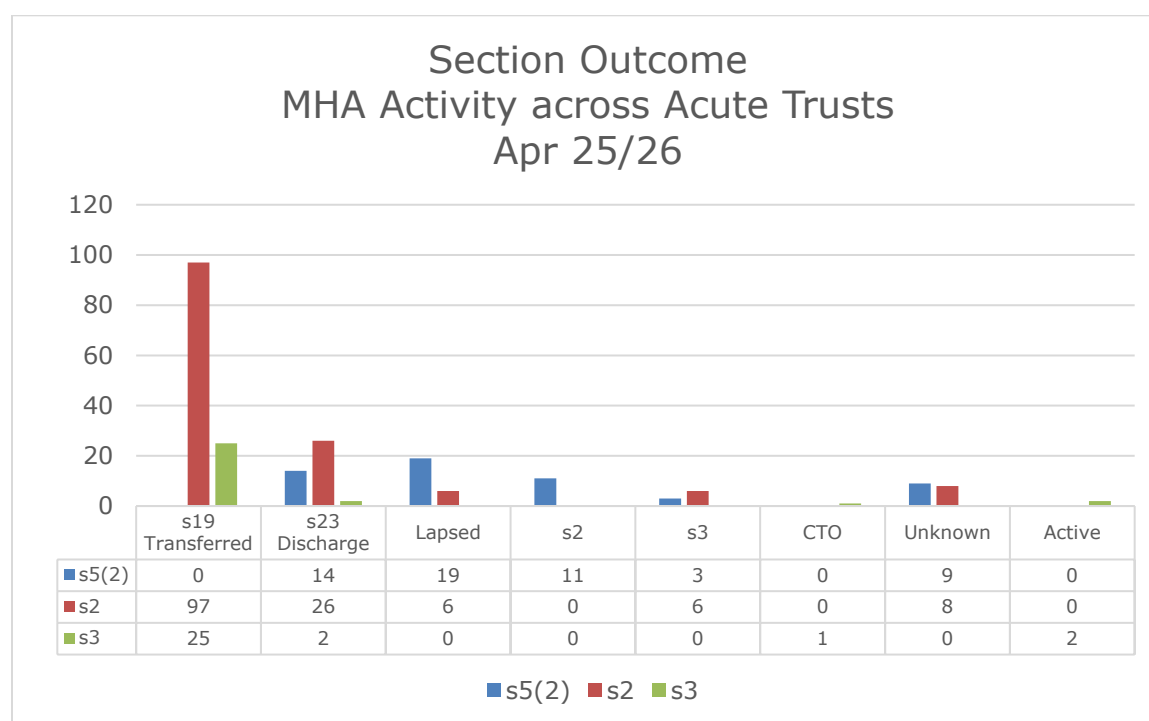
MHA Activity across Acute Trusts

The table below offers a detailed overview of recent MHA activity at our partner acute Trusts, highlighting the prevalence and distribution of detentions across various part II sections of the Act. It illustrates key outcomes, including the predominance of Section 19 transfers of detention between organisations. As such the following data relates to patients not detained in EPUT.

There were 17 cases where detention outcomes were recorded as *Unknown*, indicating communication and information sharing gaps. In addition to these, there were 25 sections not reviewed prior to expiry and recorded as *Lapsed*. Where a person continues to be kept in circumstances which amount to a deprivation of liberty, this may be considered a breach of a patient's Article 5 ECHR right to liberty. In recognition of this, MHA Managers are actively liaising with Senior RMNs, consultants and Psychiatric Liaison Teams in each organisation to initiate conversation, identify and improve recording and communication barriers and identify learning needs. A training package is being developed alongside existing packages.

Additionally, there will be a review of the service level agreements (SLAs) between partner organisations. This review will focus on clarifying roles, responsibilities, and expectations regarding statutory processes, documentation, and timely review of detentions. Strengthening SLAs will help ensure that all parties are aligned in their commitment to compliance and quality monitoring.

Improved oversight by the MHA team is also a key component of this mitigation plan. The team will implement more robust monitoring mechanisms, conduct regular audits, and provide targeted support to acute Trusts. These actions are designed to prevent lapses, address gaps in communication, and promote a culture of proactive governance and legal robustness. Collectively, these measures are expected to significantly reduce the incidence of 'Unknown' and Lapsed outcomes.



The MHA Team has noted concerns regarding the use of s5(2), namely reasons for the use of the power, in some cases, not stating reasons at all. The purpose of the statutory papers are to ensure the procedural and clinical considerations have taken place and that these are legally documented. A review and audit of s5(2)'s for quality and legality is scheduled, with findings to be shared with relevant reporting bodies and medical structures.

The MHA team are committed to ongoing efforts to streamline processes and ensure equitable, legally robust care.

Demographic Breakdown

In alignment with national data, detention activity demonstrates variation across ethnicity, gender, and age groups:

There is no disparity regarding the number of people that have been detained based on gender, ethnicity and age. The demography within Essex is largely from a white ethnic background hence the higher proportion being admitted, approximately 82%. According to the 2021 Census data, 85.1% of the population in Essex were reported as White British, this is a higher proportion compared to England which is at 73.5%.

There are noted higher detention rates among males, particularly in acute and emergency sections.

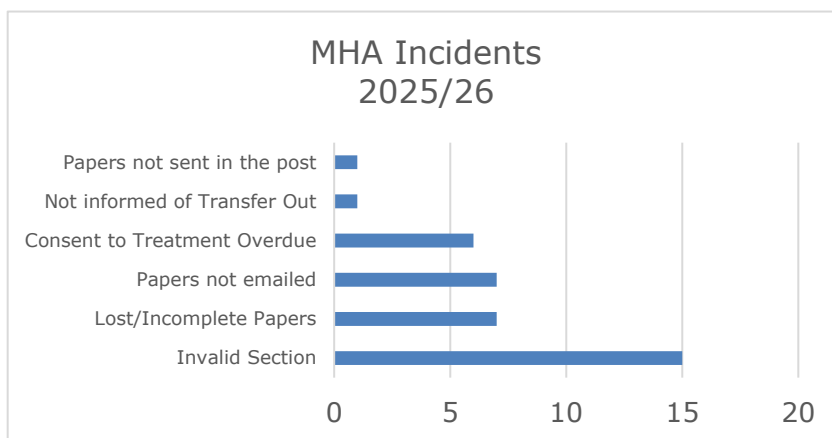
5. Incidents (Datix) and Learning

A total of 37 incidents were reported during the reviewed period. These incidents included cases of invalid sections, incomplete documentation, and delays in processes. Each of these issues reflects ongoing administrative and communication risks within the current system.

The occurrences were tracked and visualised in a graph, which covers incidents from the 2025/26 period. Notably, the most recent incident was recorded in December 2025.

In response to these challenges, actions have been implemented to address and mitigate risks.

These actions focus on enhanced tracking of incidents, targeted training for staff, and the redesign of existing processes to improve efficiency and reduce errors.



Management and Oversight of S17 Leave of Absence

Incidents relating to the management and oversight of Section 17 leave have been identified through internal governance processes, Patient Safety Incident Investigations (PSIIs), and concerns highlighted through a Prevention of Future Deaths (PFD) reports issued by the HM Coroner.

In response to these findings, the Director of Nursing and Medical Director have jointly commissioned and are leading a programme of work aimed at strengthening the governance, assurance, and operational oversight of Section 17 leave across the

Trust. This work seeks to improve compliance with statutory requirements, enhance patient safety, and ensure the consistent application of Section 17 leave processes across inpatient services.

The Mental Health Act Team have been identified as a key stakeholder within this programme and is expected to play a central role in supporting governance arrangements, quality assurance, monitoring, and compliance oversight. The involvement of the Mental Health Act Team will support the development of robust systems for monitoring leave authorisations and associated clinical decision-making. This involvement commenced and the end of 2025/26, with partnership working continuing in 2026/27 as an integral part of the MHA team annual work plan.

There are plans to consider the introduction of a digital Section 17 leave solution to replace existing paper-based processes. The implementation of a digital system is intended to strengthen oversight, improve the accuracy and accessibility of leave documentation, facilitate real-time monitoring and auditing, and provide greater assurance regarding compliance with Mental Health Act leave requirements. It is anticipated that this development will support more effective governance processes while reducing the risk of administrative errors and delays in the management of Section 17 leave.

6. Audit Programme

Audit findings indicate variability in documentation of capacity and patient views. This inconsistency suggests that, while capacity reasons were documented in 85.11% of cases, there remains a moderate gap in ensuring patient perspectives are consistently recorded.

Actions focus on improving compliance through training and monitoring.

Question	Score	Volume	Risk Interpretation
Capacity reasons documented	85.11%	45	Moderate gap
Patient views documented	85.16%	53	Moderate gap
Capacity on ward review	88.67%	578	Requires improvement

Key Findings

- Documentation of capacity assessments is inconsistent
- Recording of patient views requires improvement
- Some gaps in ward-level oversight

Actions

- Reinforcement of documentation standards
- Training and awareness sessions
- Integration into audit and scrutiny processes

7. CQC Overview

Last year's CQC themes: documentation quality, treatment concerns, and patient rights. Summarise identified issues.

Themes Identified	MHA Issues Identified
Consent, Capacity & Patient Rights	No capacity/Gillick competence assessments; incomplete capacity and best interest documentation; no consent discussions (including first 3 months); Section 132 rights not completed, delayed, or not repeated; lack of evidence of patient understanding; no IMHA referral when required; poor documentation of consent for informal admission
Medication Management & Legal Authorisation	Missing or incomplete T2/T3 forms; inappropriate or unjustified use of Section 62; medication not authorised or not checked against legal documentation; forms not attached to drug charts; RC/SOAD processes not followed; disorganised medication records
Section 17 Leave Management	Missing, expired or incomplete Section 17 forms; lack of RC authorisation; no clear leave dates/times or return recording; copies not given to patients/carers; outdated forms retained; patients on leave without valid documentation
Legal Documentation & MHA Processes (Detention & Scrutiny)	Missing/invalid section papers; incorrect section status recorded; no AMHP report; incomplete scrutiny processes; non-compliance with Section 61; lack of Community Treatment Order documentation; poor accessibility of legal records
Ward Environment, Restrictions & Patient Experience (MHA Compliance Impact)	Blanket restrictions (e.g. access to fresh air, bedrooms, leave); safety concerns (ligature risks, seclusion issues); lack of privacy (rooms, bathrooms); limited access to activities and facilities; poor communication with carers; issues with IMHA awareness; environmental risks (broken doors, unsafe spaces)

The summary of the table above highlights several key compliance issues related to consent, capacity, patient rights, medication management, Section 17 leave, legal documentation, and ward environment. To address these issues, the following actions are recommended:

- Implement regular staff training to ensure proper completion of capacity assessments, consent discussions, and documentation of patient rights.
- Strengthen medication management processes by ensuring all legal forms (T2/T3) are completed, attached to drug charts, and regularly audited for compliance.
- Standardise Section 17 leave management, including timely completion of forms, clear documentation of leave details, and provision of copies to patients and carers.
- Enhance scrutiny of legal documentation and Mental Health Act (MHA) processes by conducting routine checks, maintaining up-to-date records, and ensuring AMHP reports are completed.
- Review ward environment policies to minimize blanket restrictions, address safety concerns, and improve communication with patients and carers, including IMHA awareness.
- Escalate persistent or systemic issues to the Quality of Care Group for oversight, additional resources, and strategic intervention as necessary.

These actions should be incorporated into ongoing policy reviews, gap analyses, and the revision of Standard Operating Procedures (SOPs) to ensure sustained compliance and improved patient outcomes.

8. Developments and Challenges

The plan to renovate the team processes centres on a comprehensive review of our existing policies, procedures, and operational standards, specifically targeting gap analysis and the mitigation of compliance and quality issues. By systematically examining our current Standard Operating Procedures (SOPs), the aim is to identify areas where practice falls short, whether in consent, capacity assessments, patient rights, medication management, Section 17 leave, or ward environment controls.

The rationale for this initiative is clear: persistent compliance gaps and operational shortcomings hinder our ability to deliver safe, patient-centered care and maintain regulatory standards. Recent findings highlight blanket restrictions, environmental risks, and weaknesses in documentation and

communication. Addressing these challenges requires a proactive, evidence-driven approach to policy review and process redesign.

By next year, the team goal is to establish a robust, transparent framework for MHA team operations that ensures regular staff training, standardises CTT processes and leave management, and improves legal documentation scrutiny. The team also aims to enhance communication, particularly around s132 and IMHA awareness, and foster safer, more supportive ward relationships. Ultimately, this work will support sustained compliance, improve patient outcomes, and empower staff through clearer guidance and accountability.

The Nova Project, with its dedicated MHA module, plays a pivotal role in advancing patient safety by streamlining Mental Health Act processes and improving documentation accuracy. This module integrates with existing systems to ensure timely consent and capacity assessments, supports robust legal compliance, and enhances visibility of patient rights. As part of ongoing developments, plans are underway to review the Tendable audit tool and Datix incident reporting platform, enabling a rich data-bank of compliance gaps and safety incidents. Together, these will facilitate feedback, lessons learning, targeted interventions, and data-driven improvements, further supporting a transparent, accountable care environment.

The plan will be integrated with ongoing policy revision, gap analysis, and SOP updates, and aligned with strategic oversight from the Quality of Care Group. This will ensure that improvements are embedded, monitored, and continually adjusted in response to evolving needs and regulatory requirements.

Although the Act has received Royal Assent and some small provisions have taken effect (conditional discharge rules and applications to Tribunals), the Act is being implemented over the next decade as part of a gradual implementation plan. Formal consultation regarding a new Code of Practice is planned throughout this year. Further changes and implementation, including new part II detention criteria, are planned over the next 8-10yrs.

9. Conclusion

In summary, the comprehensive approach outlined for renovating team processes and strengthening operational standards is designed to address both immediate and systemic challenges within our care environment. By prioritising policy review, gap analysis, and SOP updates, the team is committed to closing compliance gaps, mitigating risks, and fostering a safer, more supportive ward atmosphere. The integration of advanced tools like the Nova Project's MHA module, along with enhanced audit and incident reporting

systems, reflects a forward-thinking strategy that leverages technology to streamline operations and ensure regulatory adherence.

As these developments progress, ongoing monitoring and strategic oversight from the Quality of Care Group will be essential to sustaining improvements and adapting to evolving needs. The emphasis on staff training, standardised procedures, and improved communication, especially regarding patient rights and IMHA awareness—will empower both patients and staff, strengthening trust and accountability across the organisation. Ultimately, these efforts are poised to deliver lasting benefits, ensuring compliance, promoting patient-centered care, and setting a strong foundation for future growth and excellence.

10. Closing Remarks

By Tendayi Musundire, Deputy Director of Nursing for Safeguarding and Mental Health Act

In conclusion, 2025/26 has been a challenging but productive year for the Mental Health Act team. Despite significant workforce changes, including the retirement of the senior manager towards the end of the year and changes within the administration team, the service has continued to meet its statutory responsibilities and maintain safe, lawful and responsive support across the Trust and partner organisations. The team's resilience, adaptability and shared commitment have been central to sustaining delivery during a period of increased workload and operational pressure.



Key success points include continued compliance with statutory requirements, strong mandatory training performance, positive areas of CQC feedback, ongoing support to acute care partners through the Service Level Agreement, and the continued development of governance, audit and reporting arrangements. Looking ahead, the team has identified clear areas for further development. These include producing more robust reports to evidence work delivered under the Service Level Agreement, reviewing processes to reduce duplication and improve efficiency, strengthening the use of data to support assurance and learning, and continuing to work with the Nova programme to ensure that the Mental Health Act aspects of the patient record are fit for purpose.

The arrival of a new senior manager, bringing significant Mental Health Act legal expertise, provides an important opportunity to build on existing strengths and further develop the service. I would like to offer my sincere thanks to every member of the team for their professionalism, perseverance and strong team ethic throughout the year. Their continued dedication has enabled the service to respond constructively to challenge, sustain high standards, and remain focused on protecting patient rights and supporting lawful practice across the organisation.

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11. OTHER

11.1 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING.

 Chair

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

 All

12. ANY OTHER BUSINESS

☒ Information Item

☐ ALL

13. QUESTION THE DIRECTORS SESSION

A session for members of the public to ask questions of the Board of Directors

EXCLUSION OF THE PUBLIC AND PRESS

Notice of Motion: Those members of the public and press be excluded form the remainder of the meeting by reason of the confidential nature of the business to be transacted.

DATE AND TIME OF NEXT MEETING

2 December 2026 at 10:00, The Lodge Training room 1