Essex Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS MEETING
PART 1

BOARD OF DIRECTORS MEETING PART 1

3 June 2026

10:00 GMT+1 Europe/London

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

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#0 Part 1 BoD Agenda June 2026.pdf

Meeting of the Board of Directors held in Public
Wednesday 3 June 2026 at 10:00

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

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

AGENDA

1	**APOLOGIES FOR ABSENCE**	LL	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	LL	Verbal	Noting
PRESENTATION Pharmacy and Medicines Optimisation Dr Hilary Scott, Director of Pharmacy and Accountable Officer for Controlled Drugs				
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 1 April 2026	LL	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	LL	Attached	Noting
5	Chairs Report (including Governance Update)	LL	Attached	Noting
6	Chief Executive Officer (CEO) Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
7.1	Quality & Performance Scorecard	PS	Attached	Noting
7.2	Committee Chairs Report	Chairs	Attached	Noting
7.3	Freedom to Speak-Up	BR	Attached	Noting
7.4	Learning from Deaths Q3 2025/26	AS	Attached	Noting
7.5	CQC Assurance Report	AS	Attached	Noting
7.6	Mental Health Inpatient Bi-Annual Safer Staffing Paper	AS	Attached	Noting
Questions taken from the General Public				
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
8.1	Board Assurance Framework	PS	Attached	Approval
8.2	Patient Safety Strategy	AS	Attached	Noting

Questions taken from the General Public				
9	**STRATEGIC INITIATIVES**			
9.1	Operational Plan 2026/27-2028/9	ZT/AG/ AM/TS	Attached	Noting
9.2	People Strategy	AM	Attached	Approval
9.3	Strategic Impact Report Month 12	ZT	Attached	Noting
10	**REGULATION AND COMPLIANCE**			
10.1	EPUT Provider License Review (including Code of Governance and Governor Training)	DG	Attached	Approval
10.2	Statutory Duty of Candour Annual Report 2025-2026	AS	Attached	Approval
Questions taken from the General Public				
11	**OTHER**			
11.1	Correspondence circulated to Board members since the last meeting. • Letter from Sir James Mackey, CEO for NHS England regarding the junior doctors industrial action.	LL	Verbal	Noting
12	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
12.1	Reflection on risks, issues or concerns including: • Risks for escalation to the CRR or BAF • Risks or issues to be raised with other standing committees	ALL	Verbal	Noting
13	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
14	**DATE AND TIME OF NEXT MEETING** Wednesday 5 August 2026 at 10:00, The Lodge Training room 1			
15	**DATE AND TIME OF FUTURE MEETINGS** Wednesday 7 October 2026 at 10:00, The Lodge Training room 1 Wednesday 2 December 2026 at 10:00, The Lodge Training room 1			

Loy Lobo
Acting Chair

1. APOLOGIES FOR ABSENCE

Standing item LL

2. DECLARATIONS OF INTEREST

Standing item LL

PRESENTATION: PHARMACY & MEDICINES OPTIMISATION

Information Item

Hiliary Scott

3. MINUTES OF THE PREVIOUS MEETING HELD ON: 1 APRIL 2026

Decision Item LL

REFERENCES

Only PDFs are attached

Board of Director Minutes (Part 1) 01.04.2026 FINAL.pdf

Essex Partnership University
NHS Foundation Trust

Minutes of the Board of Directors Meeting held in Public

Held on Wednesday 01 April 2026
Held in person at Trust Headquarters

MEMBERS PRESENT:

Hattie Llewelyn-Davies	HLD	Chair
Alex Green	AG	Executive Chief Operating Officer / Deputy CEO
Trevor Smith	TS	Executive Chief Finance Officer / Deputy CEO
Andrew McMenemy	AM	Executive Chief People Officer
Ann Sheridan	AS	Executive Chief Nurse
Dr Kallur Suresh	KS	Executive Chief Medical Officer
Denver Greenhalgh	DG	Executive Director of Corporate Governance
Loy Lobo	LL	Non-Executive Director / Vice Chair
Dr Mateen Jiwani	MJ	Non-Executive Director (joined by Teams)
Elena Lokteva	EL	Non-Executive Director
Sarah Teather	ST	Non-Executive Director
Richard Spencer	RS	Non-Executive Director
Diane Leacock	DL	Non-Executive Director
Ruth Jackson	RJ	Non-Executive Director

IN ATTENDANCE:

Dr Osagbai Eriki	OE	Peer Support Representative for Resident Doctors
Angela Laverick	AL	EA to Chief Executive, Chair and NEDs (minutes)
Chris Jennings	CJ	Assistant Trust Secretary
Clare Sumner	CS	Trust Secretary Administrator
Elizabeth Wells	EW	Director of Mental Health Urgent Care and Inpatient Services Trust Wide
Janette Leonard	JL	Chief Information Officer (for Zephan Trent)

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

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

The meeting commenced at 10am.

025/26	**APOLOGIES FOR ABSENCE**
	Apologies were received from Zephan Trent.
026/26	**DECLARATIONS OF INTEREST**
	There were no declarations of interest. RS advised he had been appointed to the Legal Services Consumer Panel, which he had added to his register of declarations. The appointment did not conflict with any items on the agenda.
027/26	**Introduction to Dr Eriki**
	KS introduced Dr Osagbai Erirki (OE), newly appointed Peer Support Representative for Resident Doctors, attending the Board following a request at a recent Board

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	Seminar for an introductory discussion. OE is a Specialist Registrar based in Chelmsford and has been appointed as Peer Lead for Resident Doctors, in line with NHS England's 10-Point Plan to improve resident doctor wellbeing. The plan mandates that every trust has at least one peer lead representing doctors at Board level. OE outlined early activity in the role, including a Trust-wide survey of all resident doctors to gather feedback on the 10-Point Plan and understand their experience of working within the Trust. Feedback had been mostly positive, with some challenges identified, and OE would continue to engage with resident doctors as implementation progresses. OE noted strong support from KS and emphasised the focus on ensuring the plan is fully embedded and developed over time. <u>Questions and Discussions</u> • DL welcomed the progress and asked for examples of challenges and how the Board could support. OE highlighted practical implementation issues, including ensuring drinking water in all on-call rooms and meeting the plan's requirement for access to hot drinks for staff on call across multiple sites. • RS asked whether OE had protected time for the role. OE confirmed this was not currently in place, with responsibilities being managed through a special interest session as part of higher training, noting that this had been fed back to NHS England. • AM welcomed OE's appointment and noted the value of continued engagement with KS and the wider team to support the role.
028/26	**PRESENTATION: TIME TO CARE AND PARTNERSHIP WORKING**
	AG introduced Elizabeth Wells (EW), Director of Mental Health Urgent Care and Inpatient Services (Trust-wide), who provided an overview of the impact of the Time to Care (TTC) transformation programme on inpatient mental health services, highlighting the following: • TTC has strengthened partnership working with patients, families and carers, and has delivered a major transformation in the quality of inpatient care • The programme was designed to respond to NHS workforce challenges by introducing a new staffing model and creating new roles that place the patient at the centre of a wrap-around multidisciplinary approach. This included family ambassadors, peer support workers, activity coordinators and Family Group Conferencing (FGC) • Recruitment has been strong, with 333 WTE appointed against a target of 339 WTE, leaving 5.4 WTE vacancies. • The new model incorporates more qualified staff, has been co-developed with lived experience ambassadors, and is structured around three chapters: purposeful admission, therapeutic inpatient care, and proactive discharge planning and effective discharge support • The Fundamentals of Care Framework underpins the model, with trauma-informed care as the golden thread. EW noted the Trust's ambition to become a fully trauma-informed organisation, supported by trauma champions on each ward, trauma-informed training, reflective practice, and access to "Here for You" support for staff • EW reported significant benefits realisation, including improved national benchmarking: EPUT is now 9th of 47 for average length of stay for adults aged 18 to 75. Adult PICU and older adult wards were also projected to see further reductions. There has been an increase in discharges compared with the same period last year, indicating quicker recovery and improved flow, alongside reductions in self-harm and restrictive practice

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	• Over 50 peer workers are now embedded across specialist services, contributing to a positive culture shift and a more cohesive MDT • EW also highlighted the success of the Family Group Conference (FGC) model, the only adult mental health FGC service operating nationally, supporting discharge planning, safety planning, relapse prevention and shared decision-making. Feedback had been highly positive. Future priorities include expanding FGC capacity, embedding FGC champions, and strengthening collaboration with dual diagnosis and forensic teams. An evaluation of the TTC operating model would be completed as the programme reached its first full year of implementation <u>Questions & Discussion</u> • PS commended the scale of the transformation, noting the significant effort required to secure funding and recruit new roles. He emphasised the importance of learning from TTC for future transformation programmes and thanked EW for her leadership • EL reflected on three years of progress and asked about sustaining staff motivation and retention. EW reported good retention, supported by stable leadership and strong psychology input, and reiterated the importance of the trauma-informed model in supporting staff in a high-pressure environment • LL asked how the Trust should assess the full scope of TTC benefits beyond length of stay. EW noted that quality and safety metrics, alongside richer patient and family feedback and clearer clinical outcome measures, will be key. LL emphasised the need to distinguish commissioner KPIs from broader indicators of service improvement. KS highlighted the value of combining formal KPIs with softer intelligence to understand patient experience • AM referenced recent Board Seminar feedback requesting enhanced Health Care Assistant (HCA) training for therapeutic interventions and observations. EW confirmed work is underway to develop and embed a strengthened training package focused on engagement and therapeutic activity • RJ asked how TTC will evolve as the Trust moves toward a community-first model. EW described improved partnership working, purposeful admission, safe discharge processes and locality-based multi-disciplinary collaboration that already supported this shift • ST queried whether the impacts of TTC, FGC and trauma-informed practice could be separated to see which how each element was impacting services. EW noted that the operating model integrated all three, and their combined effect is what drives improvement • AS noted that few inpatient units nationally were delivering the same level of transformation and encouraged further focus on therapeutic observation, anticipating that activity coordinators will help reduce reliance on 1:1 observations HLD thanked EW and all teams involved for their work.
029/26	**MINUTES OF THE PREVIOUS MEETING HELD ON 04 FEBRUARY 2026**
	The Board of Directors agreed the minutes of the meeting held on 4 February 2026 as an accurate record and noted the record of questions from Trust Governors and members of the public and the responses.
030/26	**ACTION LOG AND MATTERS ARISING**
	The action log was reviewed and noted all actions were either closed or not yet due.
031/26	**CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)**

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	HLD presented the report, which provided the Board of Directors with a summary of key headlines and updates on governance developments within the Trust since the previous Board meeting. The Board noted the following points: • PS's new appointment was acknowledged, with congratulations offered on his appointment as CEO of East Suffolk and North Essex NHS Foundation Trust (ESNEFT). PS was due to leave EPUT at the end of June. • The Staff Awards had taken place and were reported as a fantastic event celebrating the achievements and contributions of staff • The Trust had continued to be recognised as a Disability Confident leader following a review by the EPUT Disability and Mental Health staff network. **The Board of Directors** 1. **Received and noted the contents of the report**
032/26	**CEO REPORT**
	PS presented a report that provided the Board of Directors with a summary of key activities and information for noting. PS highlighted the following points: • Noting his appointment as CEO of ESNEFT, PS was pleased the Trust would continue with a strong and supportive leadership team, and with continuity secured through AG and TS taking up the joint CEO role • The CQC Well-Led inspection had taken place, and although formal feedback was still awaited, the CQC had commented on how open and welcoming staff had been and had observed compassion in all interactions they witnessed • Changes to the ICB structure had enabled a different approach to neighbourhood-level working, and EPUT had an important role in ensuring holistic care at neighbourhood level • The lived experience programme had continued to strengthen, supporting improvements and ensuring that the patient voice shapes services that are fit for purpose and responsive to need <u>Questions & Discussions</u> • RS noted encouragement from the pilot in North East Essex, which had established peer workers and strengthened partnership working with the voluntary sector **The Board of Directors:** **1. Received and noted the contents of the report.**
033/26	**QUALITY AND PERFORMANCE SCORECARD**
	PS presented the report providing a high-level summary of operational performance, quality indicators, safer staffing levels, finance and key NHS England metrics. The Executive Directors were invited to provide key updates for their portfolios. **Operations (AG)** • The average length of stay for adult inpatients had reduced, with the Trust ranked 9th of 47 in the National Oversight Framework. Older adult length of stay remained above target at 122 days, largely due to system-wide delays • Occupancy levels remained high across services, with PICU at 97.3%, and seven patients repatriated in February • Delayed transfers of care remained within target, though the volume of system delays continued to be significant, requiring ongoing work with partners • Front-door demand had increased, resulting in a rise in out-of-area placements in February • In Talking Therapies, access rates had reduced in North East Essex and Castle Point, while Southend had seen an increase. Both six-week and 18-week waits remained within target

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- Virtual ward occupancy in community services had been used to support the orthopaedic pathway by utilising under-used capacity

Nursing (AS)

- Cardio-metabolic monitoring compliance was at 69.7%, with 11 wards achieving 100%. Further improvement required better recording with medical colleagues
- No-harm and low-harm incidents were being closely tracked. Some variation had been observed, and weekly meetings were in place to monitor low-reporting areas. Work continued with teams and staff networks to encourage reporting and clarify harm definitions

People and Culture (AM)

- Staff sickness remained stable but high at 5.9%. Long-term sickness had reduced, while short-term sickness had increased
- Vacancy and turnover rates continued to improve, though some areas still experienced high vacancy levels
- Temporary staffing remained within target, with sustained reductions in agency and bank usage across the year. Targets for the new financial year were expected to be more challenging

Finance (TS)

- Confirmation of deficit support funding meant the Trust was now forecasting a break-even position
- Cash balances had improved significantly following deficit support and inquiry-related funding. The BAF risk SR7 had reverted to focusing on capital rather than capital and cash
- The capital programme remained on track to utilise £36m of capital funding
- A key development had been approval of the new training facility and clinical/corporate hub in Chelmsford, which would enhance facilities for the Trust and system partners, increase clinical space, support innovative working and consolidate the estate

<u>Questions & Discussions</u>

- ST asked about improving outcomes for older adults through system partnership working. AG described recent joint discharge workshops with local authorities, actions to reduce housing delays, earlier involvement of social care in inpatient stays, improved provider responsiveness and streamlining of funding panels. ST suggested a deep dive at a future Board Seminar, which AG supported
- LL queried whether out-of-area funding could be flexibly redirected to housing solutions. AG confirmed this would be explored, alongside aligning leadership with ICB and local authority structures and ensuring the future target operating model was locality-focused
- EL raised concerns about the 70 out-of-area placements. AG confirmed that all but 13 were within local geography and that continuity-of-care processes were in place
- OE asked about technology to support metabolic monitoring. JL noted that while investment in current systems was not viable due to an upcoming system replacement, future opportunities would be explored
- RJ highlighted the strong work on long-term sickness management, noting confidence in the approach being scaled across the organisation
- DL acknowledged the finance team's work in achieving the break-even position. TS emphasised that this had been a collective effort, supported by improvements in temporary staffing and performance

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	• RS noted the detailed scrutiny of the report at Finance and Performance Committee and commended the organisation-wide effort to manage uncertainty and risk • LL queried whether mental health trusts received a cash bonus for break-even performance. TS confirmed that deficit support funding had been contingent on break-even delivery, equating to £20.5m, but no additional bonus had been received beyond inquiry-related support • HLD welcomed the development of the new training hub, noting its strategic importance **The Board of Directors:** **1. Received and noted the content of the report**
034/26	**COMMITTEE CHAIRS' REPORT**
	HLD introduced a report that provided the Board of Directors with a summary of key assurance and issues identified by the Board Standing Committees. The report included the Annual Reports for the Audit Committee, Finance and Performance Committee and People Committee, each setting out their activity during 2026/27. The Committees confirmed that they had fulfilled their respective Terms of Reference and that each had completed an effectiveness review, agreeing key priorities for 2026/27 to support continued improvement and oversight. The Board was asked to approve the revised Terms of Reference for the three Committees. **The Board of Directors:** **1. Received and noted the contents of the report and the assurance provided** **2. Approved the 2026/27 Terms of Reference for the Audit Committee, Finance and Performance Committee and People Committee, along with their agreed priorities for the year ahead**
035/26	**CQC ASSURANCE REPORT**
	AS presented a report that provided the Board with an update on CQC-related activity, progress against the Trust's CQC Improvement Plan, findings from internal assurance work on Quality Statement compliance and recent CQC guidance and updates. AS highlighted the following key points: • The Trust remained fully registered with the CQC • Recent CQC inspection activity had included the Well-Led inspection and unannounced inspections at 439 Ipswich Road, Avocet ward and Cumberlege Intermediate Care Centre (CICC) • The CQC Improvement Plan was over 60% complete • The internal assurance programme was ongoing, with four quality assurance visits undertaken during the reporting period • A Section 29 Notice had been received for 439 Ipswich Road, relating to safeguarding practice, staff awareness of safeguarding processes, incident reporting and follow-up actions. An improvement plan had been implemented. • AS reflected on the issues at Ipswich Road and Ardleigh ward, noting that local leadership and management had been strengthened, with early signs of improvement following support to the new management team <u>Questions & Discussion</u> • AG noted that visibility of certain KPIs within the accountability framework had been adjusted to better monitor ward-level hotspots

	• DG advised that the Lead Governor had submitted a question seeking further clarity on the Section 29 Notice and its implications, and confirmed that improvement work was underway, including NED walkarounds to test and sustain progress and a review by the Trust Compliance Team to understand missed triggers and flags • DL welcomed the strengthened leadership but raised concerns about the suitability of the Ipswich Road building. AG confirmed early discussions were underway regarding the future model of care and potential relocation • EL emphasised the importance of assurance that improvements were embedded and sustained. AS outlined work to develop an early-warning system for inpatient areas, drawing on safer staffing, patient safety indicators and staff/patient feedback. AS also described thematic learning emerging from complaints, incidents and Prevention of Future Deaths reviews, including documentation quality, escalation, communication, family involvement, policy compliance and physical health • ST expressed concern about how early warning signs had been missed and asked how learning would be applied across other sites. AS emphasised the need for local ownership, clarity on outcome measures and consistent monitoring. ST requested a summary of learning be brought to a future public Board meeting • RJ asked whether the accountability framework meetings required review to ensure they remained effective. AG confirmed external reviews were already built in, with increased granularity of information. AS added that a weekly emergent incident meeting had been established to identify concerns earlier, supported by insights from temporary staffing data • LL questioned whether the Trust was taking the right approach to behaviour and culture change, suggesting a ward-by-ward transformation model. HLD noted that AM was preparing a culture review presentation for the May Board Seminar, where this discussion could be developed further **The Board of Directors:** 1. **Received and noted the contents of the report** 2. **Noted the assurance on progress against the CQC Improvement Plan** **Action:** 1. **Provide a summary of learning from the Section 29A Warning Notice for 439 Ipswich Road, including early warning signs and how learning would be applied across other services (AS)**
036/26	**NATIONAL STAFF SURVEY – BENCHMARKING, RESULTS ANALYSIS AND NEXT STEPS**
	AM presented the report, which provided a summary, analysis and set of Trust-wide priorities based on the 2025 NHS Staff Survey results. AM highlighted that the report included both the Trust's original analysis and benchmarking of EPUT against other organisations. Key findings were noted as follows: • Performance across the People Promise categories had improved in all but one area • EPUT had performed favourably compared with other organisations within the Essex system • Morale and staff engagement scores had improved compared with 2024 **Questions & Discussion** • HLD welcomed the increased engagement with the survey and congratulated the team on achieving this

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	• RS observed that although scores had improved on the previous year, they were not yet at 2023 levels. AM confirmed that earlier years' results had been reviewed and that the impact of the Covid-19 pandemic remained evident in longer-term trends **The Board of Directors:** **1. Discussed and noted the results analysis and next steps following the 2025 National Staff Survey benchmarked results**
037/26	**QUESTIONS TAKEN FROM THE GENERAL PUBLIC**
	Member of the Public Regarding the issue of delayed discharges from the presentation with the aim to reduce these, what measures were in place to ensure patients were not discharged too early and was there data on re-admission rates following improvement with delayed discharges? EW advised re-admission rates were below national target. The Operational Model implemented by the Trust described in detail safe and effective discharge, with the focus on transition back to the community, ensuring it is safe, timely and community support was wrapped-around the individual. The emphasis was on ensuring the patient was clinically well enough and that appropriate support was in place following discharge. **Member of the Public** Regarding lengths of stay for older adults, was there any reason for this and what was the range in terms of what was considered older adult? AG advised the definition of older adult was based on age (75+) but also on levels of frailty. AG advised there was a difference between functional and dementia wards, with delays often around arranging complex packages of care on discharge, which emphasised the importance of working with social care colleagues in a different way. **Member of the Public** Regarding the action log, a response had been provided that questions raised by members of the public received a written response when the individual did not attend the Board meeting to ask the question. The Member of the Public asked if specific situations where this had occurred had been reviewed and how feedback was provided. DG advised that in the majority of occasions, feedback had been provided. Where feedback had not been provided, this was because the questions had been personal in nature and had been passed to the Trust's complaints team or relevant service management colleagues for a response. Additional processes had been established to ensure individuals receive a response in such instances.
038/26	**BOARD ASSURANCE FRAMEWORK**

	PS presented the report, which provided a high-level summary of the strategic risks and corporate (operational) risks, along with progress against actions designed to moderate those risks. PS highlighted the following key points:
	• Three new risks had been escalated by the Executive Team to the Corporate Risk Register:
	  ○ A risk relating to delivery of the NOVA programme, should it not be completed on time
	  ○ Two new demand-related risks, where service demand did not align with the commissioned service specification; early system-level discussions had begun

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	• An emergent risk had been identified relating to backlog maintenance and hard to recruit roles, which would be incorporated into the developing Estates Strategy and aligned with ongoing estate consolidation work • PS drew attention to the Lampard Inquiry, noting a significant and unexpected increase in activity since December. The Trust had maintained ongoing dialogue with the Inquiry's team to agree priorities. The volume of work, each with a four-week turnaround, continued to present a material risk • The inquiry project team had been expanded to manage both current and anticipated inquiry activity. PS thanked the Board for approving the associated resources and funding. Work was underway to assess the impact of redeploying internal staff into the inquiry team, including the potential effect of delays in backfilling their substantive roles **The Board of Directors:** **1. Noted the contents of the report** **2. Noted the new corporate risks** **3. Did not request any further information or action**
039/26	**END OF LIFE ANNUAL REPORT**
	AS presented the report, which provided the Board of Directors with an update on ongoing actions and the quality of care linked to the Trust's 2025/26 End of Life Care Priorities. The report outlined progress against national guidance, supported monitoring of the End of Life Care work plan and framework, and offered assurance on the delivery of end of life care services. AS highlighted the following: • The Trust had continued to maintain performance above the national average, delivering consistent personalised end of life care • There had been strong partnership working across this area of care delivery • Work was underway to embed gold-standard care across inpatient areas and care homes • Areas for further development included strengthening feedback through I Want Great Care, increasing training capacity within mental health services and enhancing staff support relating to end of life care **The Board of Directors:** **1. Noted the contents of the report** **2. Approved the report** **3. Did not request any further information or action**
040/26	**LEARNING FROM DEATHS – MORTALITY REPORT Q2**
	AS presented the report, which included data relating to deaths recorded on Datix for Q2 2025/26 (1 July to 30 September 2025), a summary of progress on reviews of deaths from previous periods, and examples of key learning and actions arising from the various review methodologies since the last report to Board. AS highlighted the following: • There had been 148 deaths reported in this period, with 151 Datix entries due to some duplication. Of these, 20 had met the statutory mandatory review requirement • Key learning and themes indicated that the majority of deaths were linked to physical health needs, reinforcing the importance of joined-up working between physical and mental health services **The Board of Directors:** **1. Noted the information presented** **2. Noted the assurance that the Trust had robust processes, in line with national guidance, to review deaths appropriately as part of its continuous quality-improvement approach**

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	3. **Did not request any further information or action**
041/26	**PUBLIC SECTOR EQUALITY DUTY (PSED)**
	AM presented the report, one of the Trust's three statutory submissions consolidating the Public Sector Equality Duty, the Equality Delivery System and Pay Gap Reporting requirements. The report demonstrated how, during 2024/25, EPUT had given due regard to eliminating discrimination and advancing equality of opportunity by publishing annual workforce data, narrative analysis and the actions being taken to address identified inequalities. It met the Trust's legal publishing obligations and provided clear, accessible evidence of progress and priorities. **The Board of Directors:** 1. **Noted the contents of the report, including the Trust's 2024/25 performance in supporting equal opportunities for staff, patients and communities with protected characteristics, the insights gained and the areas of focus continuing into current work plans** 2. **Approved the report for publication on the Trust's external website**
042/26	**EQUALITY DELIVERY SYSTEM (EDS)**
	AM presented the report, which set out the agreed framework supporting fair and inclusive services for patients, carers and the workforce by addressing inequity in experience and ensuring equitable access for all. AM highlighted that: • The report covered the period ending March 2025. It was expected that the 2025/26 annual report would be brought to the Board in October 2026, ensuring that the information presented would be more current and relevant **The Board of Directors:** 1. **Discussed and approved the contents of the report, noting the Trust's ratings across the three themes supporting equal opportunities for staff with protected characteristics, the insights gained and the areas of focus** 2. **Approved the publication and submission of the report and appendices to the Essex Integrated Care Board and for publication on the Trust's external website**
043/26	**PAY GAP REPORT 2025**
	AM presented the report, which set out the agreed framework supporting fair and inclusive services for patients, carers and the workforce by addressing inequity in experience and ensuring equitable access for all. AM highlighted that: • The report covered the period ending March 2025. It was expected that the 2025/26 annual report would be brought to the Board in October 2026, ensuring that the information presented would be more current and relevant **The Board of Directors:** • **Discussed and approved the contents of the report, noting the Trust's ratings across the three themes supporting equal**

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	opportunities for staff with protected characteristics, the insights gained and the areas of focus • **Approved the publication and submission of the report and appendices to the Essex Integrated Care Board and for publication on the Trust's external website**
044/26	**QUESTIONS TAKEN FROM THE GENERAL PUBLIC**
	Member of the Public The Member of the Public commented the previous few papers did not reference transgender or gender re-assignment. The report provided a breakdown for different protected characteristics, but did not provide a similar breakdown for transgender / gender re-assignment. AM thanked the individual for highlighting this issue. The report referred to 2024/25 and he would therefore look to ensure the impact for transgender / gender assignment was included in the report for 2025/26.
045/26	**TIME TO CARE CLOSURE REPORT**
	AG presented the report, which provided information on the outputs and learning from the Time to Care Programme. AG highlighted the following points: • The team had reflected on the process of designing and implementing the programme, identifying key learning from each stage • Despite initial barriers, there had been clear progress, with the programme contributing to a significant culture shift across inpatient services • The programme had now transitioned into the embedding and optimisation phase, with the model becoming part of business as usual **The Board of Directors:** **1. Noted the contents of the report** **2. Noted the transition of the programme to business as usual**
046/26	**EPUT CONSTITUTION**
	DG presented the report, which set out the reviewed EPUT Constitution for approval. DG highlighted the following key points: • The Trust was required to review its Constitution annually • The previous review had taken place in March 2025 • The review required approval from both the Council of Governors and the Board of Directors • The Constitution had been reviewed and no amendments were recommended • The document had been circulated to both bodies, with comments considered at the Council of Governors meeting on 11 March 2026. The Council of Governors approved the reviewed Constitution at that meeting • The Board was therefore asked to approve the reviewed EPUT Constitution **The Board of Directors:** **1. Approved the reviewed EPUT Constitution**
049/26	**CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING**

DRAFT

	Letter to Essex leaders regarding the future of local authorities in Essex.
050/26	**NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING**
	There were no new risks identified to be added to the Risk Register, nor any items that should be removed that were not discussed as part of the BAF discussions.
051/26	**REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS**
	HLD reflected that there had been positive open discussions at the meeting and welcomed the reports which encouraged these discussions.
052/26	**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.
053/26	**ANY OTHER BUSINESS**
	LL reflected on the Mental Health Emergency Department which was an innovative concept now being rolled out in other parts of the country. The concept was originally developed as a coproduction project with significant input from Mark Dale who had now sadly passed away. LL proposed having a commemorative plaque at the Basildon Mental Health Emergency Department to reflect the input of Mark, but also highlight the importance of coproduction and developing new services utilising the patient voice. The Board of Directors supported the proposal.
054/26	**QUESTION THE DIRECTORS SESSION**
	Questions from Governors submitted to the Trust Secretary prior to the Board meeting and also submitted during the meeting are detailed in Appendix 1.
055/26	**DATE OF NEXT MEETING**
	The next meeting of the Board of Directors is to be held on Wednesday 3 June 2026. The meeting closed at Chris to insert.

Signed: Date:

Hattie Llewelyn-Davies, Chair

DRAFT

Appendix 1: Governors / Public / Members Query Tracker (Item 053/26)

Governor / Member of the Public	Query	Response
Member of the Public	The Member of the Public was encouraged by the meeting today, particularly with prevalence of holistic understanding that is recognised among professionals. The individual was a patient on Dune Ward and raised a concern regarding staffing levels, where staff are asked to attend other wards due to shortages of staff, which means staff on Dune Ward are left with the inability to take people on escorted leave.	AM advised that staffing levels were reviewed weekly and he was aware of more incidents of staff moving across wards, which was not ideal, but added that this action was often undertaken instead of utilising temporary staff. The next meeting was due to take place the following day and he would raise Dune Ward to ensure safer staffing and the impact of the movement of staff was considered.
	The Member of the Public raised a concern regarding patients not being allowed use of mobile phones / laptops on the ward. However, when on unescorted leave patients are able to access these items. The individual felt that access to these devices was a human right and highlighted the contradiction in being able to access whilst on unescorted leave, but not when back on the ward.	AG agreed to review the protocol in relation to use of mobile phones and laptops with the leadership team.
Member of the Public	The individual was a patient with lived experience and had written a short book about thinking and how patients think. The book was not published yet, but they encouraged the Board to read it.	HLD agreed and suggested the individual allowed the Board to have a copy once published to read and return.
Member of the Public	The Member of the Public raised a concern that the Trust's Violence and Aggression Policy had a completed an equality impact assessment which provided that the document did not impact any of the protected characteristics. It also appeared the document had been completed after the policy had already been approved.	DG advised that policies are driven by an expert management group and oversight is provided through a Policy Oversight Group. There were occasions where policies were presented to the Oversight Group with no equality impact assessment and referred back, possibly accounting for this particular situation. DG agreed to review the specific example and also confirmed she would seek a review of the equality impact assessment to ensure it has considered the document's, impact in line with the protected characteristics.

DRAFT

Governor / Member of the Public	Query	Response
		Action: **1. Ensure the equality impact assessment for the Violence and Aggression Policy is reviewed to ensure it has considered the impact of the document on protected characteristics. (DG)**

DRAFT

4. ACTION LOG AND MATTERS ARISING

Standing item LL

REFERENCES

Only PDFs are attached

Action Log Part 1 03.06.2026.pdf

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting held on the 1 April 2026

Lead	Initials	Lead	Initials	Lead	Initials
Denver Greenhalgh	DG	Ann Sheridan	AS		
Andrew McMenemy	AM				

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

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
012/26 024/26 February	Review comments made by member of the public in regards to instruction to staff if a patient reports experiencing abuse and whether this needs to be explicit in policy.	AM	June 2026	Member of the Public sent relevant policies to confirm where there are instructions to staff if a patient reports experiencing abuse. The Member of the Public acknowledged they had receive the response from the Chief People Officer.	Closed	
035/26 April	Provide a summary of learning from the Section 29A Warning Notice for 439 Ipswich Road, including early warning signs and how learning would be applied across other services	AS	June 2026	This has been incorporated into the CQC Assurance Report for presentation to the Board in June.	Closed	
053/26 April	Ensure the equality impact assessment for the Violence and Aggression Policy is reviewed to ensure it has considered the impact of the document on protected characteristics.	DG	June 2026	Thank you for raising the comments regarding the Equality Impact Assessment (EIA). We truly appreciate feedback and recognise its importance in helping us continuously improve. We acknowledge that the current EIA, does not sufficiently articulate the potential for differential impact across protected groups. The assessment previously concluded “no impact” based on the policy’s requirement to review each incident of violence and abuse individually, with responses tailored to the specific circumstances of each case. However, we appreciate that this rationale was not set out within the EIA itself.	Closed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
				To address, we will review the EIA to facilitate improved capture of this information and highlight the safeguards within the policy, such as the use of clinical judgement, multidisciplinary review, and proportionality, ensuring these are clearly linked to our equality duties and best practice. On the broader picture, we are arranging training for members of the Policy Oversight and Ratification Group on EIAs and assurances to be sought from the policy owner; and will extend this to all our staff who are designated document owners. Thank you again for your constructive feedback		

5. CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

Information Item LL

REFERENCES

Only PDFs are attached

Chair's Report 03.06.2026 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	June2026

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

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

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

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

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

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

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

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

Acronyms/Terms Used in the Report			

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

Lead
 Loy Lobo **Acting Chair**

CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

1.0 PURPOSE OF REPORT

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

2.0 CHAIR'S REPORT

2.1 Hattie Llewelyn-Davies

As I write this Chair's report for Board it is with a sense of great personal sadness for the loss of our Chair Hattie Llewelyn-Davis. Hattie passed away very recently, following a short illness, and leaves a massive legacy across both the NHS, housing sector and many other aspects of public life. She was an inspirational leader and I have personally valued the time worked with her on the EPUT Board – her strategic focus on the Trust's future direction with communities and patients at the centre was hugely impressive. She will be much missed by colleagues across the Trust and I want to pass on my condolences to her family and many friends.

2.2 Changes to the Board of Directors

As many will be aware, Paul Scott has taken the decision to step down from the role of Chief Executive Officer at EPUT, following his successful appointment as Chief Executive Officer at East Suffolk and North Essex NHS Foundation Trust (ESNEFT).

Paul has driven improvement in every area of EPUT. It has been a tough job to manage through some challenging times including the Inquiry and Covid alongside the normal challenges of working in an NHS Trust. He has fulfilled this role driven by our shared values and a compelling vision of putting our service users and their families at the heart of everything we do. He has done it with great success and compassion.

My Board colleagues share with me our sadness at his leaving, but it also provides us with new leadership from our newly appointed Interim Joint CEOs, Alex Green and Trevor Smith, who will work together to achieve our plans and ambitions.

The Board wishes Paul every success in his new role at ESNEFT and thank him for his passion and dedication to improving services for our patients and staff at EPUT. We look forward to continuing to work with him, but in a different role as part of our system partners.

2.3 Chair and NED Visits

The NEDs and I continue to visit services across the geography of the Trust, including Quality Assurance Visits with Governors. This is a welcome opportunity to visit our staff on the front line to see and hear first-hand the challenges they face as well as their continuing dedication to supporting our patients.

2.4 Future of the Council of Governors

NHS England circulated a letter on the 6 May 2026 to all Foundation Trust Chief Executive Officers, clarifying the role of Governors in light set-out in the ten-year plan. The letter confirmed that the role of Governors remained unchanged until legislation is passed which removes the statutory role. The letter also provides that Trusts should consider their constitutions in determining whether to go ahead with Governor elections during the uncertain time.

Following the receipt of the letter, I met with some of our Governors, Executive Director of Corporate Governance and Assistant Trust Secretary as part of a pre-planned meeting to discuss the future of our Council of Governors. We agreed that we should continue to hold Governor Elections as planned this year, to ensure we have a strong Council until such a time as any new legislation has passed. You will see on the agenda a report detailing our proposed plans for undertaking the elections this year. We will continue to discuss how we wish to continue engaging with members of

the public and patients following any change in legislation and I will keep you informed as more clarity is provided.

2.5 Support and Resources for our staff

At EPUT we are proud of our diversity and celebrate that over 90 nationalities and many faiths are represented in our workforce and we stand together in our united dedication to deliver the best possible care for our patients. Below is a summary of just some of the support, resources and initiatives taking place across the Trust to support our staff.

Mental Health Awareness Week

Mental Health Awareness Week is a chance for us all to reflect on the difference we are making to the lives of so many across our services, throughout the week the Communications team shared stories from staff, patients and peer workers. It is only right that we put patients at the heart of all that we do, but Mental Health Awareness Week should also remind us of the importance of looking after our own mental health, as well as supporting each other and our patients. Staff are encouraged to take time for themselves, reach out if they are in need of support and encourage open conversations about mental health within teams.

Support following Recent national events

Following recent tragic national events, communications have been circulated to our workforce reiterating that we stand with our staff and there is support available via our Employee Assistance Programme or Occupational Health.

The National Threat Level has also been raised and staff have been reminded to review team's Business Continuity Plans and the Trust's Major Incident policy. Staff are also encouraged to reach out to their line managers if they have any concerns.

Care in Conversation Podcast

Everyone in the NHS brings with them unique experiences, personal, emotional and unexpected, that improve how they provide care. The Care in Conversation podcast hears real people share their journeys: the milestones that shaped them and the challenges they've faced. The podcast shines a spotlight on staff, patients, volunteers and contributors who all work to support positive change in mental health and community services. Episode 1 one marked Maternal Mental Health Week. New episodes will be released twice a month and are available on Spotify.

Virtual Wellness Sessions for Staff

Recognising the importance of staff wellbeing and continuing the success of our virtual wellness sessions, further sessions have been scheduled including virtual Pilates, breathwork therapy, yoga and distance Reiki. The Trus also hold a Neuro-Inclusive Café, which is a safe space for any EPUT colleague who has a neurodivergent condition, suspected neurodivergent condition or may be supporting someone else. The café is a relaxed environment for staff to seek guidance and peer support.

International Nurses Day

To mark International Nurses Day the Trust welcomed more than 200 of our nurses and healthcare assistants at our conference 'Reclaiming our Professional Pride and Reconnecting with out Patients'. This event was an opportunity to take time out from busy roles to look at our culture and address honestly where we need to improve to provide the best patient care. The Trust were delighted to be joined by Acosia Nyanin, Deputy Chief Nursing Officer NHS England, and had some really valuable discussions about Fundamentals of Care, what this means for us and the importance of connecting with our patients throughout their care journeys.

2.6 Support and Resources for our Patients

Schwarz Round / Dying Matters Awareness Week

The coincide with this year's Dying Matters Awareness Week (04 – 10 May) a Schwarz round took place at St Margaret's Hospital, with the theme of 'how a conversation about death and dying changed my practice'. This event was facilitated by the Clinical Lead for End of Life Care.

A "Death Café" event was also held in partnership with Haven's Hospitals, RRAVS, Rayleigh and district and Rochford District PCNs. This event was open to all and provided a relaxed, welcoming space to have an open, informal conversation about death and find out what support is available.

Essex Therapy Dogs

Volunteers from Essex Therapy Dogs regularly visit patients at the Linden Centre and Crystal Centre as part of the therapeutic activities we offer to patients. Their visits are just part of our commitment to providing personalised, inclusive care that improves mental health for everyone.

Stroke Vocational Rehabilitation Service

The Stroke Vocational Rehabilitation Service in West Essex and Hertfordshire are one of the few dedicated services of its kind in the UK. The team work across EPUT, Hertfordshire Community NHS Trust and Central London Community Healthcare NHS Trust. It helps people who need additional specialist support to either return to employment or education, and those who have already returned but are struggling to manage the cognitive, physical or emotional demands as a result of their stroke. The team recommends practical strategies to help people manage how stroke has affected their physical abilities, thinking skills, speech and communication, and energy levels by helping them practise skills specific to their job role, and supporting both the individual and their employer to plan a safe and successful return to work.

VE Day / Op COURAGE

The Trust marked Victory in Europe (VE) day with a moment of pause, to remember and honour the courage, sacrifice and resilience of those who served during the Second World War. VE day is a moment of national reflection, recognising the contribution of the armed forces community, both past and present, and the lasting impact of service on individuals and families. At EPUT we are proud to support veterans, reservists, service leavers and their families through Op COURAGE: The Veterans Mental Health and Wellbeing service. The service understand the unique experiences of military life and offers tailored support, including help with mental health difficulties, adjusting to civilian life and accessing wider health and social support.

3.0 Legal and Policy Update

3.1 The Renewed Women's Health Strategy For England

The Renewed Women's Health Strategy for England was published on 16 April 2026. This strategy outlines the Government's next steps to improve health outcomes and access to care for women and girls across England.

The refreshed strategy builds on previous commitments and sets out a clear programme of action to address longstanding inequalities in women's healthcare. It forms a key component of the wider 10 Year Health Plan, focusing on improving prevention, early diagnosis, treatment, and access to services across the life course.

For Information: The Renewed Women's Health Strategy for England

3.2 Additional Sections Of The Mental Health Act 2025 Are Now in Force

Additional provisions of the Mental Health Act 2025 have now come into force. Please refer to the first link below for details of the legislative changes, which introduce new section 142C into the Mental Health Act 1983. This provision establishes that certain private registered care providers will be regarded as exercising functions of a public nature for the purposes of the Human Rights Act 1998 (see second link). The report outlining these changes was published on 30 April 2026.

For Information: Mental Health Act 1983
Human Rights Act 1998

3.3 Tobacco and Vapes Bill (Now the Tobacco and Vapes Act 2026)

The Tobacco and Vapes Bill has now completed its passage through Parliament and received Royal Assent on 29 April 2026, at which point it became the Tobacco and Vapes Act 2026. The Act represents one of the most significant public health reforms introduced in a generation and marks a decisive step towards the creation of the UK's first legally defined smoke-free generation.

This world-leading legislation introduces a progressive approach to tobacco control by prohibiting the sale of tobacco products to individuals born on or after 1 January 2009. As a result, today's children will never legally be sold cigarettes, breaking the long-standing cycle of addiction, ill health, and health inequality associated with smoking.

The Act is intended to prevent future harm rather than criminalise current behaviour, while supporting broader public health objectives, including reducing preventable illness, easing pressure on health services, and promoting healthier outcomes for future generations. By focusing on prevention and early protection, the legislation establishes a strong foundation for sustained improvements in population health over the long term.

For Information: Tobacco and Vapes Bill becomes law - GOV.UK

3.4 New Guidance On Neighbourhood Health Centres

NHS England have published new details and guidance on the Neighbourhood Health Centres (NHCs) programme NHCs are intended to underpin a key aspect of the 10 Year Plan to move services out of hospitals into the community under the neighbourhood health model.

The Government has set out plans to deliver 250 NHCs by 2035, with 120 of those by 2030. These will comprise a mixture of upgrades to existing buildings and new build centres. Facilities that could be upgraded and reconfigured include existing GP, community or other NHS buildings. High street premises, libraries, leisure centres or other civic assets could also be repurposed.

The guidance says that NHCs are to aid delivery of multidisciplinary working and seamless collaboration, including across general practice, community services, social care, mental health, diagnostics, wider LA and public services, and civil society.

The first link is a copy of Neighbourhood health centre guidance for regions and integrated care boards.

The second link is a copy of Neighbourhood health centres: design and performance specification.

For Information:
NHS England » Neighbourhood health centre guidance for regions and integrated care boards
NHS England » Neighbourhood health centres: design and performance specification

3.5 NHS England Sets Out The Rules for Safe Use of Ambient AI Scribes

With interest in artificial intelligence (AI) tools growing rapidly, particularly those designed to reduce the administrative burden on clinicians, NHS England has published new national guidance on the safe use of AI-enabled ambient scribing products in health and care settings. These tools passively capture clinical conversations and automatically generate consultation notes or correspondence and are commonly referred to as ambient AI scribes.

The guidance provides clear direction for patients, healthcare professionals, and information governance teams, with a focus on responsible deployment, transparency, clinical safety, and data protection.

For Information: Using AI-enabled ambient scribing products in health and care settings - NHS Transformation Directorate

6. CHIEF EXECUTIVE OFFICER (CEO) REPORT

Information Item PS

REFERENCES

Only PDFs are attached

CEO Report 03.06.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	3 June 2026

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

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

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

Recommendations/Action Required

The Board of Directors is asked to:

1. Receive and note the content of the report.

Summary of Key Points

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

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

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

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

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

Supporting Reports and/or Appendices

CEO Report.

Executive/ Non-Executive Lead / Committee Lead:

Paul Scott
Chief Executive Officer

CHIEF EXECUTIVE OFFICER REPORT

1. CEO UPDATES

1.1 Hattie Llewelyn-Davies

It's with much personal sadness that I'm sharing the news that our Chair, Hattie Llewelyn-Davies has passed away, following a short illness. Hattie was an inspirational leader with extensive experience Chairing a number NHS organisations including Hertfordshire Partnership Foundation Trust, Buckinghamshire Healthcare NHS Trust and most recently The Princess Alexandra Hospital NHS Trust. Hattie also contributed to social housing organisations as well as many other areas of public life - she will be much missed across the NHS and beyond.

Since Hattie joined us over a year ago she has provided unwavering support to me as CEO and the wider Executive team – leading the Board to focus on the Trust's strategic priorities with communities and patients at the centre of every decision. It has been a personal privilege to work closely with Hattie. She was a wise, compassionate and kind person and I know colleagues across EPUT will feel her loss deeply.

Our thoughts and condolences are with Hattie's family and many friends at this sad time and we send them our support and thoughts.

1.2 Changes to the Board of Directors

As you will know, I've taken the decision to leave EPUT at the end of June to become Chief Executive Officer at East Suffolk and North East Essex Foundation Trust (ESNEFT). While I'm excited to take up the role of leading a nearby acute Trust, I will be sad to leave colleagues at EPUT.

I'm delighted however that our Deputy CEOs Alex Green and Trevor Smith will be leading the Trust as interim joint Chief Executive Officers. I know that EPUT is in the best possible hands to take forward our ambitious plans to transform our services for our patients – with their voice and that of their families at the heart of all we do.

As a result of Alex and Trevor stepping into the role of Interim Joint CEO, following a recruitment process further interim appointments have been made, with Lizzy Wells appointed as Interim Executive Chief Operating Officer and Jenny Davis as Interim Executive Chief Finance Officer. Lizzy is currently our Director of Inpatient and Urgent Care and comes with a wide operational experience and is a registered Mental Health nurse. Jenny is a Chartered Accountant and is currently one of the Trust's Finance Directors with a focus on our capital programme. Lizzy and Jenny will take up these roles in June.

Catherine O'Connell has also joined us as the Director / Senior Responsible Officer overseeing the Lampard Inquiry, working alongside the wider Executive Team, reporting to the Interim CEOs as well as advising the Board directly. Catherine comes with a long track record of senior roles in the NHS both regionally and nationally and has extensive experience of working with Inquiries.

Thank you to Denver Greenhalgh, our Executive Director of Corporate Governance who has been the Executive lead for the Inquiry over the past year. During that time, Denver has made a huge contribution to the way in which we are working with the Lampard Inquiry, strengthening the EPUT project team and attending Inquiry hearings. The scale and impact of the Inquiry on EPUT has become much clearer over the last few months with significant requests for information and data. At a time when there are changes at Executive team level, it is more important than ever that Denver concentrates on her role as Executive Director of Corporate Governance, ensuring that we operate in our legal and regulatory framework and overseeing the strategic direction for the Board.

I would like to take this opportunity to thank the dedicated staff at EPUT and to reflect on the changes I've seen over the last six years. There are too many to list here, but If I pause and think about the things that I am most proud of – putting the voice of patients at the heart of what we do and listening to their families and carers really stands out. That's not to underplay the huge

investment in our wards – making them safer more therapeutic places, the investment in our community services, digital transformation and I could go on. What also stands out for me is the energy and the passion of colleagues across teams – from the mental health wards, our community mental and physical health services and the corporate teams who make sure that our frontline clinical teams can deliver the care our patients need and deserve.

Of course there's more to do and I know that Alex and Trevor will keep the Trust focussed on delivering our key priorities of extending the involvement of patients and their families across all areas of the Trust, delivering Nova - our ground breaking new Electronic Patient Record system, and transforming our community services, building on the success of our Time to Care programme.

So in closing, thank you to the Board, Governors and staff at EPUT for being passionate, supportive and dedicated colleagues and I wish Alex and Trevor all the best in their news roles – ably supported by the wider Executive team.

1.3 Lampard Inquiry Hearings

Pre-recorded Public hearings took place from 20 April – 07 May, which heard evidence from bereaved families and those with lived experience of treatment under the care of Essex mental health services. It is critical that we do all we can to support the Inquiry. I think it's fair to say that the challenges of identifying millions of sources of information across a 24 year period and two predecessor organisations has been more difficult than any of us could have predicted, and to this end we have taken steps to strengthen and support the EPUT Inquiry project team.

1.4 Nova Electronic Patient Record

Colleagues who have been involved in the development of our new Electronic Patient Record (EPR), recently had the opportunity to see how the system will work in practice at a Nova showcase event. Nova will sit across both EPUT and Mid and South Essex NHS Foundation Trust (MSEFT) – the first in type across an acute and mental health community Trust. The recent showcase focussed on how it will transform acute services and hospital care, supporting the workflows and processes to meet the needs of our staff and patients. Colleagues were given practical demonstrations of its use in day to day operations, using real life patient scenarios across elderly medicine, general surgery, maternity and complex care. A second showcase is planned for later in the year which will be focussed on the entire patient journey to include mental health and community services, supporting its ambition to deliver a single patient record across all three areas.

1.5 EPUT is a Regional Champion in the NHS Excellence Awards

I am delighted that EPUT has been selected as a regional Champion in the Sustainable Healthcare category for the first NHS Excellence Awards. There were over 2500 entries over the 10 award categories so being selected as a regional champion is a fantastic achievement and something that all staff should be proud of as everyone makes a contribution towards sustainability at the Trust.

The NHS Excellence Awards shine a light on local projects and teams who are making a real difference to patients and communities, delivering on the ambitions of the NHS 10 year plan and inspiring other to adopt innovative approaches in their local area. This achievement reflects the impact of EPUT's work and commitment to meeting the sustainability challenge and achieving net zero by learning, listening and innovating so that we deliver the highest quality care and sustainability. As a regional champion, we will find out in June if we are a national winner.

1.6 Peer Workers / Lived Experience Ambassadors

At EPUT we understand the valuable contribution that those with lived experience can bring to our services and there are currently more than 400 people who draw on their personal experiences to support others through their treatment journeys on the Trust's mental health wards. Peer workers are in a unique position where they may have shared experiences with our patients, and can use that shared experience to provide support and understanding, ensuring patients feel heard, understood and connected while they continue their treatment journey.

1.7 Digital Healthcare Summit

Colleagues from EPUT and Mid and South Essex NHS Foundation Trust (MSEFT) recently came together for a digital healthcare summit exploring the future of care and how we work. The event

featured internal and external speakers covering the NHS 10 year plan, the Nova Electronic Patient Record (EPR), frontline experiences, digital inclusion, cybersecurity and AI. It gave attendees the change to build understanding, share ideas and connect national strategy with every day practice. The summit closed with a strong sense of shared purpose and excitement about our digital future.

1.8 Autism Acceptance Month

April is World Autism Acceptance Month. Dr Catherine Dakin, Psychiatrist and All Ages Specialist Neurodivergence Advisory is supporting one of our Trust core priorities to improve support for neurodivergent people. For many autistic people, the path to diagnosis can be long and painful, for women in particular, autism has historically been missed, misunderstood, or misattributed – often resulting in diagnoses such as Emotionally Unstable Personality Disorder (EUPD) that while sometimes capturing real distress, can fail to address its root causes. Catherine's role was initially part time, but has recently expanded to full time to support all clinicians, teams and services across the Trust, with a focus not just on autism, but all neurodivergence and suspected neurodivergence, including ADHD, Tourette's and dyslexia. Expanding this scope allows us to think more holistically about people's needs and how we design care with and for them. Catherine's role is helping to shape the future direction of services, supporting teams to reflect on how care is currently delivered and where it can be adapted to work better for neurodivergent people.

2. EXECUTIVE UPDATES

2.1 Nursing and Quality – Ann Sheridan, Executive Nurse

NHS England Chief Nursing Officer Gold Award

Allen Senivassen, Student Education Facilitator and Preceptorship Lead at EPUT, has been awarded the NHS England Chief Nursing Officer Gold Award in recognition of his outstanding contribution to nursing over a 51-year career. Since joining the NHS in 1975, Allen has been a passionate advocate for patient-centred care, education and staff development, influencing thousands of healthcare professionals and helping to improve patient outcomes. His work at EPUT, including his contribution to the Trust achieving the National Preceptorship Interim Quality Mark in 2024, reflects his enduring commitment to high-quality care, compassion and innovation in mental health services.

EPUT's Nursing Conference

EPUT's nursing conference held on 11 May at Anglia Ruskin University brought together more than 200 nurses and healthcare assistants for a day focused on "Reclaiming our Professional Pride and Reconnecting with our Patients." The event provided valuable time to reflect on organisational culture and identify opportunities to strengthen patient care. Attendees were joined by the NHS England Deputy Chief Nursing Officer, with discussions centred on the Fundamentals of Care and the importance of meaningful patient connection. The conference also celebrated staff achievements, with over 130 nominations received for International Nurses' Day 'nursing hero' awards, highlighting the dedication and impact of colleagues across the Trust.

Fundamentals of Care

EPUT's work to embed the Fundamentals of Care framework continues to gain national and international recognition. This has been featured in the *Leading Minds* April Publication (National Mental Health and Learning Disability Nurse Directors Forum), highlighting our impact on advancing person-centred, high-quality care and early improvements in patient experience, staff engagement and safety outcomes. In addition, an abstract describing this work has been accepted for oral presentation at the International Learning Collaborative Conference in Oxford on 13 June 2026, to be delivered by Dr Rebecca Pulford. This reflects the growing external recognition of EPUT's leadership in quality improvement and innovation across mental health and learning disability services.

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

Pay Award for medical and dental staff

The latest national circular confirms revised pay arrangements for those covered by the national medical and dental terms and conditions of service in England was released 11 May 2026, effective

from 1 April 2026. The new national salaries, fees, and allowances should be implemented as soon as possible.

Specifically, salary scales have been increased by 3.5% to basic pay for medical and dental consultants from 1 April 2026. This same increase applies to specialty and specialist doctors on the 2021 contracts, as well as practitioners in the staff grade, specialty, and associate specialist group on pre-2021 contracts. Additionally, doctors and dentists in training will receive a 3.5% increase to pay points, following the government's acceptance of the DDRB recommendation.

Industrial Action
Resident doctors undertook a period of industrial action in April 2026 as part of the ongoing national dispute regarding pay and conditions. The Trust implemented its established business continuity arrangements, including prioritisation of urgent and inpatient care, and proactive communication with patients regarding clinic appointments.

Overall, the Trust managed the period of industrial action effectively, maintaining patient safety and minimising disruption to critical services. While some activity was postponed, the impact was contained and recovery plans were enacted promptly following the action. Key learning has been captured to further strengthen resilience for any future industrial action.

The British Medical Association (BMA) has formally opened a statutory ballot of consultants and SAS doctors in England on 11 May 2026, which will remain open for 8 weeks until 6 July 2026.

Employment Rights Act (ERA) Consultation – Collective Redundancy Thresholds
The Government is currently consulting on proposed changes to collective redundancy consultation thresholds under the Employment Rights Act (ERA). The consultation, which closed on 21 May 2026, seeks views on potential reforms that may alter when employers are required to undertake collective consultation processes, with implications for organisational change programmes and workforce management.

The Trust has contributed to the consultation via the NHS Employers Terms and Conditions network, ensuring that NHS system perspectives are represented. The proposals, if implemented, could impact the scale and timing of formal consultation requirements and may increase administrative and legal obligations for employers.

The Trust will monitor the outcome of the consultation and assess any implications for future workforce change processes, updating the Board as further detail becomes available.

Employment Rights Act (ERA)
From 6 April 2026, sexual harassment is recognised as a protected disclosure under whistleblowing legislation; the Trust is reviewing and updating its whistleblowing and speaking up policies, and reinforced staff guidance and training to reflect this change. From October 2026, the Employment Rights Act strengthens requirements further by placing a duty on employers to take all reasonable steps to prevent sexual harassment and introduces employer liability for third-party harassment, including from patients; the Trust is reviewing and enhancing its policies, training, and risk controls to ensure compliance.

Equality Diversity and Inclusion
Proposals to strengthen Equality, Diversity and Inclusion through a formal staff-networks model and executive EDI objectives have been approved by the executive and were announced on the International Day of Staff Networks. Network Chairs are now working with the OD & Culture team to formalise the model. The International Women's Day "Women in Leadership" speed-mentoring event delivered strong senior-leader engagement and an additional session in May will support the development of a Trust-wide mentoring programme later this year. We will shortly publish progress on this year's WRES and WDES, together with a full set of agreed improvement priorities, including targeted work to address harassment, bullying and abuse from patients and the public.

Leadership Development
Following extensive co-design sessions, the first cohort of the new EPUT Leadership Programme will commence in September 2026. Care units and corporate teams are finalising participant lists following a series of talent mapping sessions. The programme, developed with The King's Fund and BRAP, will offer a distinctive, transformational approach to leadership development across the Trust.

Partnership Working
EPUT has been exploring with Anglia Ruskin University (ARU) and other NHS providers in the East of England region the development of a middle management leadership programme. The current proposal is to have three levels (4 – Service, Quality and Improvement, 5 – Improvement Specialist, and 6 – Improvement Leader). ARU will be looking to develop the curriculum content and then share this with the providers for review.

7. QUALITY AND OPERATIONAL PERFORMANCE

7.1 QUALITY & PERFORMANCE SCORECARD

Information Item PS

REFERENCES

Only PDFs are attached

Quality & Performance Scorecard 03.06.2026 (1).pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	3 June 2026

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

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

Purpose of the Report		
This report provides the Board of Directors with: • A high-level summary of operational performance, quality indicators, safer staffing levels, finance and key NHSE metrics. • The report is provided to the Board of Directors to draw attention to the key issues that are being considered by the standing committees of the Board.	**Approval**	
	Discussion	
	Information	✓

• The content has been considered by those committees, and it is not the intention that further in-depth scrutiny is required at the Board meeting.		

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

Operations

Mental Health Inpatient Capacity:

- Adult Occupancy reported at 97.8%, remaining outside of target - Target <93%
- PICU Occupancy reported at 96.5%, remaining outside of target - Target <88%
- Specialist Occupancy reported at 84.8%, remaining outside of target - Target >95%
- Older Adult Occupancy reported at 87.5%, remaining outside of target – Target <86%

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

Average Length of Stay:

Adult Average Length of Stay on Discharge

- Adult ALoS (Including the Assessment Unit) reported at 46.2 days - Target <60 (Oversight Framework)
- 129 discharges in April (68 Assessment Unit) – 20 long stays (60+ days)
- Long stay discharge breakdown:
  - **60+ days –** 7 discharges
  - **100+ days –** 5 discharges
  - **200+ days –** 8 discharges

In the most recently published National Oversight Framework league tables (2025/26 Q3), EPUT is ranked 9th out of 47 for **Percentage of inpatients aged 18-65 with over 60-day length of stay.** (2025/26 Q1 EPUT ranked 25th out of 47 and in Q2 EPUT ranked 14th out of 47). This evidence's a period of sustained improvement because of service transformation and internal process control.

Annual planning forecasts for average length of stay have been reviewed following receipt of regional feedback on our planning submission.

Older Adult Average Length of Stay on Discharge

- Older Adult ALoS reported at 101.8 days - Target <90 (Oversight Framework)
- 43 discharges in April – 23 long stays (60+ days)
- Long stay discharge breakdown:
  - **60+ days –** 9 discharges
  - **100+ days –** 9 discharges
  - **200+ days –** 5 discharges

PICU average length of stay

- PICU ALoS reported at 58.3 days – Target <50
- 14 discharges in April – 5 long stays (60+ days)
  - **60+ days –** 1 discharges
  - **100+ days –** 3 discharges

Rates of Patients Clinically Ready for Discharge:
Patients with a delayed transfer of care have all been reporting within target limits for the last 4 months, except for PICU. PICU experienced an increase to 4.1% in April, this was caused by 1 patient that was delayed for 30 days.

Inappropriate Out of Area Placements:

From 27th March, OOA placements have been reclassified based on NHSE criteria. Where a patient is placed within EPUT boundaries, it will now be deemed Appropriate. Therefore, where a patient was placed in an "Essex" locality, they were changed from "Inappropriate" to "Appropriate".

Due to this change, the number of OOA remaining at month end in March reduced to 16, and in April has reported at 26.

- In April, a total of 55 patients were placed out of area, 20 of these were deemed "Inappropriate"
    - 17 placed in Adults
    - 1 placed in Older Adult
    - 2 placed in PICU
- At the end of April, 106 patients were placed out of areal 26 were deemed Inappropriate
    - Adult – 21
    - PICU - 5

The planning commitment has been reviewed and is now to reduce this to 0 by March 2029, following receipt of regional feedback on our planning submission. The trajectory to 0 assumed a position of 46 at the end of April 2026, which has been achieved.

Quality

Cardio Metabolic (Inpatient):
Overall compliance reported at 72.2% in April and remains below target of >90%:

- Thirteen inpatient wards reported fully compliant in April (439 Ipswich Road, Gosfield, Henneage, Peter Bruff, Tower, Chelmer, Kitwood, Ruby, Topaz, Cherrydown, Beech, Larkwood and Poplar (CAMHS))

The Inpatient & Urgent Care Unit will undertake a targeted review of wards consistently achieving compliance, to identify and document the key practices supporting sustained performance. This learning will be incorporated into overarching policy and shared across the service, with Lizzy Wells overseeing to ensure that best practice is adopted within areas not currently meeting target.

Cardio Metabolic (Community):
April compliance reached 63.5%, remaining below the 75% target. Performance continues to be impacted by incomplete records, partial checks, and inclusion of inappropriate cohorts in reporting. During the focused works, key issues have been Identified such as:

- **Incomplete Data Capture:** High volume of partial checks with inconsistent follow-through by clinical teams
- **Accountability Gaps:** Results shared with teams are not always actioned or recorded on EPR
- **Cohort Definition:** Inclusion of patients assigned solely to non-secondary Mental Health teams may be skewing compliance figures

Actions currently in progress to improve performance include:

- Data quality improvement, our productivity team are proactively retrieving blood results from ICE/Pathology systems to update EPR once reviewed (sent to clinical teams to action).
- Strengthened escalation around non-actioned or partial checks are now escalated directly to productivity lead and then DDQS if required to drive resolution and completion.
- Cohort Review: Productivity teams are reviewing cases linked only to non-secondary Mental Health teams to assess exclusion where necessary.

- Targeted oversight: Review of non-covered teams to determine whether cases should be closed or redirected to GPs.
- Performance Monitoring: Weekly progress reporting introduced within the locality to support improved tracking and accountability.

NHS Talking Therapies:
CPR and NEE experienced an increase in referrals, whereas SOS had a slight reduction. Both the 6wk and 18wk wait to treatment are reporting 100%.

The moving to recovery indicator continues to report above the 50% target, with 55.5% reported in April.

No Harm / Low Harm Incident Rates:
The NHS Patient Safety Incident Response Framework (PSIRF) and Learning from Patient Safety Events (LFPSE) emphasise accurate incident reporting, appropriate harm classification, and learning for improvement, rather than performance against numerical targets.

Since March 2024, the Trust has consistently reported between 85.10% and 91.57% of incidents as resulting in no or low harm (with the exception of May 2025). This remains within established statistical control limits, indicating variation within expected parameters.

It is recognised that incident data reflects both safety performance and reporting culture. The Trust continues to promote open reporting, and higher rates of no and low harm incidents are considered indicative of a positive reporting culture.

Robust governance is in place, with incidents and associated learning reviewed weekly through Care Unit Incident Review Groups and the Emerging Incident Review Group to ensure oversight and support continuous improvement.

Virtual Ward Occupancy:
MSE reported below target with 73%. West has seen an increase in performance to 49% in March. We are awaiting the outcome of the extensive review of the Virtual Hospital process across East North Herts and West Essex. This will be shared back at F&P once received.

Workforce

Staff Sickness:
Sickness absence remains above target, with the April position at 5.5% against a target of 4.9%, showing a slight improvement from earlier in the year but still 0.6% above KPI. This continues to present a pressure on workforce capacity contributing to demand for temporary staffing.

An analysis of sickness data presented to People Committee in April highlights a potential emerging risk that the Trust is reporting a shift from acute seasonal illness towards an emerging wellbeing-related risk through increased absence aligned to mental health reasons. An action plan overseen by Operational HR has been developed that sets out how identified sickness absence trend drivers are being addressed through targeted interventions.

Vacancy Rate & Turnover:
The vacancy rate has continued its positive trajectory, with April reporting 8.6%, maintaining improvement over the last 18 months and remaining within the expected trajectory against the Trust's target. This reflects sustained recruitment activity and a continued focus on building a stable and sustainable workforce to support service delivery and patient safety.

There have been strong recruitment outcomes across key staff groups. However, there remain areas where vacancy levels remain above desired levels and require continued targeted intervention which are being led through the Trust Recruitment Plan.

Turnover in April stands at 9.0% against a target of 10%, demonstrating a stable position within acceptable parameters. Ongoing focus is required to sustain this position, particularly in high-turnover areas and within the first 12 months of employment.

Temporary Staffing:
April 2026 shows a material improvement in temporary staffing utilisation compared to March 2026, with total usage reducing by 204 WTE. This reflects the combined impact of strengthened governance, improved control measures, and the normalisation of year-end operational pressures seen in March.

Despite a significant reduction in temporary staffing usage between March and April, overall usage remains above the planned 26/27 trajectory, requiring sustained delivery to avoid re-escalation later in the year. Temporary staffing reductions achieved in April are not yet fully structural and remain sensitive to pressures including inpatient acuity, medical vacancies and sickness absence.

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

Finance

FY2526 Outturn

The pre-audited FY2526 financial results are :-

Income & Expenditure:
A revenue surplus of £0.1m (including deficit support funding of £20.5m). This position was underpinned by delivery of £30.1m of efficiency savings.

Temporary Staffing:
Temporary staffing outturn was £51.3m, a £15.8m reduction spend from FY2324 (£67.1m).

Capital:
Gross Capital spend was £43.7m consistent with plan.

Cash:
Cash balance at 31 March 26 was £45.3m including revenue and deficit support funding.

FY2627 Month 01 Results

Income & Expenditure
The Trust reported a deficit of £2.1m, £0.5m adverse to plan. The adverse variances relate to Out of Area expenditure, industrial action, shortfall on pay award the efficiency programme.

Capital:
Capital expenditure totals £1.5m, £0.1m above the plan.

Cash:
Cash balance is £31.2m, above plan by £10.4m.

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

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

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

Acronyms/Terms Used in the Report			
ALOS	Average Length of Stay	OOA	Out of Area
CPA	Care Programme Approach		

Supporting Reports/ Appendices /or further reading
EPUT Quality & Performance Board Report **HERE.** Financial Dashboard

Lead

Paul Scott
Chief Executive Officer

NHS
Essex Partnership University
NHS Foundation Trust

Financial Performance Headlines

- FY2526 – Outturn Results

- FY2627 - Month 01

EPUT

FY2526 Financial Results

FY2526 FINANCIAL RESULTS

Strong financial performance with positive year-end outcomes

INCOME & EXPENDITURE	EFFICIENCY	CAPITAL	CASH
£0.1m	£30.1m	£43.7m	£45.3m
£0.1m above plan	£1.3m below plan	On plan	£35.6m above plan

Year-end surplus: £0.1m.

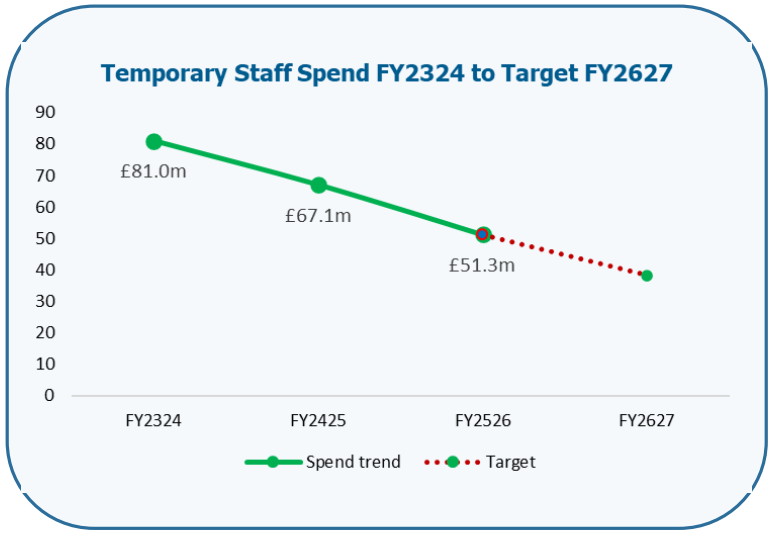
Includes £20.5m Deficit Support Funding (DSF).

FY2526 efficiency delivery: £30.1m I

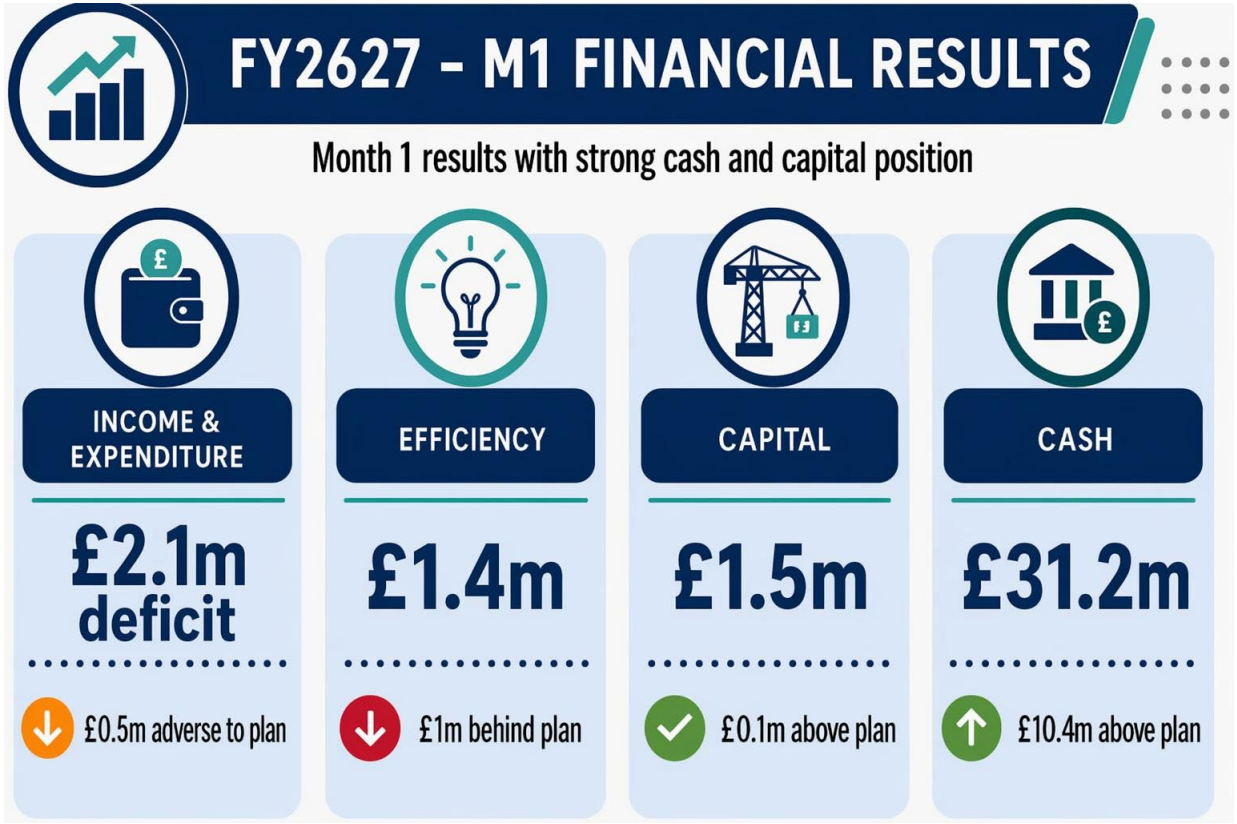
Includes temporary staffing £15.8m.

Total capital expenditure in FY2526 was £43.7m, offset by £7.4m of lease disposals in-year, resulting in a final outturn of £36.5m.

Cash balance is £45.3m, above plan by £35.6m due to receipt of additional cash income in M12 and capital creditors.



FY2627 – Month 1 Financial Results



Month 1 deficit £2.1m

£0.5m off plan relating to Out of Area, industrial action, shortfall on pay award.

Total delivery £1.4m

£1m off plan largely as a result in shortfalls in Out of Area placements and temporary staffing and locality targets.

Capital spend £1.5m, £0.1m above plan, reflecting continued delivery of projects carried forward from the previous year alongside the commencement of the 2026/27 programme.

Cash balance £31.2m, £10.4m above plan due to higher closing FY2526 balances.

7.2 COMMITTEE CHAIRS REPORT

Information Item Chairs

REFERENCES

Only PDFs are attached

Committee Chairs Report 03.06.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	3 June 2026

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

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

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

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

Summary of Key Points
The Board of Directors regularly delegates authority to the standing committees of the Board in line with the Trust's Governance arrangements (SoRD, SFIs etc). Standing Committees present regular reports to the Board of Directors, providing assurance on the key items discussed and progress made to resolve any identified issues. For each Board meeting, Chairs of standing committees will provide details of meetings held and report: • Assurance – any key assurances to be provided to the Board. • Information – any issues previously identified which have now been resolved, including lessons learned. • Alert – any issues / hotspots for escalation to the Board. • Action – any issues where the Standing Committee is requesting action from the Board. The attached report provides updates in relation to the following Standing Committees: 1. Audit Committee (Elena Lokteva) 2. Finance & Performance Committee (Diane Leacock) 3. People Committee (Ruth Jackson) 4. Quality Committee (Dr Mateen Jiwani)

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices
Committee Chairs Report

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

NHS
Essex Partnership University
NHS Foundation Trust

Committee Chairs Report

Board of Directors

JUNE 2026

EPUT

INTRODUCTION

Purpose of the report

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

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

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

- **Assurance** - Any key assurances to be provided to the Board
- **Information** – Any issues previously identified which have now been resolved, including the identification of lessons learned
- **Alerts** - Any issues / hotspots for escalation to the Board
- **Action** - Any issues where the standing committee is requesting action from the Board

NHS
Essex Partnership University
NHS Foundation Trust

1. AUDIT COMMITTEE

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

Committee meeting held: 8 May 2026

Assurance

Internal Audit Progress
Three final reports received 'reasonable' assurance ratings, as follows:

- BAF & Risk Management
- Fit and Proper Persons
- Payroll including salary overpayment

Two audits within the 2025/26 programme remained in progress and were due to conclude shortly.

Comparative annual improvement in completion of audits reports with timeliness of audit programme remaining under scrutiny.

External Audit Plan
External Audit Plan from new Auditors (Grant Thornton) received. Plan covered approach to audit of year end accounts with increased focus on VFM assessments including Lampard Inquiry and CQC ratings and action plans.

The Committee approved the Audit Plan.

Procurement Breaches
The Committee received a report on Procurement breaches during February and March. Procurement breaches are monitored and reported through the Executive Operational Committee.

Information

Anti-Crime Progress Report
The Committee received an update on Counter Fraud Activity. Training and awareness measures are in place.

Anti-Crime Annual Report
The Committee received 2025/26 Fraud Functional Standard Assessment return with overall 'Green' rating compliance. Return to be submitted by 31 May.

Action

No Actions for the Board.

Alert

No Alerts for the Board.

NHS
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NHS Foundation Trust

1. AUDIT COMMITTEE

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

Committee meeting held: 8 May 2026

Assurance

Draft Annual Accounts and Annual Report
Committee received draft 2025/26 annual accounts and annual report. Revenue results - £0.1m surplus, Capital expenditure £43.7m. Accounts have been subject to comprehensive review by Finance team, Audit and Executive Committee. Audit commenced 27 April with ambition to complete field work early. Key area of judgement will be Lampard Inquiry cost provision. The draft annual accounts are due to be submitted on the 24th June.

Head of Internal Audit Opinion
The draft Head of Internal Audit Opinion was received. Based on work performed to date the report concludes the Trust has a reasonable rating for risk management, control and governance processes in place. Final report to be issued end May.

Risk Management Assurance Framework Annual Report
The Committee were assured of risk management arrangements across the Trust including transition to the Enterprise Risk Management system.

Information

Losses and Special Payments
For 2025/26 the Trust reported £151k loss relating to 75 cases, of which, £77k (25 cases) related to reviews associated with application of Limitations Act. All losses having previously provided for.

Conflict of Interest
The Trust was compliant with NHSE Conflicts of Interest guidance during 2025/26. No issues identified.

Standing Committees Annual Reports
Reports demonstrated high engagement and evidence of continuous improvement.

Directors Expenses
The Committee received a breakdown of Directors Expenses during 2025/26 - £17k.

Action

No Actions for the Board.

Alert

No Alerts for the Board.

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2. FINANCE & PERFORMANCE COMMITTEE

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

Committee meeting held: 21 May 2026

Assurance

Integrated Performance Report

- There was extensive discussion on the IPR including:
  - Work with system partners and Flow programme to reduce inappropriate out of area placements.
  - The provision of mental health interventions at an earlier stage.
  - Developing new channels of communication to reduce the burden on the Contact Centre.

Financial Report

- The Committee received a report providing Month 1 financial results.
- The revenue position is currently £0.5m adverse to plan, attributable to out of area expenditure, shortfall relating to the pay award, and the impact of industrial action.
- The Committee noted the challenges of the efficiency agenda.
- Cash balances are better than plan (£10.4m), mainly due to receipt of revenue support funding at the end of 2025/26.
- Capital spend is £1.5m, £0.1m ahead of plan. Annual plan £24.1m.
- Work on the audit of accounts and mobilisation of new external auditors is progressing well.

Information

Estates & Facilities Update Report

- The Committee received an update on Estates & Facilities activities.
- Recruitment is currently being undertaken to reduce temporary staffing within the teams.
- Work on the Estates Strategy is moving forward, with a number of major schemes planned.
- The Trust's 2026-2029 Green Plan has been launched, with a number of ambitious targets .

BAF Risk Deep Dive – AI Risks

- The Committee received a Deep Dive exploring potential risks that Artificial Intelligence may pose to the Trust, and current and future planned mitigations.
- An AI Programme Board will be established to provide strategic oversight, strengthen governance and support safe organisation-wide AI adoption.

Action

Strategic Impact Report

- The Committee approved the Strategic Impact Report for presentation to the Board of Directors.

EPUT Provider Licence Review

- The Committee approved the detailed review of Trust compliance against the Provider Licence (including the Code of Governance) for presentation to the Board of Directors.

Alert

No Alerts for Board

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NHS Foundation Trust

3. PEOPLE COMMITTEE

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

Committee meeting held: 30 April 2026

Assurance

Assurance Reports

- The following assurance reports were received by the Committee:
  - Annual Workforce Plan End of Year Report 2025/26
  - Board Assurance Framework / People & Culture Risk Register
  - Education Strategy
  - Employee Relations Annual Report 2025/26
  - Freedom to Speak Up
  - Guardian of Safe Working
  - National Education & Training Survey
  - National Staff Survey & Pulse Survey
  - People Strategy & Implementation Plan
  - Recruitment Plan
  - Staff Experience
  - Workforce Key Performance Indicators

Information

Appraisal Framework

- A new appraisal framework has now been rolled out, including 365 degree feedback.

National Job Re-Evaluation for Band 5 and 6 Nurses

- A national job re-evaluation for Band 5 and 6 Nurses is currently underway.

Regional People Board

- The Trust will be leading on the development of a Regional People Board.

Action

No Actions for the Board.

Alert

People Strategy & Implementation Plan

- The Committee endorsed the draft People Strategy for presentation to the Board of Directors for approval. This will be presented in a separate Agenda item.

Strategic Impact Report

- The Committee approved the Strategic Impact Report for presentation to the Board of Directors. This will be presented in a separate Agenda item.

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4. QUALITY COMMITTEE

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

Committee meeting held: 9 April & 14 May 2026

Assurance

Assurance Reports

- The Committee received the following assurance reports:
  - Board Assurance Framework (Aligned Risks)
  - Controlled Drugs Management
  - Clinical Audit & NICE
  - CQC & PFD
  - CQC Community Mental Health Survey 2025
  - Digital Clinical Safety Framework
  - Duty of Candour Annual Report 2025/26
  - Executive Emergent Issues
  - Learning from Deaths
  - Mental Health Act
  - Patient Experience, Lived Experience & Volunteering Annual Report 2025/26
  - Patient Safety Strategy
  - Quality of Care Performance Dashboard
  - Quality Senate
  - Reducing Health Inequalities
  - Reducing Restrictive Practice
  - Strategic Impact Report
  - Suicide Prevention
  - Working with Neurodivergence

Information

Deep Dives

- The Committee received Deep Dives on the following topics:
  - Controlled Drugs Management – The Group noted that some improvement had been made but there are still poor performance issues and that it was important to hold people to account through the capability process. This will continue tor remain on the QC agenda.
  - Deprivation of Liberty – This is an extension to the Mental Health Act. Significant increase in referrals. Dols and Older Adults are the two areas that are significantly affected. Need to understand where we sit on the spectrum with other organisations?
  - End of Life Care – Review currently underway regarding the recent patient fall. Question was asked as to what arrangements were in place to ensure equality of care for all patients including those with learning difficulties.

Controlled Drugs Update

- The Committee received an update in relation to improvements and mitigations made in relation to controlled drugs. The Committee agreed for the item to remain on the agenda to ensure oversight of improvement and staff to share improvements and challenges at a future meeting.

Quality Account

- An updated version of the Quality Account was presented for consultation.

Action

No Actions for the Board.

Alert

Strategic Impact Report

- The Committee approved the Strategic Impact Report for presentation to the Board of Directors. This will be presented in a separate Agenda item.

7.3 FREEDOM TO SPEAK UP

Information Item BR

REFERENCES

Only PDFs are attached

Freedom to Speak Up Service 03.06.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	03 June 2026

Report Title:	**Freedom to Speak Up Service**					
Executive/ Non-Executive Lead / Committee Lead:	Denver Greenhalgh – Executive Director of Corporate Governance					
Report Author(s):	Bernie Rochford – Principal Freedom to Speak Up Guardian					
Report discussed previously at:	People Committee 30 April 2026					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

Purpose of the Report		
The purpose of the report is to inform the Board of Directors of • Freedom to Speak Up activity with a particular update on activity from 01 October 2025 to 31 March 2026 • Emerging themes and cultural shift around Speaking Up behaviour • Action taken to strengthen accountability when Listening and Following Up And to • Gain support for greater clarity around all Speak Up routes across the Trust, how they align, who holds data triangulation and where the FTSU service sits within the wider trust SU approach	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors are asked to:

1. Note the contents of the report.
2. Agree, in principle, next steps are set out in the priority section.
3. Support greater clarity around all trust wide Speak Up routes, alignment, and triangulation of data.

Summary of Key Points

Pg 3 – Three hundred and Nineteen PSU in 2025-26 with a sharp rise in concerns raised in Q1.
This is a 21% increase in PSU from last year. The majority of whom SU Anonymously (129 / 41%).

Pg 4 – Main issues raised include elements of perceived unfairness, inconsistencies, delays, processes.
Managers / HR not Listening *prior to* or *after* colleagues contact FTSU appears to be the bigger issue

Pg 5 – Lack of direct, appropriate, timely responses by managers / HR / investigators needs addressing.
The focus of the service has been approximately 99% reactive rather than proactive over the last year.
The immediate aim is for case performance to move through the Accountability Framework.
A model to develop a greater trust wide model of signposting and responding to PSU is proposed

Pg 6 – The backlog of ~300 outstanding open cases has been cleared. Now ~ 35 open cases.
Colleagues are using the service for sense-checks / working out issues as well as raising them

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

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

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

Acronyms/Terms Used in the Report			
FTSU	Freedom to Speak Up	MARS	Mutually Agreed Resignation Scheme
PSU	Person / People Speaking Up	SU	Speaking Up / Spoke Up
HR	Employee Relations	MDP	Manager Development Programme

Supporting Reports and/or Appendices

Freedom to Speak-Up Service Report

Appendix 1 – Freedom to Speak Up Data between 01 April 2025 – 31 March 2026

Appendix 2 – Freedom to Speak Up Data: Factors to Consider

Appendix 3 – Proposed trust-wide SU model

Executive/ Non-Executive Lead / Committee Lead:

Denver Greenhalgh
Executive Director Corporate Governance

Freedom to Speak Up Service

1. Purpose of Report

Inform the Board of

- Freedom to Speak Up activity with a particular update on activity from 01 October 2025 to 31 March 2026
- Emerging themes and cultural shift around Speaking Up behaviour
- Action taken to strengthen accountability when Listening Up and Following Up

And to

- Gain support for greater clarity around all Speak Up routes across the Trust, how they align, who holds data triangulation and where the FTSU service sits within the wider trust SU approach

2. Board Responsibilities

2.1 The table below summarises the Trust position against Board responsibilities

Board Responsibility	Requirement	Trust Position
FTSU E-learning Modules	Implement FTSU e-learning modules on a par with mandatory training	August 2025 – The trust moved previously annual FTSU training to three yearly As of 31 March 2026, the following achievement of FTSU training is reported: 000 Speak Up 97% 000 Listen Up 94% 000 Follow Up 93%
NHSE FTSU Board Reflection and Planning Tool	Board to reflect and complete Assessment and Planning tool	Completed and presented to the Board of Directors September 2024 (seminar session).
NHSE FTSU Board Improvement Plan	Board to assess, review and monitor progress	Due to limited capacity since presenting at the Board of Directors September 2024, progression of agreed areas of focus had been halted. With a change of SRO – this is being reviewed and a development plan for the service is being developed. This will report to the Board early 2026, along with a timeline for when we will refresh the planning tool.
FTSU Policy review	Align local and national policy by January 2024	Completed.

3. Freedom to Speak Up Data

3.1 *Number of People Speaking Up (PSU)*

In Q3 and Q4 of 2025-26, 76 and 65 PSU respectively through the FTSU Guardian service; totalling 319 PSU for the full year. A 21% increase on the previous year (264 PSU). [Appendix 1. Fig 1]

3.2 *Approach taken to Speaking Up*

In Q3 and Q4, 43 (30%) PSU Anonymously. Over the full 2025-26 period, the majority of PSU did so anonymously (129 / 41%). The remainder (59%) were split evenly between Confidential and Open. Speaking Up Anonymously has been steadily on the rise for the last four years. [Appendix 1. Fig 2 and 3]

3.3 *Speaking Up by professional / worker group*

Due to high levels of anonymous reporting, the professional group for 124 / 39% cases are unknown. Where professional group was shared, the majority of concerns were raised by Administrative & Clerical staff (63 / 20%), Nurses (49 /15%), and Allied Health Professionals (30 / 9%) [Appendix 1. Fig 4]

3.4 *Method of contact*

The majority of issues were raised via the online form route (131). The majority of which were raised anonymously (113 / 86%). The next preferred method was via email (21/ 6.5%). [Appendix 1. Fig 5 and 6]

3.5 *Themes and issues raised through the FTSU service (NGO Themes)*

Issues around worker safety / well-being was the main reason PSU (186). Inappropriate attitudes / behaviours (131) often raised in tandem, is reflected in these being the two highest reported. Raising concerns about patient safety / quality remains the least reported issue through the FTSU service but was on a par with Bullying and Harassment this year [Appendix 1. Fig 7, 8, 9]

3.6 *Open Cases*

As reported to the Board in December 2025, at the end of Q2 2025/26, 291 FTSU cases were open. 72 from Q1 and Q2 of 2025 and 219 outstanding from prior years. By the end of Q4, 20 cases including 2 from Q4 2024 – 25 were open. Over the last 6 months, 412 cases were processed including 291 outstanding / open cases plus a further 121 new ones [Appendix 1. Fig 10].

3.7 *Projections – Factors to consider when comparing annual FTSU data*

The data recording / reporting has changed over time which may distort the picture. [Appendix 2. Fig 1].

4. Analysis of FTSU data

The number of PSU in Q3 / Q4 (141) was similar to Q3 / Q4 last year (133). The Q1 total (98) appears to be a spike. There are no other known indicators to explain the sharp rise in PSU except at this time, an announcement was made for the MARS. MARS may create a wider sense of uncertainty for some although not directly expressed as a causative factor for PSU.

The yearly rise in PSU anonymously is a concerning trend. The majority spoke up anonymously (41%) and report they spoke up to others prior to contacting the service. The number of anonymous cases in the first half of 2025-26 alone, exceeded the total for the previous year. The number fell slightly in Q3 and Q4 but more concerns were raised anonymously than in previous years and is being monitored. Fear and Futility because issues are not addressed at first point of contact are the most common cited reasons for PSU to a FTSU Guardian. But other contextual issues need to be considered as potential contributory factors – cost savings, budget cuts / freezes, general uncertainty around job security, MARS announcement and the Lampard inquiry. The latter is often cited as the next point of escalation if concerns remain unaddressed.

Anonymous Speaking Up may also be linked to ease / lack of visibility. More PSU via online forms which may drive up anonymity behaviour. The form offers choice for PSU to identify themselves, but 86% chose not to. Anonymous contact via email was 15% and 11% via phone. An increasing caseload whilst resetting / maintaining a service has meant less visibility around the Trust and therefore now less PSU in person (<2%).

The worker group for 39% of PSU is unknown. Where known, Administrative & Clerical colleagues spoke up the most (63 / 20%). The MARS scheme for non-clinical staff and historic longer-term unresolved relationship issues within this group are likely factors. Nurses and Allied Health professionals were next highest.

Eight people reported detriment after raising concerns. The majority came from the same area and related to a specific set of circumstances. The only recourse to action appears to be through the raising of another grievance which tends to further inflame the situation. More work is needed in this area. Retaliation and detriment received, perceived or even just feared increases the likelihood of PSU becoming sick / off work for extended periods of time. It also reduces the potential for resolution. Although retaliatory detriment is not usually reported, sickness causing lengthy periods of time off work is often cited as a direct consequence of unaddressed or unresolved concerns raised. This type of sickness, should be considered secondary detriment. Plans for this to be more systematically reported on are in progress. In some cases where colleagues have taken sick leave as they can no longer tolerate the delays, uncertainty and stress of the mismanagement of their concerns, work on addressing the concerns appears to be suspended pending their return. This is a false economy as it has the reverse effect.

Using NGO themes, the majority of concerns raised were about worker safety / well-being, followed by inappropriate attitudes / behaviours. This is consistent with previous reporting periods and remains as the main reason PSU at EPUT. These issues may indirectly impact patient safety but were only cited in 20% of cases and remains the least reported theme. This does not reflect the original vision for the national set-up of FTSU Guardian services. The majority of concerns centre on unresolved management / HR stressor and tension issues and delays in grievances and investigations. The FTSU Guardian service is not resourced to manage the overflow of manager / HR issues. The majority of which, include elements of perceived unfairness, inconsistencies, delays and unfair application of systems, processes and policies. Monthly meetings with HR leads have been established and are helping to address this.

Due to a recording issue, it is not possible to report with exact figures on the Failure Demand Rate i.e. how many PSU spoke up to their managers / HR prior to contacting a Guardian. But given the Failure Demand Rate was previously reported to be ~95%, little has changed in the interim and colleagues report increasing frustration and futility, it is safe to say the cause of the majority of PSU through the FTSU Guardian service is due to Failure Demand elsewhere. Therefore, the bigger problem lies in the Listening and Following Up territory – both *prior* to and *after* contacting the FTSU service. More work in supporting managers is needed. Due to capacity / resourcing issues, the Guardian service has had no presence on the Manager Development Programme since early 2023. It is unclear, who is providing training and upskilling for them around Listening Up, problem solving and communication skills.

Other themes for contacting the FTSU service such as seeking support / advice, signposting, sense-checking, pastoral care, grievances, impact of consultations, leadership, system issues etc are not externally recorded. A start was made in categorising these but as yet the terminology / data collection is not consistently reliable enough to report on. The same applies to reliable data on protected characteristics and primary reason for Speaking Up. Work on developing these via a bespoke Datix module was suspended in order to focus on clearing outstanding cases and maintaining a level of service.

Previously as a sole Guardian responding to a high volume of PSU, there was little capacity to repeatedly chase for updates, hence the high number of cases remaining open as there was no evidence to support action had been taken, lessons learnt or change as a result. The lack of feedback on action taken or to be taken by managers and investigators creates a ***few hundred extra*** unplanned meetings for me with staff as they come back for answers not received directly and timely elsewhere. It also directly leads to increased sickness and time off work for colleagues SU; and in clinical areas, backfill to cover their time off. Little proactive resolution, updates or feedback to inform the closure of cases or to provide support for those speaking up, directly impacts on Guardian resource and capacity to develop the service.

Thankfully over the last year, the service benefited from a second Guardian who handled the majority of new cases. These were predominantly anonymous and via the online form. These cases tend to be quicker and easier to manage as they do not involve lengthy distressing repeat meetings with staff. The downside though is the forms are reliant on PSU being 'good historians' which isn't always the case and the opportunity is lost to unpack surface issues, identify risks or stabilise / reassure the person.

The outstanding backlog of open cases has largely been cleared. As previously reported to the Board in December 2025, at the end of Q2 2025/26, 291 FTSU cases were open. 72 from Q1 and Q2 of 2025 and 219 outstanding from prior years. By the end of Q4, 20 cases including 2 from Q4 2024 – 25 were open. Over the last 6 months, 412 cases were processed including 291 outstanding / open cases plus a further 121 new ones [Appendix 1. Fig 10].

I am also pleased to report the number of colleagues completing their FTSU e-learning training has increased since reported on at the end of Q2 and at year end stood at over 90% for each module. Unfortunately, mid-year, the modules were downgraded from annual training to three yearly as per NHSE guidance. In and of itself conserving time is understandable but when triangulated with other data / evidence, delays in managers / HR / investigators responding to concerns, resulting in ill health, fear and futility, it is a concern. It suggests completion of the e-learning training is not enough to drive a change in behaviours. I am awaiting a clearer idea of what the Kings Fund / Brap leadership and cultural change program will look like to identify where the FTSU messages can dovetail.

5. Further factors to consider

There has been a number of changes over the last year including a change of Chair, FTSU Executive Director, NED and a second Guardian who has now left.

The demand on the service has increased. The immediate aim is for casework performance to move through the Accountability Framework, to provide increased oversight, aid resolution, and to evidence action and learning. Due to capacity / budget / resourcing issues, the Guardian service since 2023 has largely been reactive rather than proactively raising awareness, visibility / upskilling managers.

Case numbers has steadily increased since the start of COVID, as has the complexity of issues and how staff present. Resourcing needs to reflect the demand and complexity. The number of PSU continues to rise even without including students, who now largely report through a separate Purple Flag system. It was agreed the FTSU service would ease back from direct promotion to students, so a clearer process and chain of escalation could be re-established between the students, wards, universities and preceptor leads.

To maintain a service, several factors need to be considered. In addition to budget, resourcing, roles and remits, signposting etc, the data needs revisiting. Appendix 1, Fig 3 appears to show, a steady increase in the number of concerns raised post-covid with a negative arc of PSU anonymously. Appendix 2, Fig 1 however illustrates a more complex picture which has been distorted through the use of different reporting parameters over time.

Prior to Q2 2023, the *number of issues* raised, including those discussed with champions, was reported on rather than the *number of PSU to a Guardian*. Reporting now on the latter, illustrates the extra demands on the service, managers and HR. For example, one PSU usually creates 3 or more concerns to address, with many of the cases exceeding 5 or more elements that need responding to. The longer the PSU has held onto the concern, usually the more complex and more elements there are. Last year 319 PSU through the service, with ~1400 issues that should be addressed, actioned, responded to, documented with evidence that learning has taken place as a result. The impact of re-introducing ~1400 more concerns to be addressed second time round does impact on time, resourcing and goodwill. Managers cherry-picking which issues or elements of the issues to respond to, leads to a growing sense of futility, more open unresolved issues / cases and repeat demand on the Guardian time for pastoral care whilst distressed staff await updates.

Prior to 2023, the FTSU champion network had faded out. Clearer, more timely Follow Up responses must be established before another champion network encouraging more colleagues to SU can be considered.

It is evident other speak up routes need to be strengthened. The FTSU service exists as an organisational safety valve by picking up unresolved / new / existing issues. Why these issues are not addressed at the first point-of-call needs exploring. Manager / HR delays in updating or responding to issues raised, backs up, displaces and causes increased pressure on the FTSU service. It generates further demand and pressure to provide support, reassurance and pastoral care not provided elsewhere. Monthly meetings between the Guardian / OD / HR Directors / Associate Director to discuss key themes and casework is enormously helpful.

Overall impression of Speaking Up across the Trust is there needs to be greater flow, accountability, alignment and consistency within and between different routes colleagues can speak up through. Clarity is needed around who and what is being done, where, how it all ties together and where the FTSU service fits into the overall model for an open SU culture.

The setting of a model, with clear remits and aligning of different approaches would provide greater clarity and assurance for staff; as well as improve the quality and efficiency of responses to issues raised, action taken, lessons learnt and change as a result. Appendix 3 illustrates a proposed model for developing an open trust wide transparent Speak Up ethos that would aid resolution, learning and data triangulation. Who would oversee and coordinate it would need to be determined but the overarching aim is to simplify the multiple routes through which PSU and define where the FTSU Guardian service fits within the overall picture; ensuring colleagues are heard and issues followed up, resolved and learnt from.

6. Highs and Lows

Lows

- Since April 2024, 27 people progressively SU about serious issues within one service. Unclear protracted processes resulted in severe staff distress, with many becoming ill and off sick for lengthy periods during this time. Assistance from NHS England was sought. However, there was a delayed response, the situation deteriorated further and then I went on leave. Two years later, apart from four outstanding cases and a further hearing, the issues have mostly been addressed. A key learning from this and other cases involving collaborative partnership between trusts is the need to look at management and cross organisational contract and support arrangements
- Where resolution to issues raised does not fit squarely within someone's remit or spans multiple people, disciplines or directorates, they tend to become protracted or unresolved
- Demand on the service has grown, without matching the capacity to meet it. Demand is likely to increase further hence a review of the service, resources, approach alongside other Speak Up routes is urgently needed. The additional Guardian who joined the service moved to another team in April.

Highs

- The backlog of ~ 300 open cases has been cleared and currently (Mid-May) stands at 35.
- Confidence in the service remains. More staff are coming forward to Speak Up as well as using it for sense-checks / working out issues rather than just raising them.
- The FTSU policy and intranet site were reviewed and updated. I met with the OD lead to consider joint work on developing Cultural Ambassadors rather than several individual themed champions.
- I completed my overseas Churchill Fellowship travel on Speaking Up / Whistleblowing practice. More details to follow after my close out report is completed.

7. Identified Next Steps and priorities

Bring the FTSU data / broad themes to the Accountability Framework Meetings to aid inclusion within the round of issues for each directorate, increase accountability, follow up and learning.

Trust-wide Speaking Up as well as via the FTSU service would benefit from re-engineering. Evidence indicates a concerning trend and cultural shift in how the FTSU service is being used. To develop transparency, accountability, learning and change, the flow of Speaking Up, Listening Up and Following Up through the Trust needs reviewing, revising and re-education at all levels / areas. Growing demand indicates proactive work at source is needed to ensure the FTSU service remains a fall-back safety conduit.

The immediate areas for focus / development over the next six months are:

1. **The Board reach agreement re Speaking Up flow across the trust / FTSU**

2. **Action plans** – Following the above, develop and agree what action needs to be taken in preparation for a trust wide re-education piece on Speaking Up, FTSU in particular and who does what. With a focus on what FTSU is / isn't / how to make it work for everyone.

3. **Budget / Recruitment** - Build capacity into the FTSU service to meet demand / service need. Understand what budget is available and how the service can fulfil its purpose.

8. Recommendations

Once a trust wide Speak Up model has been agreed an action plan with agreed time frames should be developed and used as a live tool for ensuring alignment and improvements are made.

The Board is asked to:

1. Note the contents of the report.
2. Agree, in principle, next steps are set out in the priority section and action will be taken to address the cultural shift changes.
3. Gain support / greater clarity around all Speak Up routes across the trust, how they align, who holds data triangulation and where does FTSU service fit in

Report prepared by:

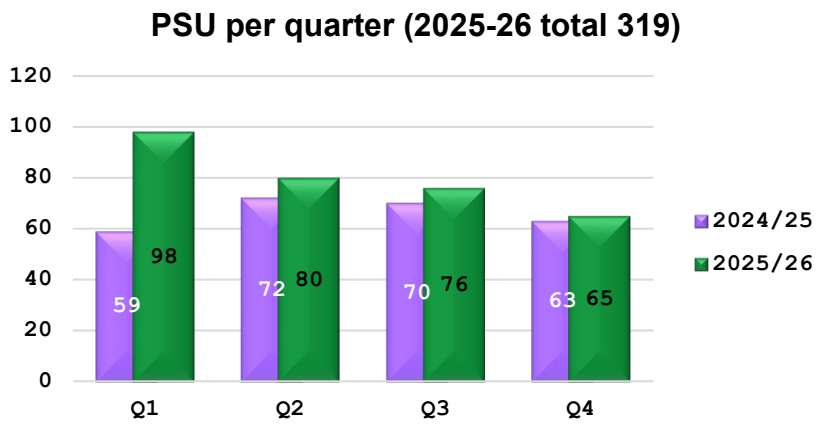
Bernie Rochford MBE
Principal Freedom to Speak Up Guardian

On behalf of:

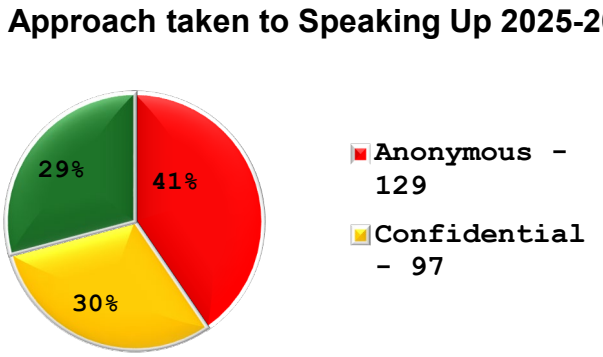
Denver Greenhalgh
Executive Director of Governance

APPENDIX ONE FTSU DATA

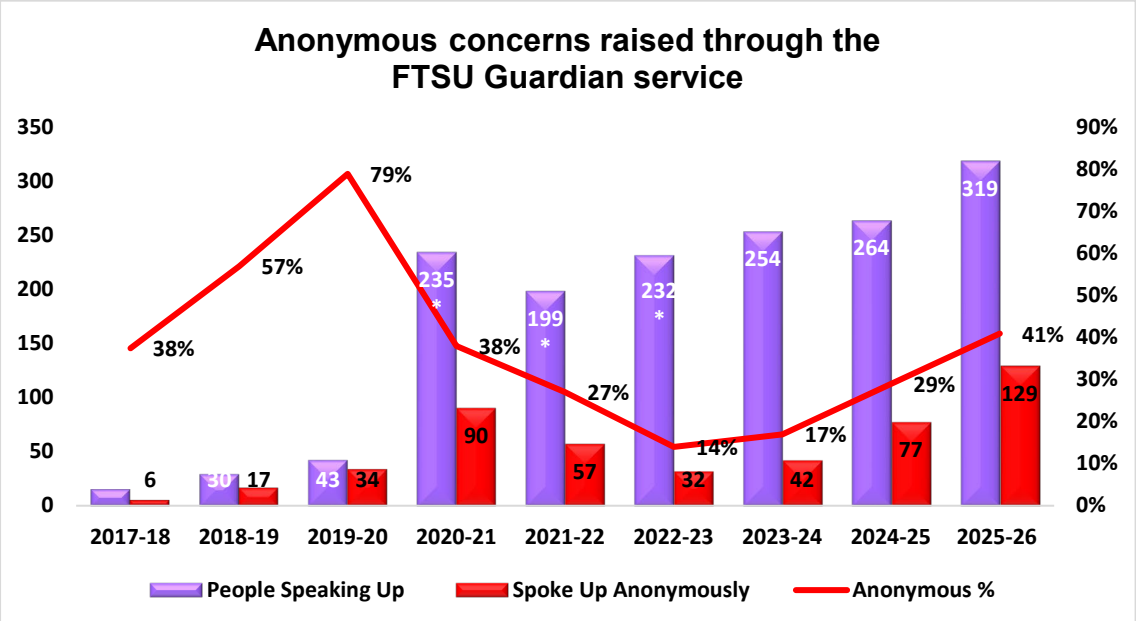
1. *Number of People Speaking Up (PSU) through the FTSU Service*



2. *Approach taken to Speaking Up*



3. *Percentage of Anonymous FTSU concerns over time*

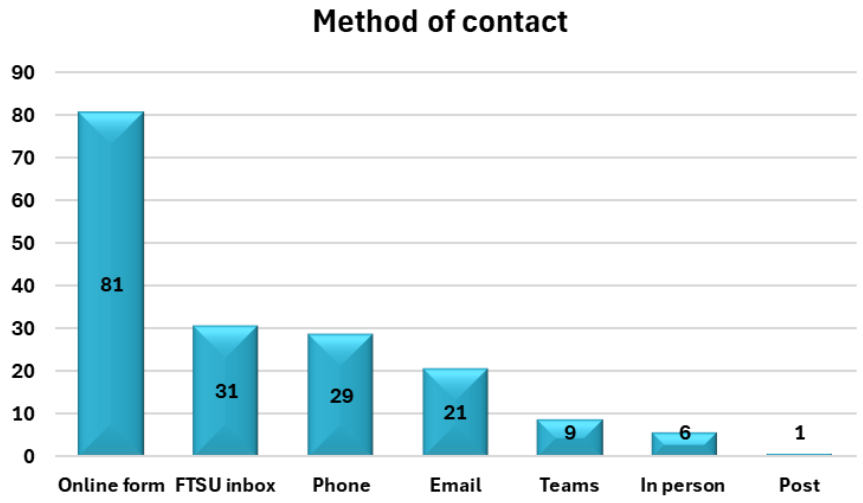


*NB: Number of issues was counted interchangeably with number of PSU. The trajectory therefore is steeper than appears

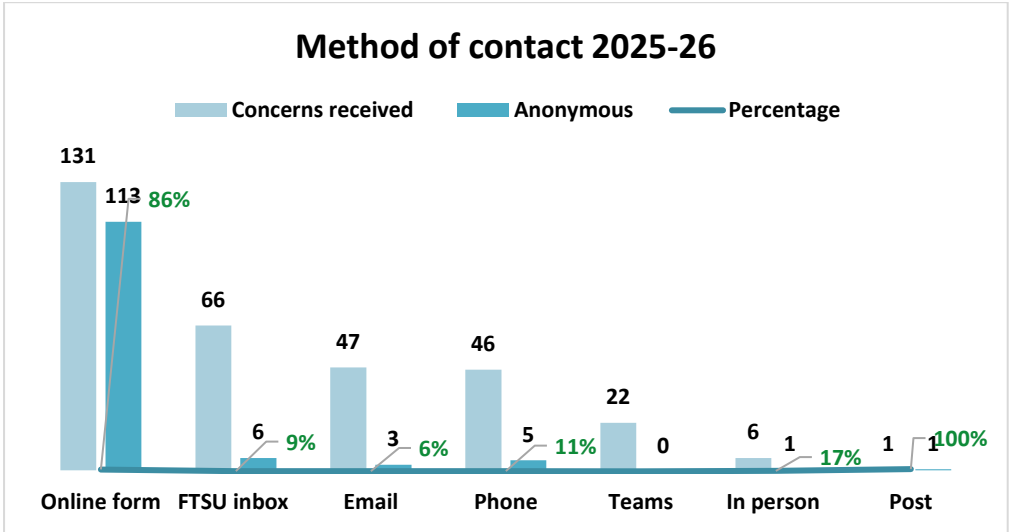
4. *Speaking Up by professional / worker group*

Number of PSU by professional / worker group	01 April 2025 – 31 March 2026
Additional Clinical Service – support clinical roles, HCAs, call operators	26
Additional Professional Scientific/ Technical – Social workers, pharmacy, psychology	11
Administrative & Clerical	**63**
Allied Health Professionals	**30**
Estates and Ancillary	8
Medical and Dental	4
Nurses & Midwifery	**49**
Students	2
Other	2
Not Known / Anon	**124**
Total number of colleagues Speaking Up through FTSU	**319**

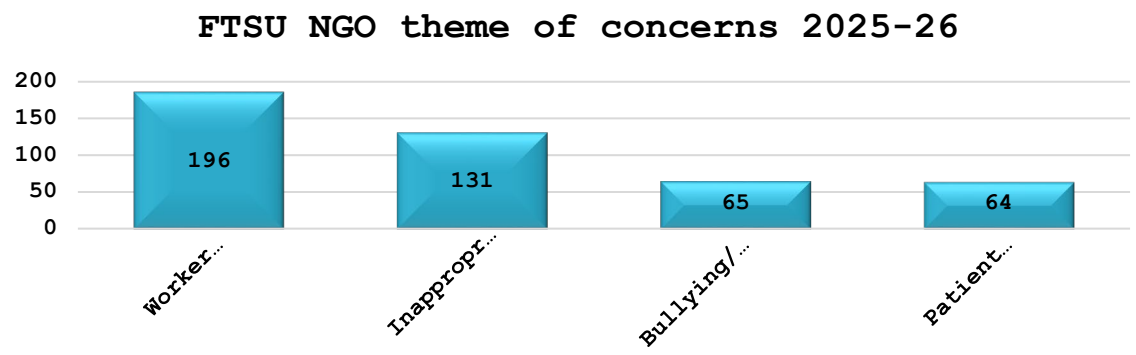
5. *Method of contact*



6. *Method of contact*

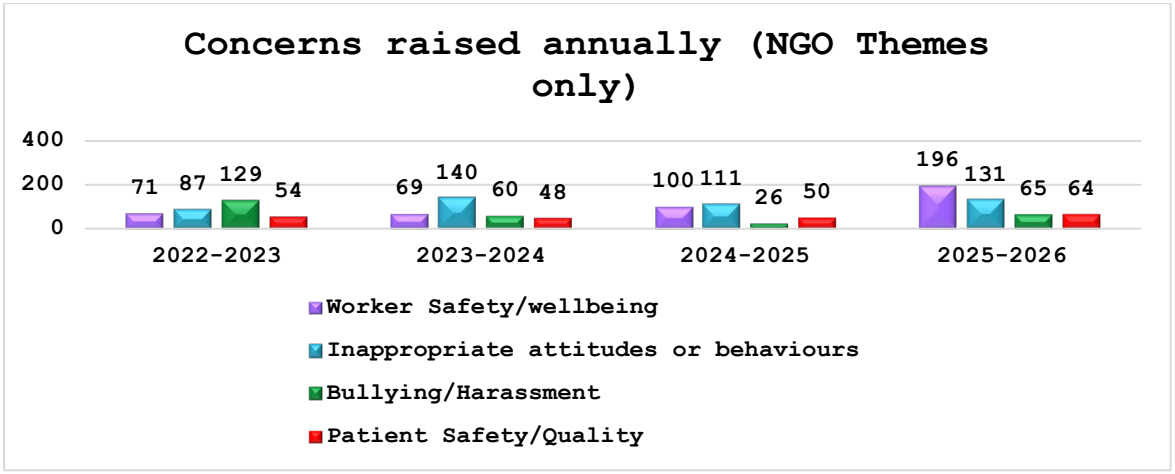


7. *Themes and issues raised through the FTSU service (NGO themes)*

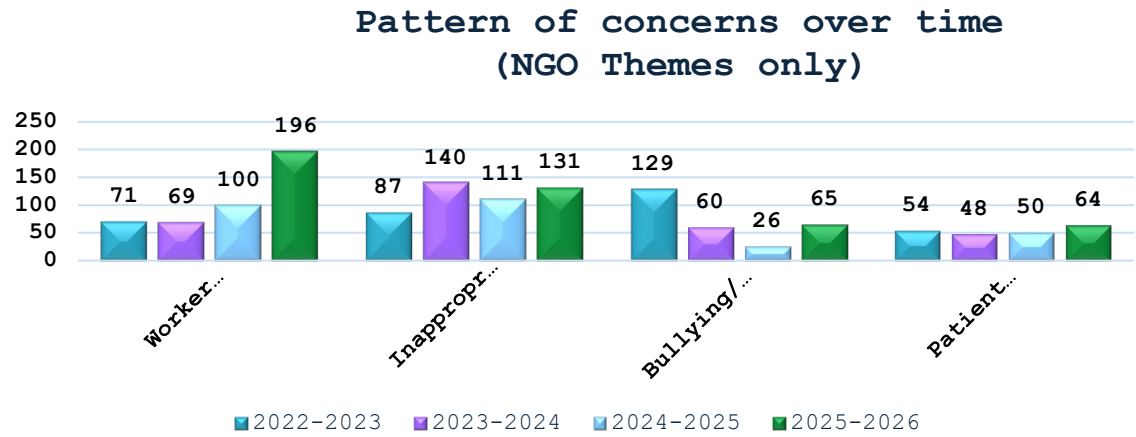


NB: PSU raise multiple issues, therefore the number of issues raised is higher than the number of PSU.

8. *Concerns raised through the FTSU service over time (NGO themes only)*



9. *Pattern of concerns raised over time (NGO themes only)*

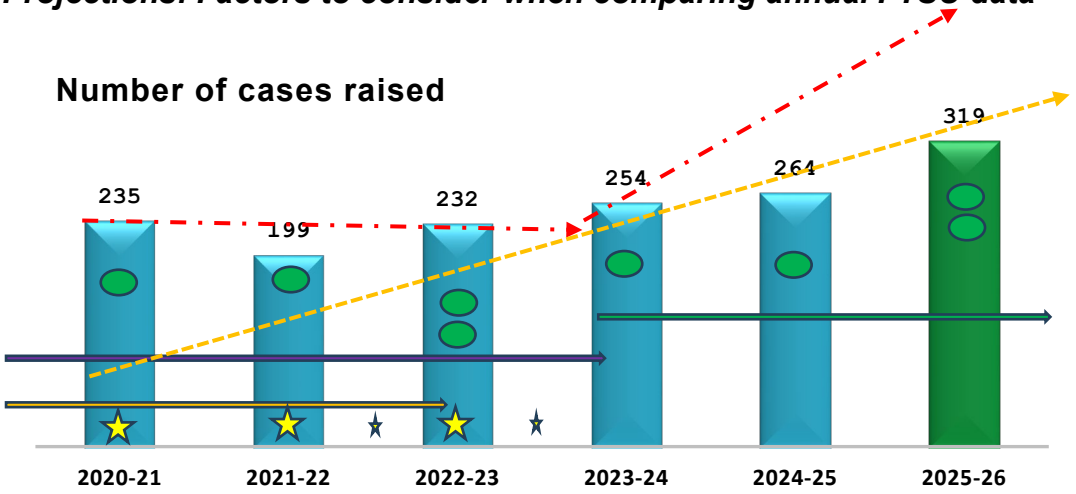


10. *Open FTSU cases*

FTSU Cases	*Open*	*Pre-2025-26* *Longest open cases*	*2025 – 26*			
31.03.26 (end Q4)	20	2	18			
		07.01.25	Q1 – 2	Q2 – 4	Q3 – 7	Q4 - 5
30.09.25 (end Q2)	291	219	72			
		27.07.23	08.04.26			

APPENDIX TWO FTSU DATA

1. *Projections: Factors to consider when comparing annual FTSU data*



The data does not reflect the true picture of the FTSU Guardian service.
On paper it would appear the number of PSU through the FTSU Guardian service over time gradually increased. However, prior to Q2 2023, the number of issues was reported on rather than the number of PSU. And as each PSU more often raises multiple issues, the increase in PSU / issues raised has increased more dramatically first appears.

A new Guardian was appointed annually during the first few years of introducing the FTSU service, and the number of cases reported on remained relatively low and were largely anonymous (therefore no one to feedback to). The number of cases rose considerably in 2020-21 (covid time). [See Appendix 1. Figure 3]

[Appendix 2. Figure 1 above shows] There was no increase in Guardian resource to withstand this until the Guardian was replaced by a further two new Guardians in 2022-23. Each Guardian restart involved a steep learning curve and variations in reporting / documentation curves whilst the service largely restarted from ground zero each time. In addition, from 2020-21 FTSU Champions were appointed. However, the terms Champion and Guardian were used interchangeably causing some confusion and the data reporting from 2020 – Q2 2023 including a mix of issues and pathways. The 2020 champion network gradually wound down before reignition in 2022-23.

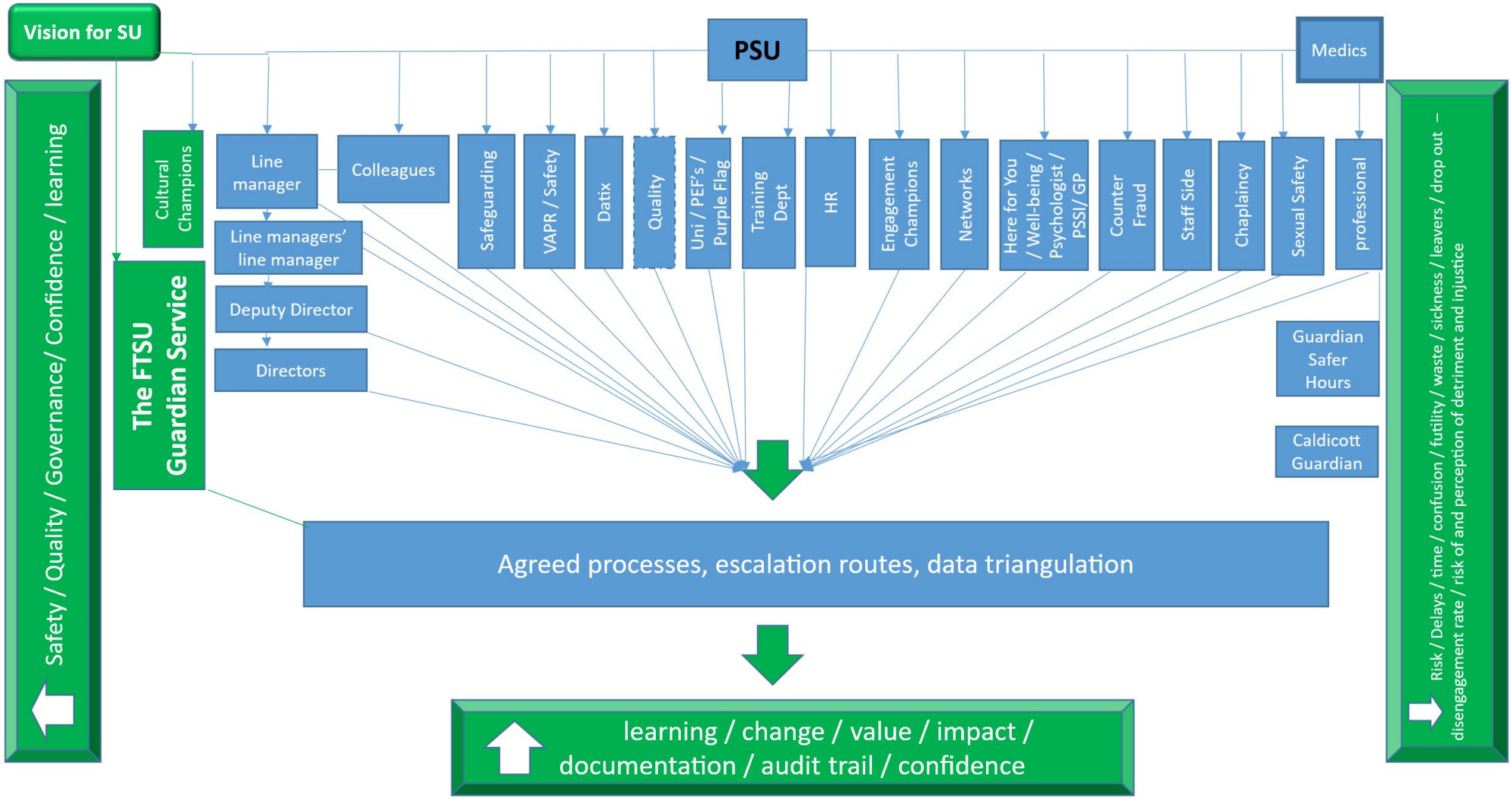
By Q2 2023, the champion network was non-existent, moved out of the Workforce Directorate and the two insitu Guardians were replaced and reduced to one solo new-to-the-trust Guardian. Due to increasing demand and priority need to stabilise the service, no FTSU Champion network has been re-introduced since. Guardian (and manager / ER) capacity to meet the increasing need and demand to respond to concerns raised has to balance and offset any increased visibility and roadshow raising awareness campaign.

If the data were cleansed and reset to include consistent data reporting to provide a clearer picture of how the FTSU service was / is being used, then we need to look at either the number of PSU or the number of issues and concerns raised. The NGO directive is to report on the number of PSU to a Guardian. But if we look at:

1) *individual PSU to a Guardian (NGO directive).* The yellow dashed arrow trajectory line would start lower in 2020 rising up to Q2 2023 where only the number of PSU to the Guardian has since been recorded (regardless of how many issues and concerns they are raising).
2) *the number of issues and concerns raised.* The red dashed arrow trajectory line would start higher in Q2 2023 and has continued to rise and become more complex since.

One Guardian held the service from Q2 2023 - Q1 2025 with rising numbers of PSU and complexity of cases. A second Guardian was appointed and helped cover until year end. The service is now run single-handed with a projection of rising numbers of PSU with greater complexity of displaced issues.

Appendix 3 Proposed Trust wide Speak Up Model



7.4 LEARNING FROM DEATHS Q3 2025-26

Discussion Item AS

REFERENCES

Only PDFs are attached

Learning from Deaths Q3 2025-26 03.06.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	03 June 2026

Report Title:	**Learning from Deaths Q3 2025/26**					
Executive/ Non-Executive Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Michelle Bourner, Senior Project Lead - Mortality					
Report discussed previously at:	Learning from Deaths Oversight Group, Learning Oversight Sub-Committee, Quality of Care Group and Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
To present the final draft *Q3 2025/26 Learning from Deaths – Quarterly Overview of Learning and Data* report, which includes the following: • Data relating to deaths recorded on Datix for Q3 2025/26 (01 October – 31 December 2025) • Summary of progress of reviews of deaths occurring in previous periods • Examples of key learning and actions arising from the review of deaths under various methodologies since the last report to the Board.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required
The Board of Directors is asked to: • Note the information presented • Note the assurance provided by the content of this report that there are robust processes in the Trust in line with national guidance to review deaths appropriately, forming part of the Trust's processes for continually reviewing care and ensuring that patients are receiving safe, high quality services • Request any further information or action

Summary of Key Points
The report presents the data which the Trust is nationally mandated to report to Public Board meetings on a quarterly basis, i.e. the number of deaths in scope; the number reviewed and level of those reviews; and the assessment of problems in care. The report also provides an overview of key learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements and actions being taken as a result. This learning is presented in detail on a monthly basis to the Trust's Learning from Deaths Oversight Group and/or Learning Oversight Sub-Committee. There are immediate actions taken as a result of learning identified, as well as longer term actions that form part of the Trust's Safety Improvement Plans.

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

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

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

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

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

Supporting Reports / Appendices / for further reading

Q3 2025/26 Learning from Deaths – Quarterly Overview of Learning and Data Report

Executive Lead:

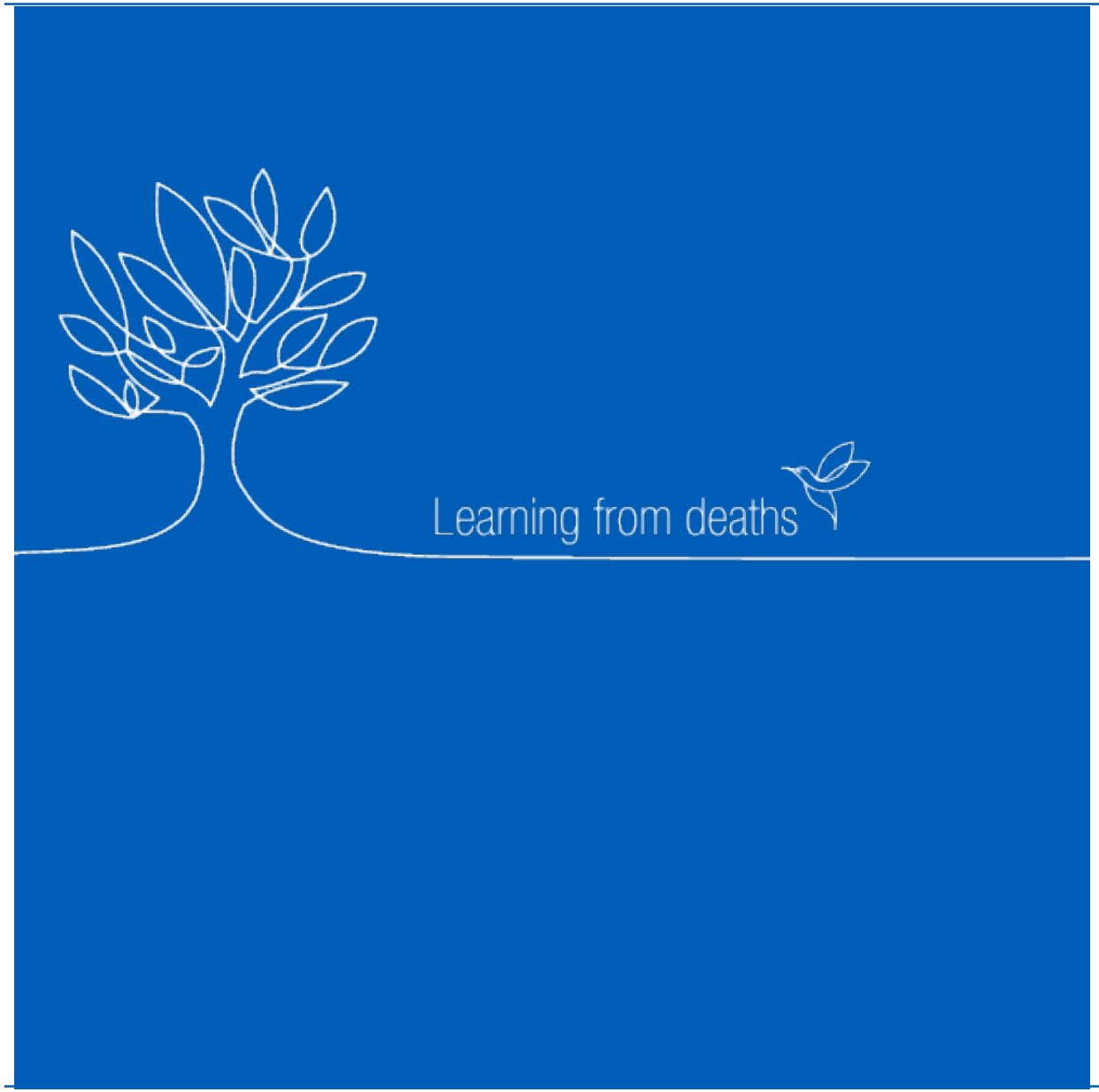
Ann Sheridan
Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

QUARTERLY OVERVIEW OF LEARNING AND DATA

Learning from deaths

QUARTER 3 - 2025/26



CONTENT OF THE REPORT

- Summary of Quarter 3 2025/26 mortality data
- Summary of progress with reviews of deaths occurring in previous periods
- Summary of data 2020/22 – 2025/26
- Key learning themes
- Breakdown of death reviews closed

Summary of Quarter 3 2025/26 mortality data (as at 09/02/26) (Page 1)

Total number of deaths reported: There were a total of 197 reports of deaths made on Datix (the Trust's incident management system), relating to 189 deaths for Q3 2025/26 (these include those not falling within the scope for mandatory reporting).

To date, of the 189 deaths, the following were deemed in scope for mandated reporting under the Learning from Deaths Policy:

- 6 inpatient deaths and 10 nursing homes deaths (see below)
- 8 Learning Disability / Autism client deaths (see below)
- 14 Essex Drug and Alcohol Partnership (EDAP) client deaths
- 8 were deaths requiring review under the Patient Safety Incident Response Framework (PSIRF)

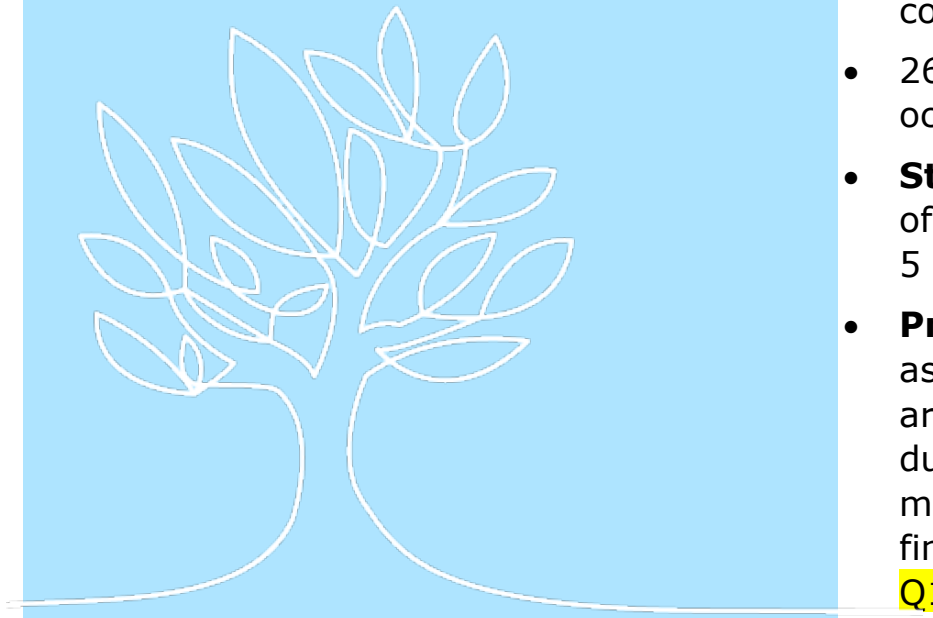
Statistical Process Control is utilised to monitor the number of deaths reported on Datix and the number of deaths in scope to identify any areas of concern for action. This indicates that the figures for Q3 are within usual parameters.

Inpatient / nursing homes deaths: Of the 189 deaths reported in Q3, 4 were EPUT community health services inpatient deaths, 2 were EPUT mental health services inpatient deaths, and 10 were EPUT nursing home deaths. All these deaths have been confirmed as expected natural causes deaths, with the exception of one mental health inpatient services death, which has been confirmed as unexpected natural causes.

LeDeR reporting validation: 7 of the 8 reported Learning Disability / Autism deaths have been confirmed as reported to the national LeDeR Programme – a programme aimed at learning from the lives and deaths of people with a learning disability and autistic people. Confirmation is awaited for the remaining death

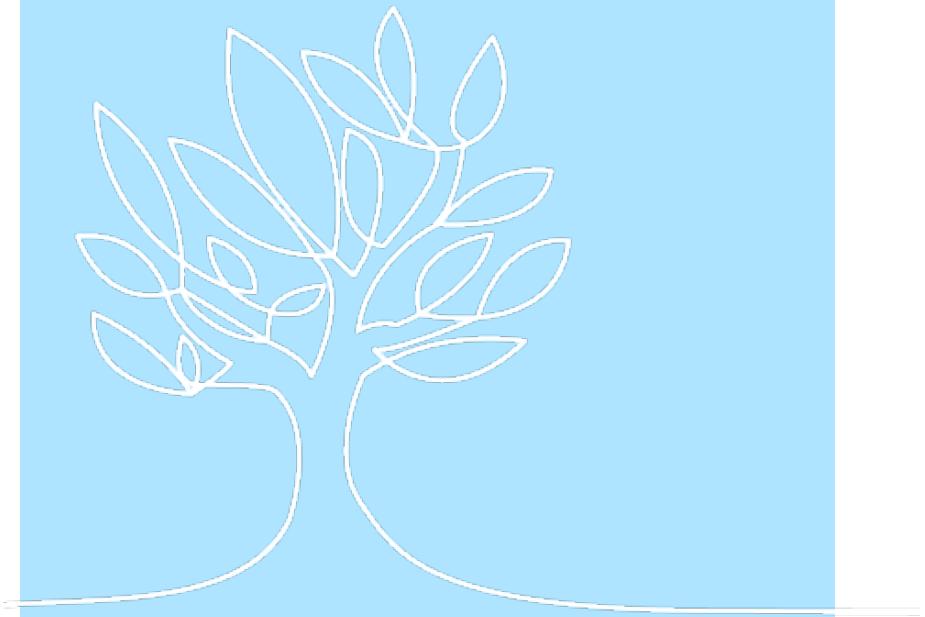
.

Summary of Quarter 3 2025/26 mortality data (as at 09/02/26) (Page 2)



- **Stage 1 (Datix) reviews:** To date, a total of 151 Stage 1 learning from deaths reviews have been conducted by a local service manager in respect of the Q3 deaths. A total of 29 Stage 1 reviews are recorded as outstanding. Targeted work continues to ensure timely completion of Stage 1 reviews, monitored weekly by the Emerging Incidents Review Group.
- **Stage 2 (clinical case note) reviews:** A total of 0 deaths in Q3 have been identified to date for Stage 2 mortality clinical case note review / thematic review.
- **Decision Monitoring Tools (DMT):** The number of deaths referred for Stage 2 review is low as care units will often commission immediate completion of a Decision Monitoring Tool (DMT) or SWARM which is designed to assist a decision in terms of any PSIRF review required (see below). A completed DMT enables identification of learning and actions; and thus, where a comprehensive DMT has been completed, it is often deemed that completion of a Stage 2 review in addition would be unnecessary duplication.
- 26 DMTs have been commissioned to date for deaths occurring in Q3. A total of 4 deaths occurring in Q3 have so far been closed at DMT stage.
- **Stage 3 (Patient Safety Incident Response Framework - PSIRF) reviews:** A total of 8 deaths in Q3 have been identified to date for PSIRF review. All are still underway. 5 of these were PSIIs. During Q3 1 PSII was approved, commissioned on 29/05/2025.
- **Problems in care assessment:** There are 0 deaths for Q3 thus far that have been assessed as being more likely than not due to problems in care by EPUT. Where deaths are deemed via Stage 1 or Stage 2 methodologies to be potentially more likely than not due to problems in care, they are referred for review under PSIRF. A ~~l~~ocal approach to making this determination for deaths reviewed under PSIRF arrangements is being finalised as there is no national methodology in place for this; and will be implemented in Q1.

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



Since the Q2 report to the Board of Directors, the following progress has been made with reviews of deaths occurring in previous periods (as at 09/02/26):

- An additional 44 Stage 1 (local care unit) reviews have been completed
- An additional 72 Stage 1 reviews have been considered through care unit governance processes and agreed for closure at that stage
- An additional 22 deaths have been closed following completion of the Trust's DMT.
- 2 Stage 2 reviews have been approved
- 15 PSIRF reviews have been approved
- All Stage 1 reviews previously reported as awaiting completion for 2023/24 – 2024/25 have been completed. The number of outstanding Stage 1 reviews for completion for Q1 and Q2 2025/26 has reduced from 30 to 6.

High level summary data 2022/23 – 2025/26

Table 1: SUMMARY OF MORTALITY DATA (UPDATED AS AT 09/02/2026 FOR DEATHS REPORTED TO END JANUARY 2026)	2025/26 YTD (Q1-Q3)	2024/25	2023/24	2022/23
TOTAL DEATHS REPORTED ON DATIX / DEATHS IN SCOPE				
Total death reports on Datix	523	690	731	*
Total death reports on Datix (duplicates removed)	509	660	694	520
Total deaths reported on Datix confirmed in scope of learning from deaths policy to date	102	163	258	249
Total inpatient deaths **	17	23	24	23
Total nursing homes deaths	23	19	23	19
Total Learning Disability deaths (referred to LeDeR (national learning disability review programme)	20	26	30	17
LEVEL OF REVIEW				
Total death reports for which Stage 1 review awaited	35	0	0	0
Total deaths closed at Stage 1 review to date	255	465	509	322
Total deaths closed at DMT to date (included from Q2 2025/26 report onwards)	28	55	27	0
Total deaths referred to date for Stage 2 review (either individual clinical case note review or thematic review)	2	3	11	70
Total deaths referred to date for Stage 3 review (Patient Safety Incident Response Framework (PSRIF) review)	26	54	80	80
ASSESSMENT OF LIKELIHOOD OF PROBLEMS IN CARE				
Assessed as more likely than not due to PIC ***	0	0	0	0
Assessed as not more likely than not due to PIC	312	534	565	389
Not applicable (EDAP and LeDeR reviews utilising different methodology)	36	53	71	51

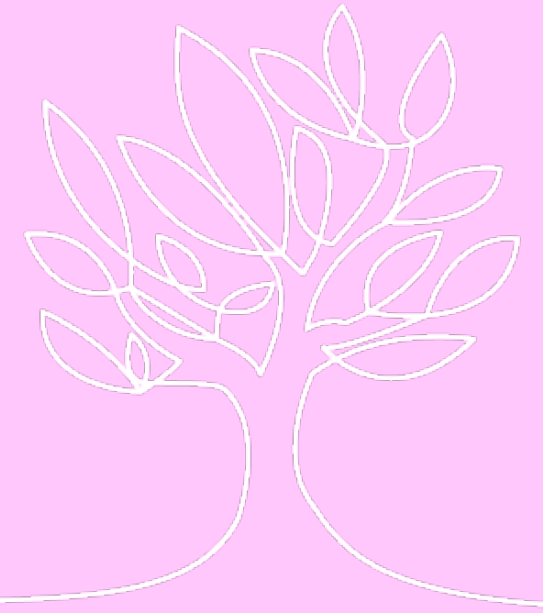
* Data collated using number of deaths only for 2022/23

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

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

Key learning themes emerging from Stage 1 reviews (Page 1)

December 2025 – February 2026



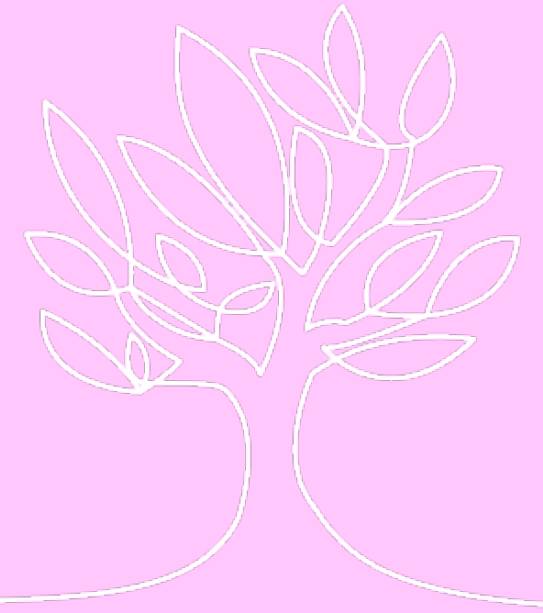
The three most common themes emerging from Stage 1 reviews of deaths in the period are detailed below. These remain consistent with themes identified in previous quarters, recognising that the majority of deaths occurring under the care of the Trust's teams are from physical health causes and many are expected deaths of patients in receipt of end of life care.

Theme 1: Recognition that the majority of the deaths reviewed are from **physical health causes** (e.g. long-term conditions, terminal illness, physical health crisis, deaths in acute trust hospitals) (cited in the learning in 22 reviews). The Trust has a specific workstream in place to strengthen physical health monitoring and how the Trust can support / contribute to the physical health care of patients. Work being undertaken includes strengthening and monitoring approaches to ensuring annual health checks of patients with Severe Mental Illness; enhancing skills and competencies of mental health staff in relation to physical health using the national competency framework and bitesize training; and commencement of a "model ward" QI project to trial the implementation of the various physical healthcare developments in a small number of wards, reviewing and progressing to roll-out.

Physical health in mental health patients is to become a safety improvement theme for 2026/2028.

Key learning themes emerging from Stage 1 reviews (Page 2)

December 2025 – February 2026



Theme 2: Recognition that many of the deaths of patients are **expected deaths of patients often receiving end of life care** (cited in the learning in 21 reviews). Again, the Trust has a specific workstream in place designed to monitor the quality of end of life care provided by the Trust and to ensure this is strengthened, including quality audits reported via the Trust's governance structures. An example of developmental work being progressed, in response to learning from deaths, is joint work with the hospices to develop pathway guidance for East of England Ambulance Service Trust staff to support appropriate responses when ambulances attend calls to patients on end of life care.

Theme 3: For a number of deaths reported on the Trust's information system, it was identified that there was **no cause of death available** at the point of reviewing the death (cited in the learning of 12 reviews). This obviously limits the identification of detailed learning. Work is underway with Essex County Council's Registry Service to secure appropriate information in terms of confirmed causes of death which it is anticipated will strengthen the Trust's ability to review and learn from deaths.

Other learning issues emerging from Stage 1 reviews during this period included referral of the death for a further level of review based on the Stage 1 review findings; opportunities to strengthen communication with partner agencies and with families; and clinical care including timely follow up of patients, risk assessments, risk planning, and routine scheduling of next appointments.

There were also a number of good practice examples cited in reviews including clear evidence of joint working with alcohol services and appropriate use of funded care; prompt action taken in response to situation on home visit; engagement with patient and maintenance of independent living at home providing a strong foundation for tailored support; and contact with patient whilst awaiting assignment of therapist and appropriate follow-up of failure to attend appointment.

Learning from PSIRF reviews is included in the Patient Safety Strategy to prevent duplication of reporting.

Key learning themes emerging from Stage 2 reviews (Page 1)

Approved December 2025 – February 2026

The following two pages highlight key learning from Stage 2 reviews that have been approved during the period December 2025 – February 2026. Deputy Directors of Quality and Safety in the relevant care units will be working with operational services to ensure the actioning and embedding of learning identified.

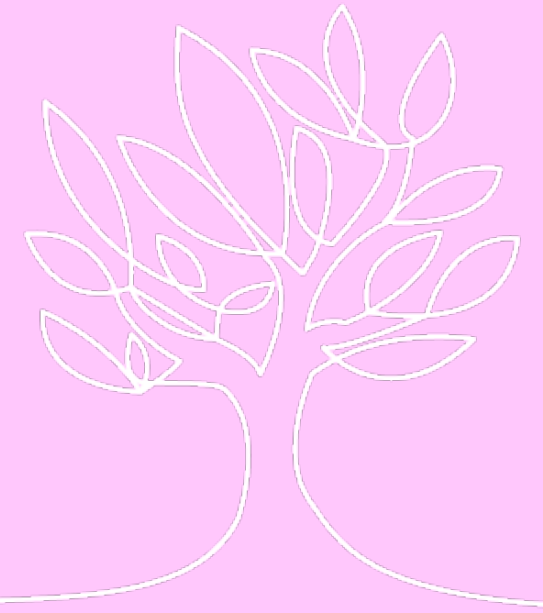
Community Physical Health Services:

- Ensuring timely and robust assessment undertaken in early phase of wound care, with clear escalation and referral pathways in place
- Ensuring improved documentation standards to support continuity and on-going review, particularly strengthening communications and documentation during transitions especially into large community teams
- Standardising wound assessment guidelines across different clinical systems / apps in use
- Ensuring timely requests, readiness and availability for equipment

The above learning was addressed immediately by awareness raising and education across the community teams; together with changes to functionality of the app in use and strengthening of the osteomyelitis assessment protocol to ensure that high risk patients receive timely face to face evaluations and diagnostic investigations.

Key learning themes emerging from Stage 2 reviews (Page 2)

Approved December 2025 – February 2026



Community Mental Health Services:

- Improving the quality of care-coordination and monitoring of patients
- Raising awareness of diagnostic overshadowing and the need for prompt referral especially on suspicion of eating disorders in the context of co-morbidities
- Improving communication with the Physical Health team, especially in patients with co-morbidities is very important
- Awareness was raised in terms of the potential for diagnostic overshadowing in eating disorder patients through highlighting of the learning in the Trust's Learning Bulletin

Community Health Inpatient Services:

- Ensuring appropriate planning for transfer of patients from the acute hospitals to the community hospitals to prevent further deterioration of physical condition and discomfort to patient. Significant quality development work has taken place since this death in relation to physical health care in nursing homes / acute hospital discharges; and actions planned by the care unit in response to this learning will take into account the developments already undertaken

Key learning themes emerging from Stage 3 reviews (PSIRF)

Approved December 2025 – February 2026

- Collateral information and documentation: Incomplete collateral info; document attempts and outcomes even if care unchanged
- Care step-down rationale: Lack of explicit rationale when stepping down care
- Admission/HTT consideration and supported transfers: Ensure support when admission/HTT considered; post-incident change already implemented
- MDT Coordination and information sharing
- Clarity of clinical pathways and consistent implementation
- Post-diagnostic support standards
- Staff training and competency in capacity assessment and working with substance misuse
- Quality assurance and adherence to care standards
- Clinical record-keeping
- Escalation and crisis response
- Risk management and observation practice
- Communication of high-risk events
- Clinical equipment competency

Analysis of information on deaths reported on Datix (as at 23/02/26) occurring from 01/04/22 – 31/12/25 for which the reviews were closed in 2025

Level of closure	Total	As a %	Summary
Stage 1 - out of scope	71	8%	Stage 1: 73%
Stage 1 - expected death no concerns	203	23%	
Stage 1 - unexpected / unknown but no criteria for further review met	366	42%	
Decision Monitoring Tool	103	12%	DMT: 12%
Stage 2 - individual mortality case note review	5	1%	Stage 2: 2%
Stage 2 - unexpected death of inpatient in last 30 days	1	-	
Stage 2 - thematic review	8	1%	
Care Unit After Action Review (AAR)	2	-	Local PSIRF: 3%
Care Unit Multi-disciplinary Team Review (MDTR)	26	3%	
Stage 3 PSIRP	43	5%	Stage 3: 5%
Essex Drug and Alcohol Partnership multi-agency collaborative review	48	5%	EDAP: 5%
TOTAL DEATH REVIEWS CLOSED 2025	**876**	**100%**	**100%**

Type of death	Total	As a %
Out of scope	1	-
Expected Natural	225	26%
Unexpected Natural	239	27%
Expected Unnatural	2	-
Unexpected Unnatural	180	21%
Unknown	222	25%
Under Determination	7	1%
TOTAL	876	100%

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

7.5 CQC ASSURANCE REPORT

Information Item AS

REFERENCES

Only PDFs are attached

CQC Assurance Report 03.06.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	3 June 2026

Report Title:	**CQC Assurance Report**					
Executive/ Non-Executive Lead:	Ann Sheridan, Executive Chief Nurse					
Report Author(s):	Nicola Jones, Director of Risk and Compliance					
Report discussed previously at:	Quality of Care 12 May 2026, Quality Committee 14 May 2026					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

- EPUT continues to be fully registered with the Care Quality Commission.
- The CQC Well Led inspection of EPUT has taken place and the Trust awaits the draft report.
- The final report for the Mental Health Long Stay Rehabilitation Unit was published with a rating of 'Requires Improvement'.
- The final report for CHS Inpatients was published with a rating of 'Good'
- The Trust has received the draft reports following unannounced visits to Ardleigh Ward (January 2026) and CAMHS (February/March 2026) for factual accuracy.
- The CQC Improvement Plan (v02) continues to be implemented. There are currently 16 CQC concerns being taken forward and as of the end of April 2026, 73 sub-actions identified for the CQC actions.
- There were four (4) CQC enquiries raised during this reporting period.
- The overall compliance against CQC quality statements remains 'Good,' based on information available from internal compliance programme and utilising the CQC scoring methodology.

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

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

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

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	EAG	Evidence Assurance Group
ICB	Integrated Care Board	EPUT	Essex Partnership University Trust

CAMHS	Child and Adolescent Mental Health Services		

Supporting Reports/ Appendices /or further reading

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

Lead

Ann Sheridan
Executive Chief Nurse

CQC Assurance Report – June 2026

1. Purpose of the report

This report provides the Board of Directors with:

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

2. CQC Registration Requirements

2.1. Registration

EPUT is fully registered with the Care Quality Commission. No registration changes made during this reporting period.

3. CQC Inspections and Improvement Plans

3.1. Well Led Inspections

The CQC undertook the Well Led inspection of EPUT in March 2026, the final report is awaited, with initial feedback provided being focused on our engagement and inclusion which is much aligned with the Trust cultural review.

3.2. CQC Unannounced inspection

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

Following the CQC unannounced visit to 439 Ipswich Road in November 2025 and associated Section 29A warning notice, the final report was published on the 8 April 2026 with a rating of 'Requires Improvement'. As required the Trust wrote to the CQC on the 30 April 2026 to outline improvements made and we await feedback / further inspection from the CQC of the unit.

As discussed at the April Board meeting, there was an opportunity arising out of a prior Quality Assurance Visit to take action on the issues identified. On review, the internal visit identified issues and appropriately escalated to the Care Unit leadership. The process followed our usually pattern of the action owner providing confirmation that actions had been completed. Unfortunately, the management declared action complete had not gone far enough to resolve the issues and, in some instances, not at all (e.g. the shed). The compounding factor in this instance is the fact that, in the Autumn of last year to January 2026, we refocused our Compliance Team to support a complex and large in scope Rule 9 issued from the Lampard Inquiry, and as such the compliance review of actions complete did not happen prior to the CQC inspection being undertaken. Whilst this reinforces the value of an independent team reviewing evidence prior to closure of improvement actions, it also shows the unintended consequence of needing to prioritise focus in this challenging time.

3.2.2. Community Health Inpatients (December 2025)

Following the CQC unannounced visits to Avocet Ward and CICC, the final report was published on 28 April 2026 with a rating of 'Good'.

3.2.3. Ardleigh Ward (January 2026)

Following the CQC unannounced visit to Ardleigh Ward in January 2026, the Trust has received the draft report for factual accuracy.

3.2.4. CAMHS (February/March 2026)

Following the CQC unannounced visit to Poplar Ward in February, Longview Ward and Larkwood Ward in March 2026, the Trust has received the draft report for factual accuracy.

Next steps from recent inspection activity are to review the final report develop further actions to address any identified gaps.

3.3. CQC Improvement Plan

Progress continues against the CQC Improvement Plan (v02).

As of end April 2026, sixteen (16) regulatory and improvement actions made up of 73 sub-actions have been developed to address the CQC recommendations.

Of the 73 sub-actions

- 1 is in recovery (Activity Cancellation KPI reporting)
- 3 are on track
- 57 reported as complete, evidence pending
- 11 Complete evidence received, not yet assured
- 1 has been closed through the evidence assurance process.

3.4. CQC Enquiries

During the reporting period (February/March 2026), the CQC raised four (4) enquiries as outlined below. Concerns and enquiries raised by the CQC are managed via the PALS process and where requested, via a director or Executive.

Received	Service	Enquiry related to
02/03/2026	North/West Essex ADHD Heath Close, Billericay	Systems & Procedures / Waiting Lists/Times
12/03/2026	First Response Team Basildon Mental Health Unit (MHU)	Communication / Communication breakdown with patient
24/03/2026	ADHD Psychological Services - MSE The Linden Centre	Systems & Procedures / Waiting Lists/Times
31/03/2026	Mid and South Essex Adult ADHD Service the Linden Centre	Systems & Procedures / Waiting Lists/Times

3.5. CQC Notifications

All providers are required to notify the CQC of key events and during the reporting period, the Trust made nine (9) notifications to the CQC including:

- Death of a person using the service (4)
- Serious injury to a person using the service (3)
- Abuse (2)

4. Assurance against CQC Quality Statements

4.1. Internal Assurance Programme

The Trust CQC assurance framework is a key component to the Trust Quality Assurance Framework (QAF) under the Quality Assurance domain. This includes:

- Service Self-Assessment: This ensures each ward and service understands the CQC regulatory requirements, how these are achieved and to inform ward/service improvement plans. This is undertaken through the suite of Tendable (quality control audits) and the clinical audit programme.
- Internal Insight: Using the information available across the Trust, alongside an internal programme of on-site inspections, to evaluate adherence with the CQC Quality Statements and regulatory requirements. Gaps in assurance are used to inform improvement plans

- CQC Inspection: Utilise outcomes of CQC inspection activity to identify areas of shared learning and improvement action required.

- Programme of joint quality assurance visits to service areas: This enables assurance of quality of care and triangulation with other known intelligence on the quality of care.

The 2025/26 programme has concluded and the 2026/27 programme approved. Focus in the 2026/27 will be:

- Service Self-Assessment: Exploring mapping Tendable audits to CQC domains for enhance triangulation.

- Internal Insight: Continue developing and enhancing the Quality Statements Assurance Framework seeking to utilise technology to better assist with triangulation. Following review of intelligence gathering from the 2025/26 programme we will be focusing on the safe and well lead domains for 2026/27.

- CQC Inspection: Delivery and testing of CQC improvement plans.

- Programme of joint quality assurance visits to wards and services: The visit framework is to be reviewed in alignment with the one Essex ICB.

4.2. Internal Assurance (Quality Statements Assurance Framework)

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

Reviews in the period found no significant gaps through current assurance sources, noting ongoing development of triangulation.

4.3. Internal Assurance (Annual Assurance Visit Programme)

The Trust annual assurance visit programme 2025/26 programme has now formally concluded, representing a year of sustained focus on strengthening compliance against the fundamental standards of care (CQC registration requirements), embedding practice improvement following external recommendations and enhancing assurance across the Trust.

Over the course of the year the 2025/26 program facilitated a more structured and proactive approach to support services in their efforts in:

- adherence to regulatory requirements.
- quality improvement; and
- their inspection readiness.

In addition, the Compliance team has continued reactive support where risks have been identified or CQC have been in attendance.

At the end of April 2026, the Trust is reporting an internal 'Good' compliance across all the domains assessed, meaning that a reasonable level of assurance has been provided by core services during Compliance visits (noting the limitations of these reviews). Internal ratings are formed through using the CQC scoring methodology to closely align with inspection programmes. Identified good practice has been shared with services and care unit leadership via Risk & Compliance reports and Accountability reports.

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

4.4. Quality Assurance Visits

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

5. Recommendation

The Board of Directors is asked to:

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

Report Prepared by:

Nicola Jones
Director of Risk and Compliance

On behalf of

Ann Sheridan
Executive Chief Nurse

7.6 MENTAL HEALTH INPATIENT BI-ANNUAL SAFER STAFFING PAPER

Information Item AS

REFERENCES

Only PDFs are attached

Mental Health Inpatient Bi-Annual Safer Staffing Paper 03.06.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	03 June 2026

Report Title:	**Mental Health Inpatient Bi-Annual Safer Staffing Paper**					
Executive/ Non-Executive Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Angela Wade Director of Nursing & Infection Prevention and Control and Ann Sheridan, Executive Nurse					
Report discussed previously at:	Quality Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

✓**please use this tick on the below**

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	The report on safer staffing provides assurance for the past 6 months in regard to inpatient mental health areas.	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Statutory Public Inquiry	✓
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	✓
	SR9 Digital and Data	
	SR10 Workforce Sustainability	✓
	SR11 Staff Retention	✓
	SR12 Organisational Development	✓
	SR13 Quality Governance	✓
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		
Are you requesting approval of financial / other resources within the paper?	No	

If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director	Ann Sheridan	May 2026
	Finance		
	Estates		
	Other		

Purpose of the Report		
The purpose of the report is to provide oversight and assurance to the Board in relation to safer staffing regulations and standards to ensure we have the right number of nursing staff, with the right skills, in the right place at the right time to deliver safe, high-quality care.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

- Confirm assurance regarding safer staffing standards
- Acknowledge progress made in relation to stage 1 of the safer staffing programme delivery and next steps.

Summary of Key Issues

Current Position

During the reporting period the Trust has continued to focus on ensuring safe and effective staffing across all mental health inpatient services, achieved through daily staffing meetings which have Executive and Director Leadership. Promoting dynamic roster management, to ensure clinical safety and good governance for the use of workforce resources, as described in detail within the previous reporting period:

- In this reporting period, fill rates for planned shifts remained above the 90% standard.
- Since October 2025 there has been a significant and sustained improvement for fill rates of registered staff both for day and night shifts and this reported at 95% for April 2026.
- The number of times during the month, per ward that the fill rate was below 90%, remains only 1 single recorded event per ward, per month. Analysis showed there was also an increased number of mental health inpatient wards with none or only 1 single occurrence in the 7 months of reporting. The mental health inpatient wards have showed an overall reduction from 15.55 to 13.86 total averaged occurrences compared with the previous reporting period.
- Risks were mitigated through daily staffing meetings providing senior clinical and professional oversight. This included the safe redeployment of staff from other areas and the use of approved temporary staffing to ensure that quality and safety were maintained.
- The Trust revised its governance arrangements for safer staffing levels in February 2025, with a further review completed in April 2026. This included the Deputy Director of Quality & Safety (DDQS), providing a central leadership role and monitoring red flags to ensure minimum safe standards of 2 registrants (with minimum 1 RMN 24/7) on shift.
- Further workforce intelligence, safer staffing BI capabilities, local clinical leadership empowerment and dedicated skilled safer staffing resource will enable improvement in the Trust's current national workforce safeguards ratings going forward.

Proposal – Part One

Development of Power Business Intelligence (BI) triangulated safer staffing and workforce data remains in development, when finalised will provide internal monthly oversight and reporting through agreed governance routes. Removal of information from the current Integrated Performance Report (IPR) to enable single data source approaches and ensure external reporting through Model Health to enable benchmarking with peer organisations and Trust obligations. This will require maximised opportunities to develop safer staffing skilled resources to meeting national requirements and elements of delivery of the safer staffing improvement plan.

Current Position - Part Two

Following Board approval in February 2026 for stage 1 of the phased roll-out of October 2025 establishment review. Progress to date is summarised as:

- Initial business case approval with focus on unregistered recruitment to reduce reliance of HCA temporary staffing
- Recruitment plan for HCA and Activity Coordinators
- Workforce oversight and monitoring
- Business case for registered staffing requirements
- Enable ring-fenced time for leadership of clinical modelling, coaching and quality improvement
- Planning of Quality Senate to focus on female mental health care
- Develop project plan and outcome measurement

Proposal – Part Two

The proposed next areas of prioritisation are:

-

- Aligning all Health Based Places of Safety (HBPoS) to host wards and transfer and alignments of budget, role, responsibilities and accountabilities.
- Cascade of model of care to all other female wards as they already sit in the next priority phase ward group.
- Brockfield House site coordination ward and realignment following specialist collaborative service reviews.
- Commence Beech older adult plan.

Conclusion and Next Steps

The Quality and People Committees will continue to seek assurance as BI safer staffing capabilities materialise and staged priority roll-out of the safer staffing development programme continues. Noting that prioritisation will be subject to update and possible amendment, as further insight is gained through ongoing triangulation of bi-annual MHOST census acuity and dependency data, triangulated with quality indicators and professional judgement. A review of the proposed implementation for year one will be assessed for impact, while developing further plans for 2027/28 and 2028/29. It is expected that the Board will receive an update on progress and outcomes as part of the next safer staffing report in six months.

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

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

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

Acronyms/Terms Used in the Report			
MHOST	Mental Health Optimal Staffing Tool	BI	Business Intelligence
DoN	Director of Nursing	HBPOS	Health Based Place of Safety
CHPPD	Care Hours Per Patient Day	CAMHS	Children, Adolescent Mental Health Services
WTE	Whole Time Equivalent	PICU	Psychiatric Intensive Care Unit
IPR	Integrated Performance report	TTC	Time to Care

Supporting Reports/ Appendices /or further reading
Mental Health Inpatient Bi-Annual Safer Staffing Paper Appendix 1: Health Based Places of Safety (HBPoS) aligned to host wards: Cedar, Christopher, Stort, (Ardleigh already prioritised for stage 1) Appendix 2: Remaining Female Wards Appendix 3: Brockfield house site coordination ward and realignment following specialist collaborative service reviews

Executive Lead

Ann Sheridan

Ann Sheridan
Executive Nurse

Introduction

Part 1 of the report presents the bi-annual safer staffing review for inpatient mental health nursing, for the period October 2025 to April 2026. Safer staffing standards enable NHS organisations to ensure they have the right number of staff, with the right skills, in the right place at the right time to deliver safe, high-quality care. The purpose of this report is to provide oversight and assurance to the Board that we are meeting the safer staffing standards and adhering to regulations in accordance with National Quality Board (NQB), NHS England safer staffing guidance and the Trust's internal governance framework, NHS England's Workforce Safeguards guidance and the Trust's internal governance framework.

Part 2 presents progress made on the stage 1 programme delivery since the annual establishment review was presented to Board in February 2026 and then details the proposed areas of focus for stage 2.

Part 1. Safer Staffing Reporting

To assess safer staffing requirements, this report draws on the Trust's available integrated performance data. Based on the review of available data for the reporting period, the following conclusions have been drawn:

Key Findings

Staffing Levels: The findings demonstrate that actual fill rates for planned shifts remained above NHS reporting standards of 90%. Additionally, since October 2025 there has been a significant and sustained improvement of fill rates for both day and night shifts for registered nurses (chart 1 and 2).

The number of times during the month, per ward that the fill rate was below 90% remains a single recorded event per ward when this occurred (Table 1 and 2).

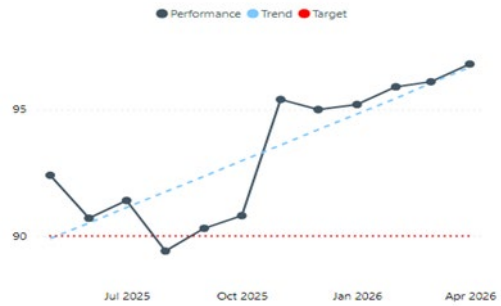
For mental health inpatient areas 5 wards: Chelmer, Kelvedon, PBU, Roding and Stort had no occurrences in the reporting period, and 5 wards only had 1 single occurrence in the 7 month period. This meant that there has been an overall reduction from 15.55 to 13.86 total averaged occurrences compared with the previous reporting period.

For specialist wards, Edward House and Woodlea Clinic have had no occurrences since November 2025, and the total averaged occurrences have remained static compared to the previous report 9.22 and 9.42 respectively.

The areas where 90% was not achieved on these single times in the month, risks were mitigated by the local care unit clinical leaders and assurance provided to the Directors of Nursing through daily staffing meetings to maintain senior clinical and professional oversight. This included the safe redeployment of staff from other areas and the use of approved temporary staffing to ensure that quality and safety were maintained.

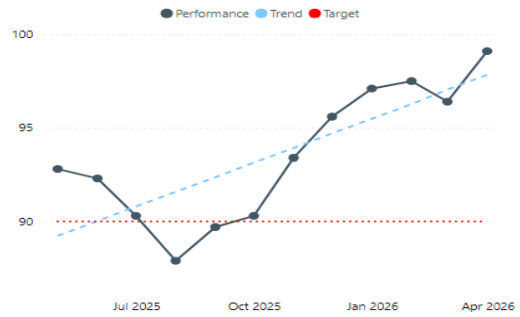
Charts 1 and 2 below show a trend of sustained improvement. Substantive recruitment to core registered nursing posts has been a positive contributory factor to achieving this.

Chart 1. Registered nursing staff day fill rates 90% or over.



Integrated Performance Report
Data as of 21/05/26

Chart 2. Registered nursing staff night fill rates 90% or over.



Integrated Performance Report
Data as of 21/05/26

Table 1. Inpatient wards which had occurrences of fill rates under 90% October 25 to April 26

Care Unit	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026
Inpatient & Urgent Care	**16**	**13**	**14**	**13**	**12**	**16**	**13**
439 Ipswich Road							1
Ardleigh Ward	1	1	1		1	1	1
Basildon Mhau	1	1	1	1	1	1	1
Beech (Rochford)				1	1	1	1
Cedar	1	1	1	1	1	1	1
Chelmer Ward							
Cherrydown							1
Christopher Unit						1	
Clifton Lodge			1	1	1	1	1
Finchingfield Ward	1	1	1	1	1	1	1
Galleywood Ward	1	1		1	1	1	1
Gloucester	1	1	1	1	1	1	1
Gosfield Ward	1	1			1	1	
Hadleigh Picu	1		1	1			
Henneage Ward	1	1	1				
Kelvedon	1						
Kitwood Ward	1	1	1	1	1	1	1
Meadowview	1	1	1	1			1
Peter Bruff Unit							
Rawreth	1	1	1	1		1	1
Roding Ward							
Ruby Ward	1	1	1	1	1	1	
Stort Ward							
Topaz Ward	1	1	1	1	1	1	
Tower	1		1			1	
Willow						1	

Total number of times fill rates were under 90% in month for the care unit

Number of times during the month on the ward that the fill rate was below 90%

Table 2. Specialist wards which had occurrences of fill rates under 90% October 25 to April 26

	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026
Specialist	**10**	**9**	**9**	**8**	**11**	**11**	**8**
Alpine	1		1		1	1	
Aurora			1	1	1	1	1
Byron Court / Heath Close	1		1	1	1	1	1
Causeway	1	1	1	1	1	1	
Dune	1	1	1	1	1	1	1
Edward House	1						
Forest		1		1	1	1	1
Fuji	1	1	1		1		
Lagoon	1	1				1	
Larkwood		1	1	1	1		
Longview	1	1	1	1	1	1	1
Poplar	1					1	1
Rainbow Unit		1	1	1	1	1	1
Robin Pinto Unit	1	1			1	1	1
Woodlea Clinic							

Integrated Performance Report
Data as of 21/05/26

Daily Oversight Meeting: The Trust revised its governance arrangements for safer staffing levels in February 2025, with a further review completed in April 2026 to refine the process.

Red Flag Shifts and Mitigation Actions: A red flag shift is defined as any shift where fewer than two registered nurses are present on duty in an inpatient mental health ward. During this reporting period, the daily staffing call reviewed all shifts which showed 1 registered staff and ensured this was addressed with mitigation of cover from senior staff such as ward manager or matron, or by moving staff from other wards if the shift was unfilled through bank requests. Daily safer staffing meetings provide senior clinical and professional oversight of planned vs actual shift fill, monitoring red flags to ensure minimum safe standards of 2 registrants (with minimum 1 RMN 24/7) on shift chaired by Directors of Nursing.

This meeting includes daily oversight at care unit management level, with the Deputy Director of Quality & Safety (DDQS) providing quality oversight in their leadership role. Which is then supported by weekly executive oversight and established escalation mechanisms. The primary purpose of the executive weekly oversight is to ensure that safe staffing levels are consistently maintained and that timely support can be mobilized when risks are identified. In addition, a weekly executive-chaired meeting, held every Thursday, reviews staffing performance over the previous seven days and undertakes a further seven-day forward review and approval process (Table 3).

Table 3 below provides an example used during the daily staffing call to review each ward is staffed in accordance with agreed daily staffing ratios that have received executive approval. Adherence to these ratios is reviewed Monday to Friday, supported by a 24-hour forward look to identify and address emerging risks and with a weekend forward view at the Friday meeting.

Table 3. April 2026 example of daily oversight planned verses actual

Date	Day 1		Day 2	
Profession	Registered	Unregistered	Registered	Unregistered
	Long Shift Equiv.	Long Shift Equiv.	Long Shift Equiv.	Long Shift Equiv.
439 Ipswich Road - Day (1&2)	1	2	1	2
439 Ipswich Road - Night (1&2)	2	1	1	2
Ardleigh Ward - Day (3&3)	4	4	4	3
Ardleigh Ward - EABAA Night (3&3)	3	4	3	4
Beech Ward -Day (3&3)	3	7	3	6
Beech Ward - EA304 Night (3&3)	3	5	3	5
Cedar Ward - Day (3&3)	2	4	3	4
Cedar Ward - EA501 Night (3&3)	2	3	3	3
Chelmer Ward Harlow - Day (3&3)	3	4	3	3
Chelmer Ward Harlow - ECCFB Night (3&3)	3	3	3	3
Cherrydown (Thorpe) Ward - Day (3&3)	3	3	3	2
Cherrydown (Thorpe) Ward - EA510 Night (3&3)	3	3	3	3
Christopher Unit - Day (4&4)	4	5	4	4
Christopher Unit - EBFKD Night (4&4)	4	4	4	4
Finchingfield Ward - Day (3&3)	3	4	3	4
Finchingfield Ward - EBFBA Night (3&3)	3	5	3	4
Galleywood Ward - Day (3&3)	3	3	3	3
Galleywood Ward - EBFCA Night (3&3)	3	3	3	3
Gloucester Ward - Day (3&3)	3	5	3	5
Gloucester Ward - EA310 Night (3&3)	3	6	3	5
Gosfield Ward - Day (3&3)	3	3	3	3
Gosfield Ward - EABBA Night (3&3)	3	3	3	3
Hadleigh Unit (Picu) - Day (4&4)	4	5	4	4
Hadleigh Unit (Picu) - EA504 Night 4&4	4	4	4	4
Henneage Ward - Day (3&3)	3	4	3	4
Henneage Ward - EAGBB Night (3&3)	3	4	3	4
Kelvedon Ward -Day (3&3)	3	3	3	3
Kelvedon Ward - EA502 Night (3&3)	3	3	3	3
Kitwood Ward - Day (3&3)	3	3	3	3
Kitwood Ward - ECAEC Night (3&3)	2	3	3	3
Meadowview Ward - Day (3&3)	3	5	3	5
Meadowview Ward - EA313 Night (3&3)	3	4	3	4

The number in brackets is the registered/unregistered required (planned) per shift.

This number represents the rostered staff for this day (actual)

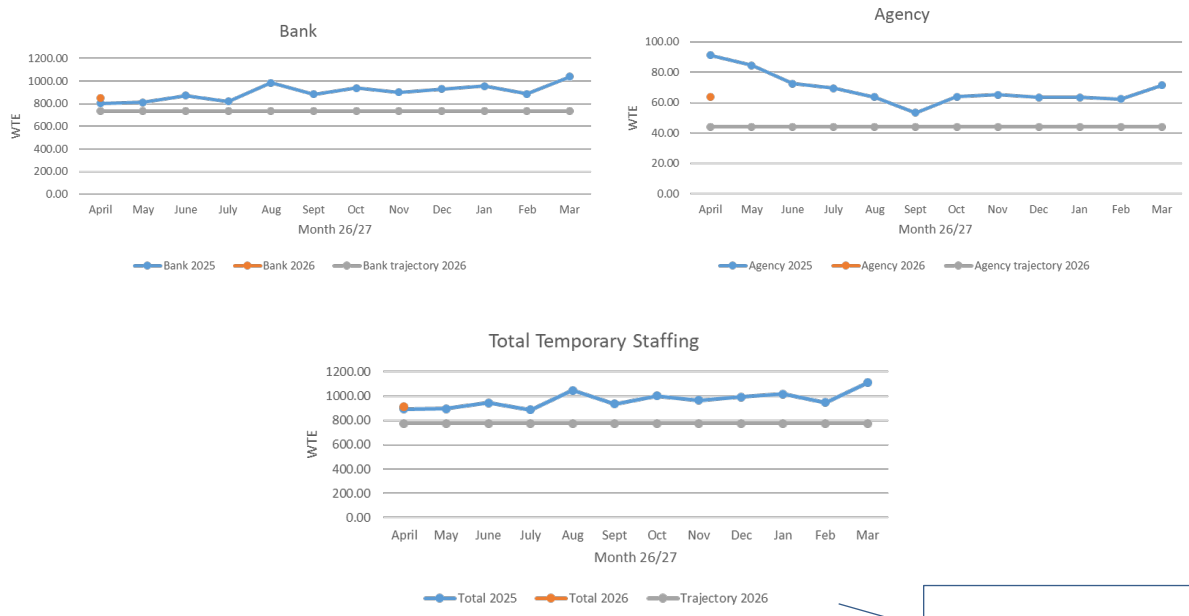
Colour code:
RED: the staffing numbers are either below safe minimum or over agreed requirement.
ORANGE: the staffing numbers are below shift requirement
GREEN: the numbers are in line with requirement.

Registered Skill Mix: Mental health wards require at least one RMN per shift to ensure lawful application of the Mental Health Act, each shift will also require a nurse in charge who holds the relevant competence to undertake these duties. The Trust's Preceptorship Programme sets out the competency requirements for this, and the Trust e-rostering system provides the opportunity for ward managers and matrons to include staff members' skills and support good roster principles when creating a roster. Other essential for role, core ward team skills such as professional registration, TASID training and ILS are also uploaded. Currently, accountability of the adherence to good roster skill mix sits with the ward matrons and verbally discussed via the DDQS at the daily staffing meetings. To further improve the oversight and assurance, the Workforce Intelligence team are creating oversight tools to support this further.

Temporary Staffing Use: High-level monitoring of temporary staffing usage and spend, predominantly bank, is reported monthly through the Executive Operational Committee, with weekly oversight provided to senior operational leadership. The bank workforce comprises both substantive staff who work additional hours and bank-only staff.

Ensuring continuity of care through competent, confident staff embedded within substantive teams remains a key priority to further reduce reliance.

Chart 3. Temporary staffing Trust-wide



Charts 3. All show sustained reduction on bank and agency use and spend Trust-wide in the reporting period and not specific to inpatient mental health wards.

Care Hours Per Patient Day (CHPPD): CHPPD data was not included in the Integrated Performance Report during the reporting period. Previous reports used data extracted from the Safe Care module within the e-roster system; however, quality assurance work identified the need for clearer confirmation of data capture points to ensure compliance with national reporting requirements. As a result, CHPPD reporting has been paused for this period.

Workforce Safeguards: During this reporting period there was an NHS England (NHS) requirement to undertake self-assessment of compliance, which was then reviewed by NHSE regionally.

Table 4. National workforce safeguards compliance assessment

Organisation	ICB	Type of review to date	Number of Safer Staffing Fellows in post	1.NQB guidance	2.Triangulation	3.Evidence based tools utilisation	4. No tool manipulation	5. Monthly Actual Vs Planned staff reporting	6. Annual statement	7. Workforce plan	8. Bi-annual establishment reviews	9. Quality dashboards	10. Quality Impact Assessments	11. Risk management & escalation	12. Board awareness
Essex Partnership University NHS Foundation Trust	MSE	Self Assessment	0	Green	Green	Amber	Green	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber
Essex Partnership University NHS Foundation Trust		Regional Assessment		Green	Green	Amber	Green	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber

Formal feedback and recommendations from NHSE remain pending. We are using evidence based tools (MHOST currently collecting 4th census data), have commenced use of Safer Nursing Care Tool (SNCT) on community rehab wards, we have updated tool licence and Community Nursing Safer Staffing Tool II (CNSST II), have started census collection and plan to include in next establishment review when a minimum of 2 cycles have been completed. Recognising complex safer staffing skills and resources are required and we are encouraged to gain support through application for future SSF programmes with support from region.

Governance and Reporting: Improved reporting capabilities remain in development but when completed still aim to present red flags and key staffing metrics, enabling care unit leaders to monitor performance and implement

mitigating actions to maintain safe staffing. These enhanced reporting tools will also support future establishment review Board reports and will include the East of England NHSE triangulation template, supporting a consistent reporting style and structure, aligned to monthly and annual requirements.

Monthly staffing reviews, triangulated with quality indicators and clinical insight, will strengthen care unit leadership oversight and inform Board-level assurance through the Quality Committee and Care Unit Accountability Framework meetings. This monthly reporting approach will address current workforce safeguard ratings (currently Amber) and will support greater empowerment and insight-driven decision-making across care unit leadership teams.

Actions and Mitigations: Continued implementation of a staged safer staffing improvement plan, with clarity of roles and responsibilities to achieve:

- Improved rostering practice
- Refresh approach to daily staffing huddles
- Define roles, responsibilities and accountability
- Data accuracy, availability, quality both internally and externally
- Triangulated data insight to empower and provide assurance for quality and safety
- Substantive workforce through recruitment and retention
- Right skills, right place, right time – newly registered staffing, continuing professional development and HCA Academy

Moving forward as power BI capabilities are finalised, a greater level of detail will be included within the safer staffing report and will align to current reporting requirements for benefits realised from the implementation of Time to Care in inpatient and specialist wards. This will allow support workforce reporting and triangulation with quality indicators to gain improved insight.

The achievement of implementing this improvement plan will be monitored by the Quality of Care Group and assurance and exception reporting through committees of the Board.

Part 2. Progress Update on Stage 1 of the Safer Staffing Programme Delivery

Following approval of the October 2025 establishment review proposal, a transition from temporary to substantive staffing has commenced. This decision was informed by triangulated evidence in line with NQB guidelines and is being implemented through a staged roll-out across priority ward groupings. The introduction of these measures aims to enhance the quality of patient care and improve staff morale by establishing a more consistent workforce.

The following wards were included in Stage 1:

- Ardleigh Ward: an 18 bedded, female working age, acute inpatient ward, which provides care for both detained and informal patients. Located at The Lakes, Colchester.
- Beech Ward: a 22 bedded mixed gender, older adults (over 65) ward, which provides care for both detained and informal patients. Located at Rochford Hospital.
- Willow Ward: a 22 bedded, female working age, acute inpatient ward, which provides care for both detained and informal patients. Located at Rochford Hospital.
- Fuji Ward: a 12 bedded female medium secure unit with specialist commission pathways. Located at Brockfield House.

It was recognised that an increase in the budgeted establishment being proposed will maintain safer staffing and enhance quality. However, it was also recognised that there are other factors that influence quality and that there will be a focus on improved models of care, coproduction with patients, implementation of evidenced base clinical practice and development of workforce skills, competence and local empowerment through a quality improvement approach. In order to achieve this, dedicated leadership at deputy director level to work collaboratively both with the local teams

across the 4 wards and with the care unit leadership teams. Oversight through the Care Unit Accountability Framework meetings and committees to the Board with agreed outcome measures will be presented with the workforce data to demonstrate impact.

Summary of Delivery Programme:

- Initial business case approval with focus on unregistered recruitment to reduce reliance of HCA temporary staffing
- Recruitment plan for HCA and Activity Coordinators
- Workforce oversight and monitoring
- Working with Finance and HR colleagues on business case for readjustments on registrant staff to meet recommended headroom for quality improvements, skill mix of registered staff for 24/7 and workforce development in accordance with the triangulation from the establishment review
- Enable ring-fenced leadership time for clinical modelling, coaching and quality improvement
- Plan Quality Senate to recommendations for female mental health care
- Develop project plan and outcome measurement

Progress - March 2026 to date:

Following executive approval of the business case for unregistered recruitment across the 4 wards, the progress made to date is summarised in Table 5 below:

Table 5: workforce recruitment update

Location / Ward	Recruitment Aim (WTE)	Key Activity	Progress / Status	Forecast Start Dates
Brockfield House – Fuji Ward	1.82 WTE HCA	Event: 10 March (complete) Interviews: 17 March (complete)	1 WTE commenced in post; 0.8 WTE in pre-employment checks (DBS outstanding) Additional recruitment above safer staffing establishment	1 WTE: 18 May 0.8 WTE: May–June 2026
Bank-to-Perm – Beech & Willow	N/A	Interviews: 10 & 17 March (15 candidates)	6.22 WTE commenced 4.8 WTE confirmed June start. 3WTE in pre-employment checks (anticipated June start)	6.22 WTE: 18 May 1 WTE: 1 June 3.8 WTE: 15 June 3 WTE: June
Southend – Beech & Willow Wards	6.51 WTE HCA	Event: 1 April (complete) Interviews: 14 April (13 candidates)	6.51 WTE in pre-employment checks forecasted start dates June 2026	June 2026
Colchester – Ardleigh Ward	16.72 WTE HCA	Event: 2 April (complete) Interviews: 16 April (17 candidates) Interviews 26 May	I WTE commenced 4 WTE confirmed 15 June 3 WTE in pre-employment checks	1 WTE: 18 May 4 WTE: 15 June Remaining: June 2026
Activity Coordinators	7.1 WTE	Awaiting shortlisting/interviews	1.79 WTE commenced 0.85 WTE confirmed 3rd June 4.46 WTE awaiting shortlisting	1.79: April 0.85 WTE 3rd June 4.46 awaiting

Workforce intelligence
Data as of 26/05/26

To support the proposed ward roster templates for shift skill mix of registered staff for 24/7 recommended headroom for quality improvements and workforce development, discussions have been held with Finance to confirm funded establishments, including the Bands 5 and 6 breakdowns. These costings will inform a further business case for each

ward for Executive approval. In the interim, HealthRoster 'shadow templates' have been developed to support implementation of the required shift patterns and necessary skills needed per shift.

Following the appointment and induction period for the secondment into the DDQS role for inpatient and urgent care on 06 May 2026, the dedicated part time (0.6WTE) deputy director leadership responsibility will commence in the week of 25 May 2026. At this time, the completion of the female ward models of care quality improvement project plan will be drawn up for each of the 3 female wards in stage 1. Some scoping work has already commenced with external expert guidance provided from the Clinical Director for Women's Services at Rampton and preparation for the Quality Senate which will take place on 30th June 2026.

The Quality Senate will review publications and expert presentations regarding women's mental healthcare in order to make recommendations for the Trust to take forward. The first stage female wards provide focused opportunity to implement Senate recommendations. Broadly the Senate will focus on:

- Hormonal dysregulation
- Diagnostic over-shadowing
- Personality disorder
- Grey paper and NICE guidance
- Interface with previous senates: neurodivergence and trauma

Stage 2 Areas of Prioritisation:

Reviewing the annual establishment review findings with further acuity and dependency, quality indicators and professional judgement gained at this 6-month point. The following areas are proposed for stage 2:

- Aligning all Health Based Places of Safety (HBPoS) to host wards and transfer and alignments of budget, role, responsibilities and accountabilities.
- Cascade of model of care to all other female wards as they already sit in the next priority phase ward group
- Brockfield House site coordination, professional nurse educator role and ward realignment following specialist collaborative service reviews
- Commence Beech older adult plan

The attached appendices show the current verses proposed core roster requirements to support the workforce changes and funded establishments for business case presentation. These will require empowerment and accountabilities held at local leadership level, with the 0.6 WTE leadership function being expanded over a wider portfolio of change. There will also be the ability to measure outcomes established in order to provide impact for evaluation and next steps.

Programme Anticipated Benefits:

Benefits will be achieved through the proposed increase in substantive regular workforce:

- Continuity of care: through the establishment of substantive teams who are confident and competent to provide holistic person-centred care built on the fundamentals of care framework, impact measured through quality indicator improvements, qualitative outcome measures showing experience improvement e.g. stronger therapeutic relationships
- Enhancing patient and staff experience: familiarisation with agreed models of care, substantive staff and patients to be involved in quality improvement, clinical practice guidance and improving the environment
- Improve staff morale and retention: reduced turnover, burnout and sickness, ability to consider workforce and career development, development of specialist skills, and increasing protected time for managers to support workforce development
- Strong team cohesion: able to build relationships / trust, better communication and positive cultures
- Improve predictability of staffing and skill mix: assuring the right skills, right place, right time principles are achieved, ability to explore self-rostering and flexible working
- Reduce reliance on temporary staffing: delivers Trust reduction targets

- Financial sustainability and efficiency: reduction of temporary staff, cost effective cover, improved budget forecasting
- Compliance with regulatory standards: CQC, NICE, NHS standards – improves safety culture, gaining organisational assurance and risk reduction
- Ensure Trust meet NQB workforce safeguard principles

Potential Risks:

Potential risks could be actual if the following areas are not in place:

- Agreed funded establishments
- Empowered local leadership accountabilities
- Dedicated quality improvement leadership and coaching
- Established reportable outcome measurements

Conclusion and Recommendation to Board

The Quality and People Committees will continue to seek assurance as BI safer staffing capabilities materialise and staged priority roll-out of the safer staffing development programme continues. Noting that prioritisation will be subject to update and possible amendment, as further insight is gained through ongoing triangulation of bi-annual MHOST census acuity and dependency data, triangulated with quality indicators and professional judgement. A review of the proposed implementation for year one will be assessed for impact, while developing further plans for 2027/28 and 2028/29.

It is expected that the Board will receive an update on progress and outcomes as part of the next safer staffing paper in 6 months.

Appendices

The appendices show current and proposed roster templates developed following the triangulation of acuity and dependency, quality indicators and professional judgement. The supporting detailed data packs are available on request and necessary budget setting and business case approval required.

Appendix 1.

Health Based Places of Safety (HBPoS) aligned to host wards: Cedar, Christopher, Stort, (Ardleigh already prioritised for stage 1)

Ward Cedar			
Current roster template 2025/26	Headroom	22%	19%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
Registered Nurse - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
AC- Day shift 0900 1700 (30)	7.5	1	1	1	1	1	1	1	7		1.40	1.40
HCA - Long Day 0700 2030 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
HCA - Night 2000 0730 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
								staffing excluding headroom		12.88	14.28	27.16
								staffing including headroom		15.71	16.99	32.71

Narrative
Minimal changes to budget to ensure all role are at 22% for ward based care. As the ward is most closely located to the HBPOS at Rochford, the HCA x2 24/7 will be included within this ward budget , confirmation required if existing budget is available

Ward Cedar			
Proposed roster template 2026/27	Headroom	22%	27.30%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
Registered Nurse - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
AC- Day shift 0900 1700 (30)	7.5	1	1	1	1	1	1	1	7		1.40	1.40
HCA - Long Day 0700 2030 (60)	11.5	5	5	5	5	5	5	5	35		10.73	10.73
HCA - Night 2000 0730 (60)	11.5	5	5	5	5	5	5	5	35		10.73	10.73
								staffing excluding headroom		12.88	22.87	35.75
								staffing including headroom		15.71	27.90	43.61

Ward PICU Christopher			
Current roster template 2025/26	Headroom	22%	19%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	3	3	3	3	3	3	3	21	6.44		6.44
Registered Nurse - Night 2000 0730 (60)	11.5	3	3	3	3	3	3	3	21	6.44		6.44
AC- Day shift 0900 1700 (30)	7.5	1	1	1	1	1	1	1	7		1.40	1.40
HCA - Long Day 0700 2030 (60)	11.5	4	4	4	4	4	4	4	28		8.59	8.59
HCA - Night 2000 0730 (60)	11.5	4	4	4	4	4	4	4	28		8.59	8.59
								staffing excluding headroom		17.17	18.57	35.75
								staffing including headroom		20.95	22.10	43.05

Narrative
recommended headroom for 28.5 to ensure Quality and Professional Judgement considerations are effectively maintained. Recruitment with recruitment and rostering requirements with the addition of HCAs for collocated site based seclusion and HPBOS , site buddy funding to be identified to include in WTE budget

Ward PICU Christopher			
Proposed roster template 2026/27	Headroom	22%	28.50%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	3	3	3	3	3	3	3	21	6.44		6.44
Registered Nurse - Night 2000 0730 (60)	11.5	3	3	3	3	3	3	3	21	6.44		6.44
AC- Day shift 0700 15:00 (30)	7.5	1	1	1	1	1	1	1	7		1.40	1.40
HCA - Long Day 0700 2030 (60)	11.5	5	5	5	5	5	5	5	35		10.73	10.73
HCA - Night 2000 0730 (60)	11.5	5	5	5	5	5	5	5	35		10.73	10.73
								staffing excluding headroom		17.17	22.87	40.04
								staffing including headroom		22.07	29.38	51.45

Ward stort			
Current roster template 2025/26	Headroom	22%	19%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
Registered Nurse - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
AC- Day shift 0900 1700 (30)	7.5	1	1	1	1	1	1	1	7		1.40	1.40
HCA - Long Day 0700 2030 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
HCA - Night 2000 0730 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
								staffing excluding headroom		12.88	14.28	27.16
								staffing including headroom		15.71	16.99	32.71

Ward Stort			
Proposed roster template 2026/27	Headroom	22%	27.30%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
Registered Nurse - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
AC- Day shift 0700-1500/1400-2200 (30)	7.5	2	2	2	2	2	2	2	14		2.80	2.80
HCA - Long Day 0700 2030 (60)	11.5	4	4	4	4	4	4	4	28		8.59	8.59
HCA - Night 2000 0730 (60)	11.5	4	4	4	4	4	4	4	28		8.59	8.59
								staffing excluding headroom		12.88	19.97	32.85
								staffing including headroom		15.71	24.37	40.08

Narrative
recommended headroom for 22% to ensure Quality and Professional Judgement considerations are effectively maintained recruitment and rostering requirements with the addition of TW cover and transfer of site buddy funding of 4.29 WTE for the collocated HBPOS

Appendix 2
Remaining female wards

Ward Chelmer			
Current roster template 2025/26	Headroom	22%	19%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
Registered Nurse - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
AC- Day shift 0900 1700 (30)	7.5	1	1	1	1	1	1	1	7		1.40	1.40
HCA - Long Day 0700 2030 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
HCA - Night 2000 0730 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
								staffing excluding headroom		12.88	14.28	27.16
								staffing including headroom		15.71	16.99	32.71

Narrative
recommended headroom for 27.3% to ensure Quality and Professional Judgement considerations are effectively maintained. Recruitment, reviewing rota rostering recquirements, the, addition of TW cover, maintaining environmental factors and models of care implementation are enabled

Ward Chelmer			
Proposed roster template 2026/27	Headroom	22%	27.30%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
Registered Nurse - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
AC- Day shift 0700 15:00/14:00 22:00 (30)	7.5	2	2	2	2	2	2	2	14		2.80	2.80
HCA - Long Day 0700 2030 (60)	11.5	4	4	4	4	4	4	4	28		8.59	8.59
HCA - Night 2000 0730 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
								staffing excluding headroom		12.88	17.83	30.71
								staffing including headroom		16.40	22.69	39.09

Ward Cherrydown			
Current roster template 2025/26	Headroom	22%	19%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
Registered Nurse - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
AC- Day shift 0900 1700 (30)	7.5	1	1	1	1	1	1	1	7		1.40	1.40
HCA - Long Day 0700 2030 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
HCA - Night 2000 0730 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
								staffing excluding headroom		12.88	14.28	27.16
								staffing including headroom		15.71	16.99	32.71

Narrative
recommended headroom for 27.3% to ensure Quality and Professional Judgement considerations are effectively maintained which for this type if ward, however noting that here has been missing A&D census collection indicates that current would meet this recruitment would meet rostering requirements with the consideration of TW AC cover, models of care implementation and environmental factors

Ward Cherrydown			
Proposed roster template 2026/27	Headroom	22%	27.30%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
Registered Nurse - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
AC- Day shift 0700 15:00/14:00 22:00 (30)	7.5	2	2	2	2	2	2	2	14		2.80	2.80
HCA - Long Day 0700 2030 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
HCA - Night 2000 0730 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
								staffing excluding headroom		12.88	15.68	28.56
								staffing including headroom		16.40	19.96	36.36

Ward Galleywood			
Current roster template 2025/26	Headroom	22%	19%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
Registered Nurse - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
AC- Day shift 0900 1700 (30)	7.5	1	1	1	1	1	1	1	7		1.40	1.40
HCA - Long Day 0700 2030 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
HCA - Night 2000 0730 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
staffing excluding headroom										12.88	14.28	27.16
staffing including headroom										15.71	16.99	32.71

Narrative
Recommended headroom for 27.3% to ensure Quality and Professional Judgement considerations are effectively maintained in female ward .Recruitment and rostering requirements with the addition of TW AC cover to support model of care and environmental factors

Ward Galleywood			
Proposed roster template 2026/27	Headroom	22%	27.30%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
Registered Nurse - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
AC- Day shift 07:30-15:00/14:00 22:00 (30)	7.5	2	2	2	2	2	2	2	14		2.80	2.80
HCA - Long Day 0700 2030 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
HCA - Night 2000 0730 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
staffing excluding headroom										12.88	15.68	28.56
staffing including headroom										16.40	19.96	36.36

Appendix 3

Brockfield house site coordination ward and realignment following specialist collaborative service reviews

Ward Aurora			
Current roster template 2025/26	Headroom	22%	19%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
HCA - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14		4.29	4.29
HCA - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7		2.15	2.15
									staffing excluding headroom	8.59	6.44	15.03
									staffing including headroom	10.48	7.66	18.14

Narrative
based on triangulation the ward can reduce some funded establishment in this review, slight WTE change to reflect 22% headroom, active recruitment to fill vacancies amd add TW activity coordinator

Ward Aurora			
Proposed roster template 2026/27	Headroom	22%	28.00%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Accitivy Coordinator Tw 1400 2200 (30)	7.5	1	1	1	1	1	1	1	7		1.40	1.40
HCA - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14		4.29	4.29
HCA - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7		2.15	2.15
									staffing excluding headroom	8.59	7.84	16.43
									staffing including headroom	10.48	9.56	18.33

Ward Alpine			
Current roster template 2025/26	Headroom	22%	19%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
Registered Nurse - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
HCA - Long Day 0700 2030 (60)	11.5	4	4	4	4	4	4	4	28		8.59	8.59
HCA - Night 2000 0730 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
									staffing excluding headroom	12.88	15.03	27.91
									staffing including headroom	15.71	17.88	33.60

Ward Alpine			
Proposed roster template 2026/27	Headroom	22%	28.00%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	3	3	3	3	3	3	3	21	6.44		6.44
Registered Nurse - Night 2000 0730 (60)	11.5	3	3	3	3	3	3	3	21	6.44		6.44
HCA - Long Day 0700 2030 (60)	11.5	4	4	4	4	4	4	4	28		8.59	8.59
HCA - Night 2000 0730 (60)	11.5	4	4	4	4	4	4	4	28		8.59	8.59
									staffing excluding headroom	17.17	17.17	34.35
									staffing including headroom	21.98	21.98	43.96

Narrative
Service redesign change to admission assessment ward, increase headroom to 28% in view of remodelling and quality transformation, active recruitment to fill vacancies

Ward Causeway			
Current roster template 2025/26	Headroom	22%	19%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
HCA - Long Day 0700 2030 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
HCA - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14		4.29	4.29
									staffing excluding headroom	8.59	10.73	19.32
									staffing including headroom	10.48	12.77	23.25

Narrative
Service redesign changes and add AC to rota headroom at 22%

Ward Causeway (linked to Dune)			
Proposed roster template 2026/27	Headroom	22%	23.20%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
	7.5	1	1	1	1	1	1	1	7		1.40	1.40
HCA - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14		4.29	4.29
HCA - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14		4.29	4.29
									staffing excluding headroom	8.59	9.99	18.57
									staffing including headroom	10.48	12.18	22.66

Ward Dune			
Current roster template 2025/26	Headroom	22%	19%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
HCA - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14		4.29	4.29
HCA - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14		4.29	4.29
									staffing excluding headroom	8.59	8.59	17.17
									staffing including headroom	10.48	10.22	20.69

Narrative
Service redesign changes and add AC to rota headroom at 22%

Ward Dune			
Proposed roster template 2026/27	Headroom	22%	23.20%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
AC- Day 0900 1700 (30)	7.5	1	1	1	1	1	1	1	7		1.40	1.40
HCA - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14		4.29	4.29
HCA - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14		4.29	4.29
									staffing excluding headroom	8.59	9.99	18.57
									staffing including headroom	10.48	12.18	22.66

Ward Forest			
Current roster template 2025/26	Headroom	22%	19%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
AC- Day shift 0900 1700 (30)	7.5	1	1	1	1	1	1	1	7		1.40	1.40
HCA - Long Day 0700 2030 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
HCA - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14		4.29	4.29
staffing excluding headroom										8.59	12.13	20.72
staffing including headroom										10.48	14.44	24.91

Ward Forest			
Proposed roster template 2026/27	Headroom	22%	28.00%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
Registered Nurse - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
AC- Day shift 0700 15:00 (30)	7.5	1	1	1	1	1	1	1	7		1.40	1.40
HCA - Long Day 0700 2030 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
HCA - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14		4.29	4.29
staffing excluding headroom										10.73	12.13	22.87
staffing including headroom										13.09	14.80	25.28

Narrative
recommended headroom 22% ensure Quality and Professional Judgement considerations met increase registered long day in line with service design

Ward Fuji			
Current roster template 2025/26	Headroom	22%	19%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
Registered Nurse - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
AC- Day shift 0900 1700 (30)	7.5	1	1	1	1	1	1	1	7		1.40	1.40
HCA - Long Day 0700 2030 (60)	11.5	4	4	4	4	4	4	4	28		8.59	8.59
HCA - Night 2000 0730 (60)	11.5	4	4	4	4	4	4	4	28		8.59	8.59
staffing excluding headroom										12.88	18.57	31.45
staffing including headroom										15.71	22.10	37.82

Ward Fuji			
Proposed roster template 2026/27	Headroom	22%	28.00%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	3	3	3	3	3	3	3	21	6.44		6.44
Registered Nurse - TW 1400 2200 (60)	7.5	1	1	1	1	1	1	1	7	1.40		1.40
Registered Nurse - Night 2000 0730 (60)	11.5	3	3	3	3	3	3	3	21	6.44		6.44
AC- Day shift 0700 15:00/14:00 22:00 (30)	7.5	2	2	2	2	2	2	2	14		2.80	2.80
HCA - Long Day 0700 2030 (60)	11.5	5	5	5	5	5	5	5	35		10.73	10.73
HCA - Night 2000 0730 (60)	11.5	5	5	5	5	5	5	5	35		10.73	10.73
staffing excluding headroom										18.57	24.27	42.84
staffing including headroom										23.77	31.06	54.84

Narrative
recommended headroom28% to ensure Quality and Professional Judgement considerations are maintained recruitment and rostering requirements with the addition of TW cover and RMN and AC to support service changes

Ward Lagoon			
Current roster template 2025/26	Headroom	22%	19%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
Registered Nurse - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
AC- Day shift 0900 1700 (30)	7.5	1	1	1	1	1	1	1	7		1.40	1.40
HCA - Long Day 0700 2030 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
HCA - Night 2000 0730 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
staffing excluding headroom										12.88	14.28	27.16
staffing including headroom										15.71	16.99	32.71

Narrative
based on triangulation the ward can remain on same funded establishment in this review, slight WTE change to reflect 22% headroom, active recruitment to fill vacancies

Ward Lagoon			
Proposed roster template 2026/27	Headroom	22%	28.00%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
Registered Nurse - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14	4.29		4.29
AC- Day shift 0700 15:00/14:00 22:00 (30)	7.5	1	1	1	1	1	1	1	7		1.40	1.40
HCA - Long Day 0700 2030 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
HCA - Night 2000 0730 (60)	11.5	3	3	3	3	3	3	3	21		6.44	6.44
staffing excluding headroom										12.88	14.28	27.16
staffing including headroom										15.71	17.42	33.14

Brockfield site coordinator and PNE			
Proposed roster template 2026/27	Headroom	22%	28.00%

	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Shifts	RN	HCA	Total staffing
Nurse in Charge - Long Day 0700 2030 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Nurse in Charge - Night 2000 0730 (60)	11.5	1	1	1	1	1	1	1	7	2.15		2.15
Registered Nurse - Long Day 0900 1700 (30)	7.5	2	2	2	2	2			10	2.00		2.00
HCA - Long Day 0700 2030 (60)	11.5	2	2	2	2	2	2	2	14		4.29	4.29
HCA - Night 2000 0730 (60)	11.5	2	2	2	2	2	2	2	14		4.29	4.29
staffing excluding headroom										6.29	8.59	14.88
staffing including headroom										7.68	10.48	43.96

Narrative
align site and PNE requirements, cover for MoJ conditions for escorts

QUESTIONS TAKEN FROM THE GENERAL PUBLIC

8. ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL

8.1 BOARD ASSURANCE FRAMEWORK

Decision Item DG

REFERENCES

Only PDFs are attached

Board Assurance Framework Report 03.06.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	3 June 2026

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

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

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

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

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

2. Note the new corporate risks
3. Request any further information of action

Summary of Key Issues

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

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

The Board is asked to note:

- Board Assurance Framework dashboard providing an oversight of the reporting period.
- There have been no changes in risk score.
- There have been no risks agreed for closure.
- 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:
    - SR6 Cyber Security – DSPT/CAF received overall High Internal Audit assurance rating (April 26).
    - SR13 Quality Governance - Following completion of all actions a re-assessment is planned to review the score and to assess whether further controls / mitigations are required.
- 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.
- Emergent risks noted at the last Board meeting are being progressed through risk escalation routes and will report to Board Committees in June 2026 and then feature on the next Board report.

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

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

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

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

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

Supporting Reports/ Appendices /or further reading

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

Lead

Denver Greenhalgh
Executive Director of Corporate Governance

NHS
Essex Partnership University
NHS Foundation Trust

Board Assurance Framework

May 2026

EPUT

Corporate Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
2	0	0	0

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

Likelihood	Consequence 1	2	3	4	5
1					
2					
3				CRR11	
4				2598	
5					

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

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
CRR11	All	Suicide Prevention	MK	Safety	4x3=15	12 12 12	Implementation of suicide prevention strategy	The Trust has maintained zero inpatient deaths by suicide for over two years. However, 12 suspected suicides were reported this quarter, all in community and urgent care pathways, reflecting wider national trends. A weekly executive-led emerging incident review, chaired by the Chief Nurse, is now in place to strengthen oversight and learning from deaths and serious incidents. Work continues to shift from risk stratification to personalised safety planning in line with NHS England guidance, supported by updated clinical tools and documentation. Self-harm incidents have reduced by 17% this quarter and 4% year-on-year, with improvement driven by targeted QI work in CAMHS and adult inpatient services. STORM training capacity has increased, with compliance at 85% in urgent care and a plan to reach 95% Trust-wide, alongside a mandatory suicide prevention module for all staff.
2598	All	Nova Programme	ZT	Safety, Quality, Service Delivery, Reputation	4x4=16	16 16	Potential for implementation delays, system integration issues, technical challenges	System list socialised and being reviewed through programme governance. Design and build underway Recruitment process for Nova Director of Operations

Strategic Risk Register

May 2026

SR3- Finance and Resources Infrastructure (2135)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5 x L3 = 15	*C5 x L3 =15*	*C5 x L2 = 10*	**Note 1:** Completed actions (1–7) have been removed from the report, and a review of remaining action is underway to ensure ongoing alignment with operational risks **Note 2:** Consideration to close Action 8, moving PAM to an annual assurance from 2026~~5~~.

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

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
EPUT Strategy	EPUT Strategy (approved Jan '23) Estates Strategy (Board approved)	Finance and Performance Committee Report (update 2 x year)	
Operational Target Operating Model	Care Unit Leadership in place Procurement Team restructured to align with TOM	Accountability Framework	
Estates and Facilities, Contracting and Business Development, Finance Teams	Established Support services	PMO support in place reporting to Executive Restructure fully recruited to	IA Estates & Facilities Performance (Moderate/Moderate Opinion)
Range of corporate, finance policies	Policy Register and procedures in place	Accountability Framework	
PMO, Capital Programme, E-expenses system,	Capital Steering Group	Capital Planning Group	
Audit Programme and ISO		Audit Committee	
Premises Assurance	Operational meetings for PFIs ERIC and PAM Groups Established	Premises Assurance Model (PAM) annually	
6-Facet Survey	Review of core premises undertaken through the Estates Strategy	6- Facet Survey completed	6-Facet Survey
Business Continuity Plans	Business continuity plan in place - updated to reflect changes relating to asbestos, fire, water, and electrical safety.		

	Actions (to modify risks)	By When	By Who	Gap	Update
8	Deliver action plan from Premises Assurance Model (PAM) self-assessment	Sep-26	MM	Control	ERIC and PAM oversight continues, with scheduled meetings to confirm progress and forward plans; no high or significant risks are currently identified. Overall, the programme is progressing well and provides a high level of assurance. Therefore, the action will be reviewed to potentially closed as results are seen as business as usual. Propose to move (PAM) to an assurance 2026. ERIC submission: Scheduled for July 2026, supported by established task and finish groups.
9	Expression of interest for NHS Property Services	Complete	MM	Control	Action complete - expression of interest submitted.
10	Enhanced Training Facilities	Complete	MM	Control	Lease agreed, enabling enhanced facilities for the Trust and system partners. Steering Group mobilised and progressing phase 1 development.

SR4- Demand and Capacity (2136)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5 x L4 = 20	*C5 x L3 =15*	*C5 x L3 = 15*	**Note 1:** Previous reported completed actions 1-6, 8-12 and 14 have been removed from the report. **Note 3:** Undertaking analysis of Trend over time for length of stay occupancy OOA placements and proportion of metal health act detainees - this will inform the current risk score and enable assessment of pro actions to mitigate the risk and arrive at a new target score.

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

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Target Operational Model		Performance Reporting Published alongside EPUT Strategy One year touch points and monitoring through accountability	
Community First Transformation Programme 4 key work streams			
Bed Stock	157 North Adult beds; 44 North Older Adult beds; 89 South Adult beds; 66 South Older Adult beds; 24 Contracted appropriate OoAP beds		

	Actions (to modify risks)	By When	By Who	Gap	Update
7	Model Out of Area bed capacity/demand to inform terms of unification project with ICBs including appropriate level of resource transfer.	Extended June 26	SC/JW	Control	The Trust awaits ICB analysis to confirm FY25/26 outturns and has put forward a Q1 deadline to agree a resource transfer value. In addition the Trust has undertaken a Flow Away Day which has identified a number of workstreams to support Out Of Area reductions. Ongoing discussions with ICBs, timescale further extended to end of Q1 Red RAG rated because of further extension (next touch point end June 2026).
13	Demand and Capacity Length of Stay Programme - Internal(EPUT)	Extended June 26	DC	Control	Steering groups established, this will feed into the Adult Acute Mental Health Programme and incorporates the Winter Plan (agreed at Board on 3 September) and the Flow Recovery Plan (FRP) hosted by EPUT but with a System wide approach/leadership. Updated Flow and Capacity Plan in place, work ongoing, timescale extended to end of Q1. Amber RAG rated because of extension beyond original timescale (next touch point end June 2026).
13a	Demand and Capacity Length of Stay Programme (System) EPUT to hold the system to account for delivery	June 26 / ongoing	DC	Control	Trust to hold the system to account for delivery of works 2nd workshop to confirm timelines & governance for oversight Action plan contains 7 themes with 25 agreed actions for system partners
15	Deliver Community First Programme	Sept '26	KS	Control	Review underway to consider if there should be a separate risk associated with the 'community first programme'. The programme involves offer for assertive outreach patients and a proposal for patients with complex emotional needs and was presented to the Executive Team in May 2026, with agreement to commence implementation where operations were ready and noted that resource gaps needed to be assessed and associated business case to be developed for commissioner discussions.

SR5 - Statutory Public Inquiry (2140)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5 x L4 = 20	*C4 x L4 = 16*	*C4 x L2 = 8*	**Note 1:** Previous reported complete actions 1-7, 9 & 10 have been removed from the Board report.

Executive Responsible Office: Lampard Inquiry Project Team SRO
Board Committee: Board

Key Controls	Controls Assurance		
	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)
Financial Resource (To meet the needs of the EPUT response to the Inquiry)	Financial allocation £8.6m to end of 2026	Finance reports, approved by Finance and Performance Committee, Audit Committee and Board	External audit of provision for the Inquiry completed for 2024/25. (Note additional cost pressure of £6.6m to end of 2026 as consequence of accounting treatment).
Inquiry Response Governance	Inquiry Project Team leadership through Project Director Multi-Disciplinary Working Group Schedule of work agreed with Legal Advisors / Counsel	Trust Board of Directors	S21 Notice issued in respect of eight Rule 9s request from the Lampard Inquiry (negative assurance)
Learning Log (this is learning noted by the Project Team during searches not in relation to themes from specific incidents. Historic learning of past events within the Inquiry is led by the Quality Committee)	Inquiry Project Team Multi-Disciplinary Working Group	Executive Operational Sub Committee	Internal audit.
Support for staff	Project Team (practical support and signposting) Here for You Provision (psychological support) Browne Jacobson (legal support) Executive & Leadership Team	Trust Board of Directors	Internal audit.
Support for families	Contract with HPFT	Trust Board of Directors	Internal audit. No referrals made to date
Communications Plan	Multi-disciplinary Project Working Group Multi-disciplinary Communications Group	Trust Board of Directors	Internal audit.
Management Development Programme (Inquiry Module)	Led by Inquiry Team - sessions ongoing		

Actions (to modify risks)		By When	By Who	Gap	Update
8	Rule 9 progress	Ext June '27	CBD	Assurance	The Trust has recovered its position in regards to the significant increase in the volume of Rule 9s reported in the last report (Noting, that in 2026 alone (up to 22 May 2026) EPUT responded to 126 Rule 9 requests, with 25 of these requiring agreement for extended timeline). And has also responded to 76 patient case summaries for factual review. The intensity of work is likely to continue between now and the end of the evidence gathering phase of the Inquiry, aligned to the published forward view on the Lampard Inquiry website.
11	Review and refocus of Project Inquiry resource to align with the skill set required to respond to the latest Rule 9's.	Extended July '26	CO	Control	A substantial programme redesign has been undertaken to strengthen the oversight and capacity in the team. This has included: The appointment of a dedicated Senior Responsible Officer; several staff secondments and transfers; increased legal, programme and clinical support; and development of a more structured Programme Management Office approach with further external support commissioned. Note extended timeline finalise moves and associated backfill arrangements for those staff seconded to the Inquiry Project Team.
12	Ensure staff receiving individual Rule 9 requests form the Inquiry are reminded of the legal support available to them. And, facilitate time (supported with backfill) for the individuals to comply with the request.	June '27	CBD	Control	Continue to connect staff who have received a Rule 9 request to line managers to agree release from duties and remind staff of the legal provision provided for an that this is independent of the team representing EPUT as corporate body.

SR6- Cyber Security (2141)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5 x L4 = 20	*C3 x L5 = 15*	*C4 x L3 = 12*	**Note 1:** Previous reported completed actions 1 - 10 have been removed from the report. **Note 2:** DSPT/CAF received overall High Internal Audit assurance rating. **Note 3:** Assess the emerging risk of AI being used to exploit cyber vulnerabilities and identify required mitigating controls.

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

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Scanning systems for assessing vulnerabilities, both internal and through NHS England and NHS mail		Reporting into IGSSC with exception reporting to Digital Strategy Group	
Cyber Team in place	Substantive post holder (Aug '23)	IGSSC IA Cyber Security (2024/25) Reasonable Assurance	NHS England Data Security Protection Toolkit (DSPT/CAF)
Range of policies and frameworks in place	Virtual and site audits Compliance with mandatory training – Cyber Assurance Framework	IGSSC; IA Cyber Security (2024/25) Reasonable Assurance	As above MSE ICS IG & Cyber Levelling Up Project (annual) 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
MSE ICS DSPT & Cyber Maturity Baseline	Completed	Audit Committee	DSPT/CAF **Action plan Implementation following TIAA audit received an overall High Internal Audit Assurance rating April 26**

Actions (to modify risks)		By When	By Who	Gap	Update
11	Deliver against DSPT CAF assurance plan to reach standards met.	30-Jun-26	AW	Assurance	The internal audit of the DSPT self-assessment has now been completed. Across all five assessed objectives, the overall risk rating was confirmed as Very Low, with the Independent Assessor expressing High confidence in the accuracy and robustness of the self-assessment. The audit concluded April 2026, and the final report will be presented to the Audit Committee for formal review and sign-off. The organisation has received an overall High Internal Audit Assurance rating. Development work to support the final DSPT submission remains on track for the 30 June deadline.
12	Assess emerging risk of AI being used to exploit cyber vulnerabilities	End of June	AW	Control	Proposal for new action which identifies gap in controls. Assess the risk and propose mitigating actions.

SR7- Capital (2142)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note 1:** Previously report completed actions 2 - 4 and 6-7 have been removed from the report.
C5 x L4 = 20	*C5 x L4 = 20*	*C5 x L3 = 15*	

Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: Finance and Performance Committee	**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	Audit Committee receives details of any waivers	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 review process in place ; internal forecasting and external review by NHSE.	Cash forecasting with cash tolerance of 5 working days	Executive Team, Finance and Performance	NHSE review cash forecasting every 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
5	Delivery Capital Plan 2025/26	Complete	JD	Control	Total capital expenditure in 2025/26 was £43.7m, offset by £7.4m of lease disposals in-year, resulting in a final outturn of £36.5m.

Actions (to modify risks)		By When	By Who	Gap	Update
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. M1 YTD expenditure is £1.5m, £0.1m ahead of plan. Capital requirements including backlog maintenance exceed annual resource availability. The Trust continues to progress with estates disposals/rationalisation to release additional CDEL and support mitigation of capital pressures. Cash balances at M1 total £32.1m, £10.4m ahead of plan, cash balances are forecast to reduce in future periods.

SR8 - Use of Resources (2143)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note 1:** Previous reported completed actions 1- 13 have been removed from the report.
C5 x L4 = 20	*C5 x L4 = 20*	*C5 x L3 = 15*	

Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: Finance and Performance Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Finance Team (Response to new resource bids and financial control oversight)	Team Establishment	Use of Resources Assessment IA Core Financial Assurance (2024/25) Substantial Assurance Opinion IA Payroll including Salary Overpayments (2024/25) - Reasonable Assurance opinion	Use of Resources NHSE Assessment Financial Assurance received substantial assurance (Feb 2026)
Standing Financial Instructions Scheme of reservation and delegation Accountability Framework	Standing Financial Instructions in place Scheme of Delegation in place Accountability Framework in place	Financial Management KPIs Audit Committee F&PC Accountability Framework	IA Key Financial Systems – Budget Management (Sep '22) Substantial opinion and Costing (March 2023). IA E-rostering - Reasonable Assurance (Nov 25) opinion. IA Consultant Job Plans - Reasonable Assurance (Feb 26) opinion.
Estates & Digital Team (Response to new resource bids)	Team in place		
Deliver efficiency savings and targets 25/26	**Transformation and Efficiency Group reporting**	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).	Temporary staffing controls / ECP panels and escalation.	NHSE Oversight - Triple lock

Actions (to modify risks)		By When	By Who	Gap	Update
14	Deliver Financial Efficiency Target 26/27	Mar '27	TS	Control	2025-26 workstream closed and 2026-27 workstream opened. The efficiency plan target is £47.1m. The target includes workforce, local schemes and reductions in OOA placements. These will be monitored within Transformation and Efficiency Group (Fortnightly meetings) and via AF meetings. Note change of action to deliver financial efficiency target for 2026/27 and new action reference 14.
15	Deliver Financial plan for 26/27	Mar '27	TS	Control	2025-26 workstream closed and 2026-27 workstream opened. The Trust has agreed a breakeven plan including £6.3m of Deficit support funding. Month 01 results are £0.5m behind plan including impact of Industrial action. Note change of action to deliver financial plan for 2026/27, and new action reference 15.

SR9 - Digital and Data Strategy (2144)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5 x L3 = 15	*C5 x L3 = 15*	*C5 x L2 = 10*	**Note 1:** Previously reported complete action 1-10 have been removed from the report. **Note 2**: Action 12 approval is required to formally close the action as new CRR entry supersedes the existing action.

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

Actions (to modify risks)		By When	By Who	Gap	Update
11	Digital Target operating model implementation - phase 2	Extended June '26	AW	Control	The June 2026 timeline is dependent on NOVA delivery. The Digital Target Operating Model will only be delivered after NOVA goes live. Given the repeated extensions, there is a need to assess whether the delivery timeline remains achievable. Action on track for June 26 Red RAG rating due to repeated extension to timeline.
12	Implementation of new UEPR	Apr-27	ZT	Control	The NOVA programme continues to make good progress. Through ongoing programme review and assurance activity, a new potential risk relating to system integration and overall programme complexity has been identified and entered onto the Trust Corporate Risk Register. The new Nova risk now tracked as CRR and links to this action.

SR10: Workforce Sustainability (2145)

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

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

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

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

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
People Strategy	People Strategy Implementation Plan 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
Workforce Planning and Modelling Team	Care Unit and Corporate workforce plans Operational Planning meeting Workforce Planning meeting	PECC oversight of workforce modelling plans at Trust level.	Submission to system plans

Actions (to modify risks)		By When	By Who	Gap	Update
6	Delivery the People Strategy Implementation Plan 2025/26	Extended June '26	Executive Director of People and Culture	Assurance	Quarterly updates through People Committee. Reviewing and refining strategy with presentation of revised draft at Executive Committee most recently in May 2026 and People Committee in April 2026. It is expected that the strategy will be ratified by Board of Directors in June 2026.

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	These actions are associated to the substantive workforce and the temporary workforce plans. In terms of the substantive staffing plan this will required enhanced controls around recruitment with an emphasis on the non-clinical workforce. In terms of the temporary workforce and achieving the plan this will be based on recruitment alongside safer staffing, oversight of observations, reduction in corporate temporary staff and a reduction in medical vacancies from the position of consultant vacancies at 22wte. Revised Governance arrangements for Establishment Control Panel and temporary staffing use commenced April 2026. Review of Guidance and Terms of reference completed and circulated to leads April 2026. Monitoring via weekly and monthly workforce reporting.

SR11: Staff Retention (2146)

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

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

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

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

Controls Assurance

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

	Actions (to modify risks)	By When	By Who	Gap	Update
6	Delivery the People and Education Strategy Implementation Plan 2025/26	Extended June '26	Executive Director of People and Culture	Assurance	Quarterly updates through People Committee. Reviewing and refining strategy with presentation of revised draft at Executive Committee most recently in May 2026 and People Committee in April 2026. It is expected that the strategy will be ratified by Board of Directors in June 2026.
7	To develop a mechanism to review exit information and identify clear trends. This information will be triangulated with pulse and annual staff survey information to better understand interventions to reduce staff turnover.	Extended April '26	Director of OD & Culture	Assurance	A quarterly retention report has been completed and will be presented at the Executive Team and People Committee on 30 April 2026. Exit interviews are led by managers and the prompt questions have been refreshed alongside a script and guidance. The managers handbook will be updated to reflect these changes in due course. The Staff Experience Intranet is under review and all resources and tools will be clearly available on a dedicated page alongside the quarterly reports. The recruitment and retention policy HR57 is next due for review in December 2026 by the head of resourcing who has been informed that retention elements will need review.

Actions (to modify risks)		By When	By Who	Gap	Update
8	Delivery of People Promise objectives with an emphasis on new starter experience.	Extended April '26	Director of OD & Culture	Assurance	Proposals for strengthened and improved induction experience will be presented to an up-coming Executive Team with trials in place through March 2026. This will work will be included in the above retention report (See action 7). These proposals are based on research from other NHS Trusts. Further work is required for local induction processes that follow corporate induction to ensure that new starter experience is enhanced.
9	To complete and publish the outcome from the Cultural Review being undertaken by BRAP/Kings Fund.	Sep-26	Director of OD & Culture	Assurance	The cultural review is nearing completion with an expectation that feedback is provided to the Board in the first instance alongside areas of focus and possible development. It is then intended to be shared across the organisation alongside action to support cultural development.
10	To commence the new senior leadership programme from September 2026 and to develop a middle manager and aspirant leadership programme.	Mar-27	Director of OD & Culture & Director of Education	Assurance	The curriculum for the senior leadership programme will be informed by the outcome of the cultural review. Nominations have been requested from Care Unit and Corporate teams with programme to be initiated in September 2026. It is expected that a new aspirant and middle manager development programme, funded by a proportion of the apprenticeship levy will be implemented by March 2027 and delivered alongside partners at Angla Risking 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.	Oct-26	AD of OD & Culture	Assurance	Alongside the staff networks, engagement and co-creation of a new model of engagement with staff is being developed, ensuring representation and a voice across the Trust that can champion, help improve staff experience and act as an relational link between the care units, corporate teams and leadership.

SR12: Organisational Development (2147)

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

Likelihood based on: limitations of workforce plans that support recruitment and development leading to workforce sustainability
Consequence based on: Staff Survey (culture indicators) and identified quality of care risks associated with workforce sustainability.

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4= 16	*C4 x L4= 16*	*C4 x L3 = 12*	**Note 1:** Previously reported completed actions 1-7 and 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
8	Culture Review and Leadership Development Programme. Initiate and deliver Trust-wide Culture review.	Extended May '26	Director of OD & Culture	Assurance	Delivery has commenced with BRAP and King's Fund commissioned to undertake a Trust-wide culture review, set out in three phases - orientation (September to November 2025), discovery (December to January) and three research site deep dives across North Essex inpatient services, West Essex Community services and the Senior Leadership Group (February to April). Board seminar held in May 2026 to outline the culture review findings and next steps with the pilot leadership programme.
10	Deliver the Senior Leadership Development Programme pilot with the King's Fund/brap	Aug-26	Director of OD & Culture	Assurance	Following the culture review, a pilot senior leadership programme will be initiated for 30 colleagues from the three research sites.
11	Develop 3 year development plans that highlights talent mapping and support succession plans for each Care Unit as well as corporate teams.	Mar-27	Director of OD & Culture	Assurance	The OD & Culture team will work closely with care unit and corporate management teams to develop 3 year succession plans for development. This will start in Q4 (25/26) with nominations for the King's Fund/brap programme with engagement continuing with care units/corporate teams in Q1/2 (26/27) to develop 3-year talent and succession plans.

Actions (to modify risks)		By When	By Who	Gap	Update
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. The role of staff networks are also being reviewed with clearer focus and measurable outcomes as part of a wider review of the Trust strategy on Equality Diversity and Inclusion.
13	Deliver the Senior Leadership Development Programme with the King's Fund/BRAP for a further 60 colleagues, based on the culture review findings and pilot leadership programme.	Oct-26	Director of OD & Culture	Assurance	Service specification currently being co-developed with the King's Fund/BRAP with support from an internal steering group. Nomination forms and a talent mapping process will be undertaken to establish the first cohort starting in Autumn 2026.
14	To develop a middle manager and aspirant leadership programme.	Mar-27	Director of OD & Culture	Assurance	It is expected that a new aspirant and middle manager development programme, funded by a proportion of the apprenticeship levy will be implemented by March 2027 and delivered alongside partners at Anglia Risking University.

SR13 - Quality Governance (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:** Following completion of all actions a re-assessment is planned to review the score and to assess whether further controls / mitigations are required - with reduction to C4 x L2 = 8.

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

Key Controls	Controls Assurance		
	Level 1 (Management)	**Level 2 (Oversight)**	**Level 3 (Independent)**
Lead roles and subject matter experts	Nursing and Quality Structure Medical Directorate Structure Care Unit Leadership Triumvirate (Including DDQS)		IA Safeguarding (outcome detail to be added) identified high level diagnostic safeguarding practice with the aim of integrating coherent governance & training system across partnership working
Patient Safety Incident Management Team	Team Established		IA PSIRF (outcome detail to be added)
Clinical (Quality) Governance Structure	Each meeting annual work plan, annual report and effectiveness reviews.		CQC inspection report for Adult MH Inpatient Wards and PICU (July '25) identified a breach in governance as a consequence of not having adequate oversight of the breaches within the Safe domain. IA reviewed CG structure process - Reasonable assurance received Feb 26
Learning Collaborative Partnership	Forum attendance and effectiveness review. Quarterly Learning events		CQC inspection report for Adult MH Inpatient Wards and PICU provided positive assurance of learning from incidents.
Learning information communications plan			CQC inspection report for Adult MH Inpatient Wards and PICU provided positive assurance of learning from incidents.
Patient Safety Dashboard	Reviewing dashboards from IPR - key quality measures to focus on metrics to support patient outcomes		
Clinical staff mandatory and essential training	Training tracker and reports	Training reports to PECC	CQC inspection reports 2024 - 2025 for Clifton Lodge, Brockfield House and Adult MH Inpatients and PICU provided positive assurance.
ESLMS			

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

Actions (to modify risks)		By When	By Who	Gap	Update

Corporate Risk Register

May 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.

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

Controls Assurance

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

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

CRR 2598 - Nova Programme

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

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*
C4 x L4 = 16	*C4 x L4 =16*	*C4 x L2 = 8*

Executive Responsible Office: Executive Director of Strategy, Transformation and Digital
Director Lead
Board Committee: ET Week 1 & 3 and Joint Steering Board (JSB)

Controls Assurance

Key Controls	Level 1	Level 2	Level 3
Governance and Assurance	Established governance framework with supplier representation embedded in core meetings Reporting and assurance process embedded Nova Implementation Group Design Authorities CODA and TDRA	Exec oversight 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

Key Controls	Level 1	Level 2	Level 3
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
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
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

Key Controls	Level 1	Level 2	Level 3
Nova Strategy and Planning	Pillar strategies approved with delivery objectives in plan Domain plan assurance into Nova Implementation Group Nova Implementation Group	Nova Joint Programme Board and Nova Joint Steering Board	DHA assurance partner oversight

	Actions (to modify risks)	By When	By Who	Gap	Update
1	The scope of the systems to be replaced or integrated requires sign off between the trusts and Oracle health and approval though Nova governance	Complete	CIO	Control	Final list sent and approved with MSE and EPUT CIOs / CCIOs / CNIOs. Future changes to the System List to be managed via the Change Control process. Action Complete May 2026
2	Complete design and build for localisation which incorporates workflows and tests scripts being fully approved	27/07/2026	PD	Control	Design and build underway
3	Strengthen EPUT operational leadership by appointing a Nova Director of Operations who will further support programme delivery	12/06/2026	PD	Control	Recruitment ongoing. Advert published and external interviews concluded with no suitable candidates. Expressions of interest re-circulated; interviews planned for the first two weeks of June (subject to panel availability).
4	Additional staff resources to be released to support programme delivery	27/07/2026	CEO	Control	Weekly executive escalation meetings established and reviewing additional staffing resource requests
5	Baseline and regularly monitor the programme plan to ensure key milestone dates are achieved, and that any changes are formally agreed with full understanding of associated impacts prior to approval	30/11/2026	PD	Control	Weekly reviews are planned to commence to further strengthen oversight and progress tracking.

Risk Movement

May 2026

EPUT

Risk Movement and Milestones

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

Risk ID	Initial Score	May 24	Jun 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	June 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
SR1	20	15	15	15	15	15	15	Closed																		
SR3	15	15	15	15	15	15	15	15	**15**	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15
SR4	20	15	15	15	15	15	15	15	**15**	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15
SR5	20	15	15	15	15	15	15	8	**8**	8	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
SR11	16						New	16	**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
SR13	20							New	**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 (May 24 – May 26)

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

8.2 PATIENT SAFETY STRATEGY

Information Item AS

REFERENCES

Only PDFs are attached

Patient Safety Strategy - Quarter 4 03.06.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	03 June 2026

Report Title:	**Patient Safety Strategy - Quarter 4**					
Executive Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Lucy Beach Director of Safety & Patient Safety Specialist					
Report discussed previously at:	Quality of Care Group and Quality Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

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

Purpose of the Report		
This report provides the Board of Directors with an outline of the development of a patient safety culture within the Trust.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

- Note the contents of the report
- Request any further information as required

Summary of Key Issues

This quarterly report for Q4 2025–2026 provides an overview of how EPUT is delivering the Patient Safety Strategy, with a focus on strengthening insight, involvement, and improvement across the organisation.

During the period January to March 2026, the Trust continued to embed a culture of safety through incident management processes, regular multidisciplinary review forums, and improved data visibility. A total of 7,142 incidents were reported, a reduction from the previous quarter, with 89% categorised as no or low harm, indicating a stable harm profile. Key incident themes remain consistent including self-harm and pressure ulcers, while work is ongoing to align processes such as pressure ulcer reviews with Patient Safety Incident Response Framework. The report also highlights ongoing challenges in system usability, data extraction, and reliance on manual processes, which can delay learning and action, alongside continued efforts to reduce overdue incidents and strengthen oversight of investigations and action plans.

A Trust-wide learning event reinforced that while improvement activity is evident, it is not yet consistently embedded, prompting a strategic focus on implementing the Fundamentals of Care through five core Safety Improvement themes:

- Policies and Standard Operating Procedure (SOP) application
- Family and carer involvement
- Record-keeping
- Communication
- Physical health care

The report also highlights developments in Duty of Candour compliance, Patient Safety Partner engagement, and training, reinforcing a continued commitment to transparency, patient involvement, and sustainable system-wide improvement. The Trust remains committed to placing patient safety at the core of all care delivery. We continue to make progress over the past quarter in implementing the components of the Patient Safety Strategy, which supports our ambition to create a culture of openness, learning, and continuous improvement.

Key Issues:
Ongoing pressures on clinical teams are impacting the Trust's ability to consistently deliver timely Patient Safety Reviews and to provide robust, high-quality evidence underpinning associated action plans across Safety Improvement Plans, Patient Safety Incident Response Framework activity, and Prevention of Future Deaths responses.

Sustainability of Patient Safety Partner Model:
Further work is required to establish a sustainable and consistent approach to the recruitment, support, and retention of Patient Safety Partners to ensure meaningful and ongoing patient and public involvement in safety governance.

Compliance with Statutory Duty of Candour:
There remains a need to strengthen assurance systems to demonstrate consistent compliance with the Statutory Duty of Candour requirements, including timely notification, documentation, and evidence of meaningful engagement with patients and families following notifiable safety incidents.

Demonstrating Impact and Sustainability of Improvement:
While a broad range of improvement activity is underway, further work is required to evidence the measurable impact of changes made, ensure learning is embedded into practice, and demonstrate sustainable improvement outcomes at scale across services.

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

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

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

Acronyms/Terms Used in the Report			
PSIRF	Patient Safety Incident Response Framework	LFD	Learning from Deaths
PFD	Prevention of Future Deaths	PSP	Patient Safety Partner
PSIM	Patient Safety Incident Management	DoC	Duty of Candour
SIP	Safety Improvement Plan	PSL	Patient Safety Lead
DMT	Decision Making Tool	ARR	After Action Review
MDT	Multi-Disciplinary Tool	PSII	Patient Safety Incident Investigation
CQC	Care Quality Commission	PSIRP	Patient Safety Incident Response Plan

Supporting Reports/ Appendices /or further reading
Patient Safety Strategy Q4 Report

Lead

Ann Sheridan

Ann Sheridan
Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

QUARTERLY REPORT

FOR:
Board of Directors
From: Lucy Beach
Director of Safety and Patient Safety Specialist

Contributors:
Lucy Beach: Director of Safety
Nicola Armstrong: Patient Safety Specialist & Nurse Consultant Patient Safety
Roshni Patel: Head of Patient Safety Incident Management
Didier Stephen: Head of Shared Learning
Bethan Simpson: Clinical Lead for Safety and Family Liaison Officer

APRIL 2026

This Collaborative Learning report contains thematic details relevant to the scope of work relating to Patient Safety Incidents, Learning Lessons, Safety Improvement Plans and Duty of Candour in the delivery of the Patient Safety Strategy within EPUT.

Reporting Period:
Financial Year: 2025/26 - Qtr. 4
January 2026 – March 2026

INTRODUCTION

Welcome to the quarterly report for **Quarter 4 of the fiscal year 2025-2026**. This report aims to provide a comprehensive overview of the delivery of the Patient Safety Strategy core components. The foundations and vision of the Patient Safety Strategy is safer culture and systems, aiming to save 1,000 lives and £100 million annually.

The strategic aims are:

- Insight: Better use of data
- Involvement: Patients and staff as partners
- Improvement: Support for innovation

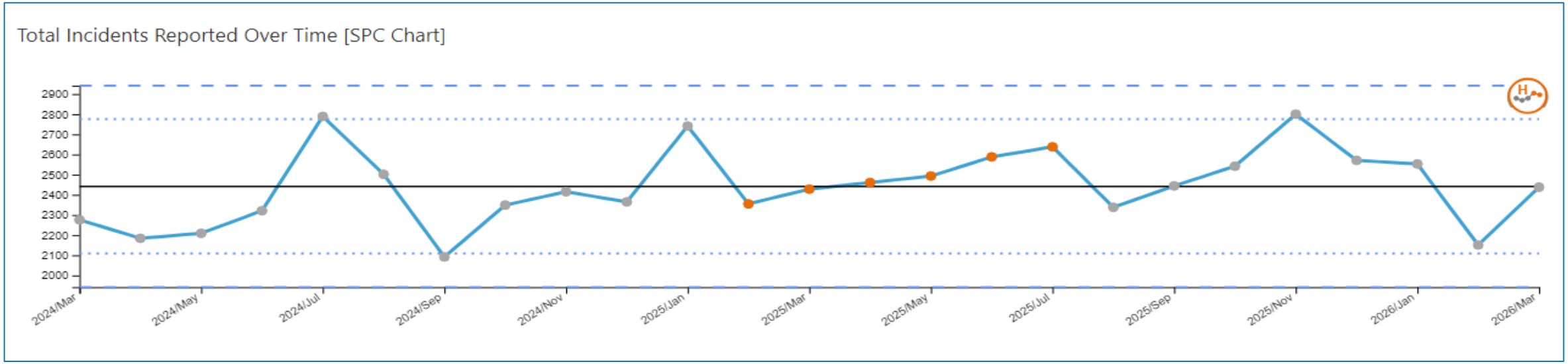
Over the past quarter, the Trust has continued to make advances in implementing the Patient Safety Strategy, ensuring that safety remains at the heart of everything we do. Our approach has focused on improving the robust management and monitoring of our incidents, embedding a culture of continuous learning, transparency, and improvement. Through collaborative working across the care units, we have strengthened systems for early identification of risks, our Duty of Candour processes and focussed on sustainable and achievable changes to improve care. These efforts reflect our commitment to reducing harm, improving patient outcomes, and fostering an environment where safety is everyone's responsibility.

PSIM: INSIGHT

Essex Partnership University NHS Foundation Trust

Patient Safety Data

SPC Chart Data – 1st March 2024 to 31st March 2026



Management of Incidents within EPUT

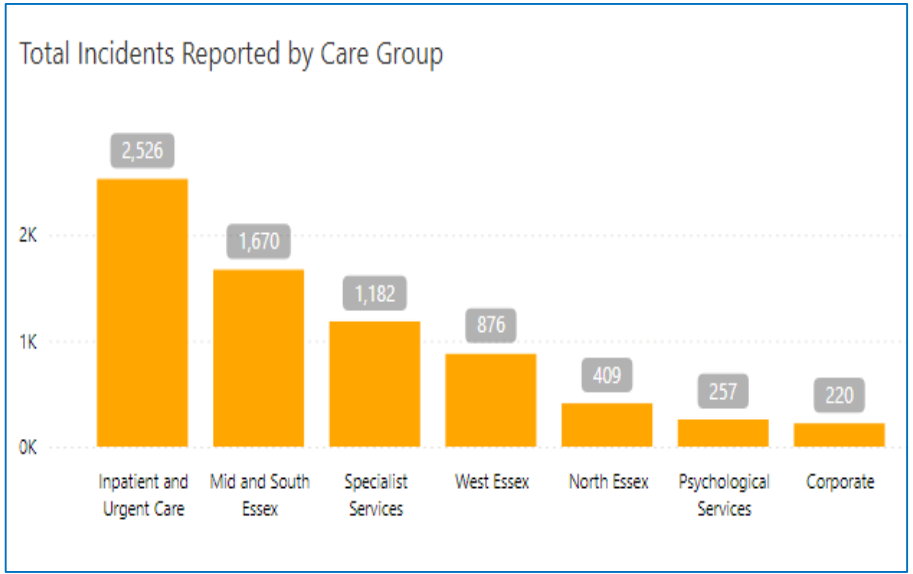
- Moderate harm and above incidents are reviewed at the daily triages (Mon-Fri) by the Patient Safety Leads and representation from the PSIM team. Incidents are also summarised and discussed at the weekly Emerging Incident Review Group. That data and discussion is included in the weekly Executive Committee report.
- All incidents are also presented on a weekly basis at the Care Unit Clinical Incident Review groups and patient safety data at the monthly Care Unit Accountability Framework meetings and the Care Unit Quality of Care Group meetings. From that later meeting, cascade through the Care Unit is expected. This flow of data demonstrates review and control of patient safety data through the organisation.
- There has been a recent request from MSE ICB that a summary of the EIR data is shared with them although we wait to see new structures in order to action that.

PSIM: INSIGHT

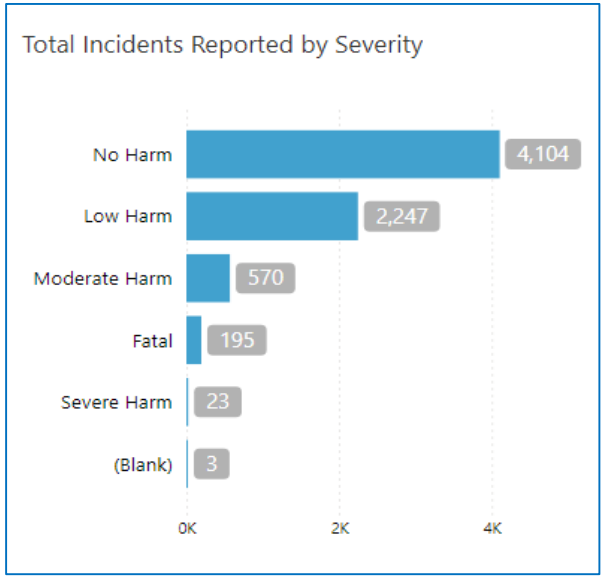
Essex Partnership University NHS Foundation Trust

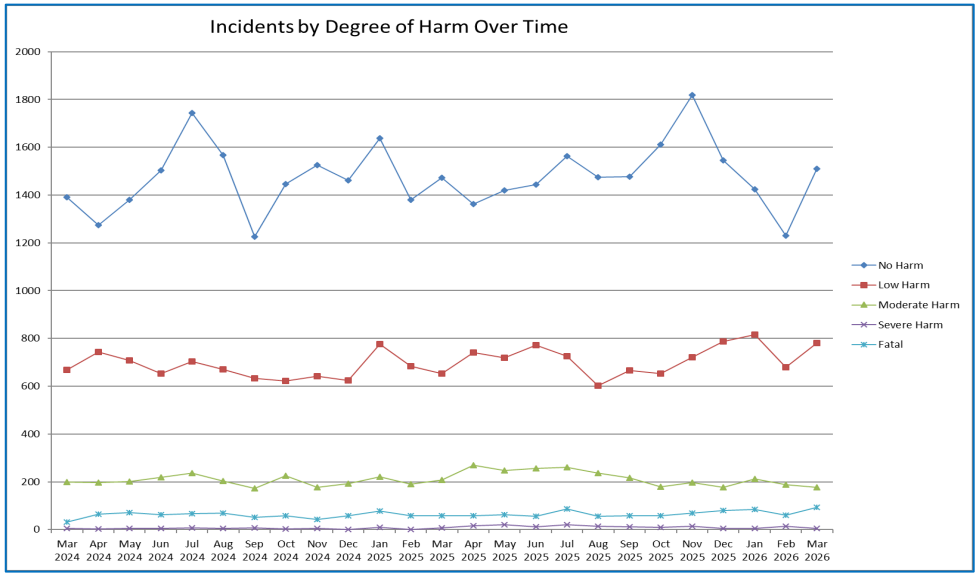
Patient Safety Data

Total Incidents by Care Group – 1st January 2026 to 31st March 2026 (Q4)



By Degree of Harm (Q4)





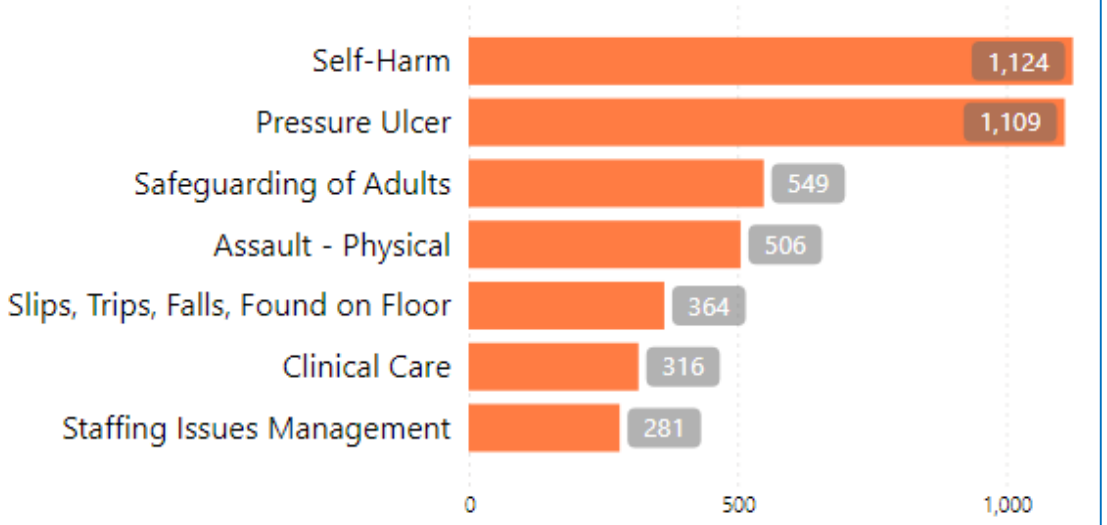
- **7,142** incidents were reported between 01/01/2026 to 31/03/2026 **(Q4).** That is **672 incidents less** than what was reported in **Q3 (7,814).** None of months or incident categories were outside of normal variation levels.
- **89%** of reported incidents were recorded as **no or low harm for Q4, Q3 was 84%**, illustrating harm profile has not changed significantly.
- Our incident reporting system relies on staff to self-report incidents, this is the same in all provider trusts although we may use different systems. In EPUT we use Datix, hence the terminology often used is number of Datix.
- We encourage staff to report incidents on Datix as this is crucial for us in understanding what is happening within the organisation. Our aim is to have a high reporting level but the harm levels to be no or low harm. Work has recently been undertaken through awareness session to increase knowledge on the NHS Patient Safety Levels of Harm. This will continue into the new reporting period.

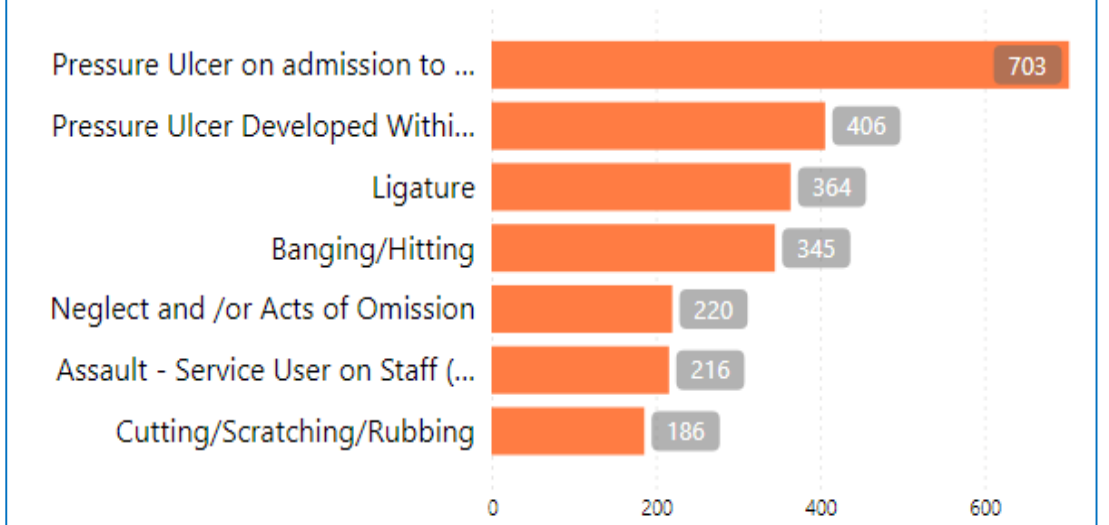
PSIM: INSIGHT

Essex Partnership University NHS Foundation Trust

Patient Safety Data

Total Incidents by Category & Sub-Category - 1st January 2026 to 31st March 2026





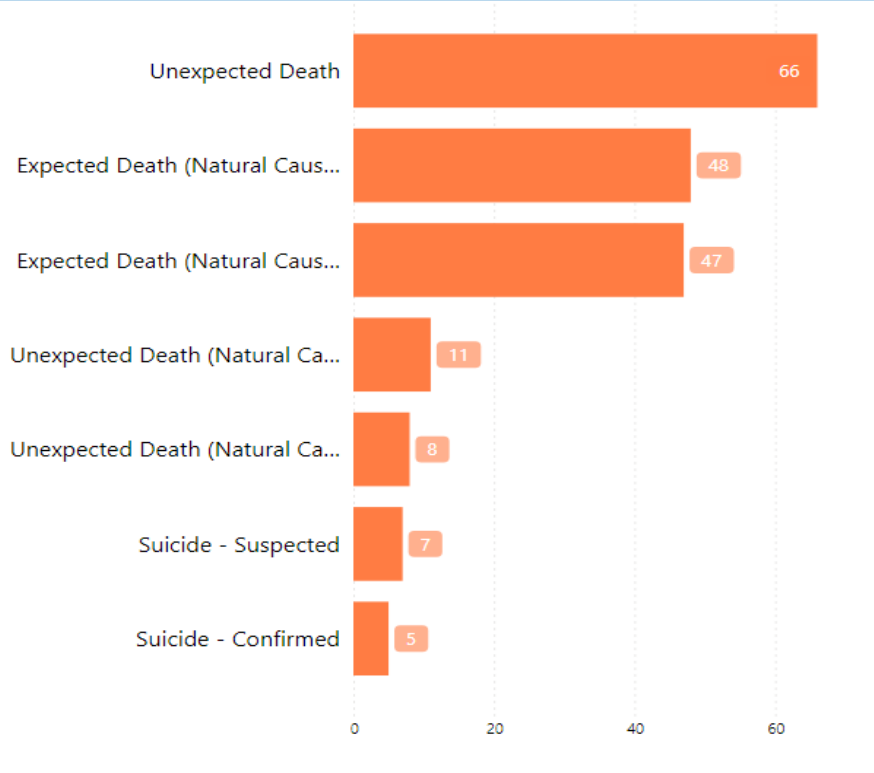
Self-harm and pressure ulcers remain the highest categories of incident which would be expected due to community health services being a core provider in both West, Mid and South-East care units. Pressure area care is a core function of community health provision. 63% of the pressure ulcers reported during this period developed not under EPUT care. Work has started to bring our process of reviewing pressure ulcers over from Root Cause Analysis to PSIRF with Tendable helping facilitate that work. There has been no concerns about the level of scrutiny given to pressure ulcers, this is more an alignment of processes.

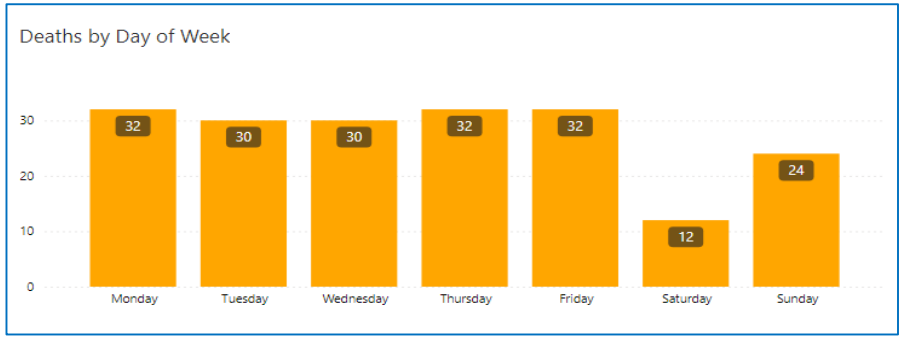
PSIM: INSIGHT

Essex Partnership University NHS Foundation Trust

Patient Safety Data

Total Deaths by Sub-Category - 1st January 2026 to 31st March 2026 (Q4 Total 192 – (191 in Q3)





Deaths Incidents

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2018	51	44	49	45	32	34	42	30	27	37	40	43	**474**
2019	50	32	51	37	26	36	35	38	20	36	37	46	**444**
2020	40	26	55	80	22	34	25	35	29	43	41	59	**489**
2021	95	51	46	26	36	40	38	39	42	39	40	45	**537**
2022	39	31	40	23	44	48	41	45	33	42	41	62	**489**
2023	54	59	75	55	80	66	51	52	55	56	83	60	**746**
2024	74	56	48	45	64	58	58	63	50	42	42	70	**670**
2025	73	60	65	44	68	50	75	45	49	57	80	78	**744**
2026	73	58	61	2									**194**
Total	**549**	**417**	**490**	**357**	**372**	**366**	**365**	**347**	**305**	**352**	**404**	**463**	**4,787**

49% of all deaths were reported as expected in Q4 (45% in Q3).

A cyclical pattern of deaths can be seen with more occurring in the winter months which is what would be expected. The increase in numbers reported from 2018 to the last couple of years is thought to be due to extension of services provided such as primary care mental health services and general increase of use of services, but this will be reviewed further.

All deaths reported on Datix undergo a Stage 1 review/Swarm or DMT. Depending on the information supplied at these, a DMT, Swarm, AAR, MDT or PSII may be commissioned.

Categories on Datix
Expected death (Natural Causes suspected)
Expected death (Natural Causes confirmed)
Unexpected death (natural)
Unexpected death (Natural Causes confirmed)

Not all patient deaths in our services meet the criteria for reporting as a patient safety incident on the incident reporting system. However, all the deaths we are informed of, which meet the Learning from Deaths criteria, are reported on our incident reporting system. As a result, the incident reporting system currently captures that a death has occurred but does not always indicate whether it was related to an incident. Further work is underway to address this limitation.

PSIM: INSIGHT

Essex Partnership University NHS Foundation Trust

Patient Safety Data

Total Number of Reports in Progress

	Total
DMT	61
AAR	1
MDT	18
PSII	16
SWARM	72
Overdue	103
Total	168

Significant work is ongoing to monitor the progress of reviews and ensure the position statement on the incident reporting system is current when data is downloaded. The care units and the PSIM team come together on a weekly basis to update progress on reviews and action plans. However, our patient safety system is not intuitive and requires multiple downloads, filtering with the overall theme being that of a system that relies on manual persistence rather than automated assurance. The delays in our processes are driven by external dependencies, fragmented information systems, over-reliance on manual chasing with learning being deferred until late stages.

Number of Overdue PSIIs in Progress Updated 30th April 2026

Ref	Incident date	Category	Care Unit	Internal Target Date	Commissioned Date	Current Status
E276796	18/08/2024	Death	Inpatient and Urgent Care	14/04/2025	20/01/2025	The PSL will be completing the report during the next fortnight and then will present at the next INPUC CUIRG
E311357	20/10/2025	Death	Mid and South Essex	09/02/2026	13/11/2025	Factual accuracy and wider stakeholder feedback 6th May, then share with family back to CIRG 20th May for sign off
E311942	28/10/2025	Death	Mid and South Essex	15/04/2026	05/01/2026	6 weeks extension approved at CIRG on 04/03/2026. Internal target date adjusted to 15/04/2026. Remains overdue, but support in place for LRL.

4 reports signed off 28/04/2026, 1 in process of being commissioned, 7 PSIIs within timescale

Total Number of Open Action Plans

	MSE	West	NE	Inpt/Uc	SS	Psychology
Number	**30**	**16**	**29**	**53**	**15**	**0**

This also remains an area where much work is required, and the proposal is we move towards an improvement plan for each care unit.

Overdue Incidents for Closure

	MSE	West	NE	Inpt/Uc	SS	Psychology	Corporate
Number	**62**	**72**	**46**	**98**	**71**	**30**	**235**

Significant work has been undertaken by staff in the care units and corporate services. This is reflected in the reduction of overdue incidents over the last few months. Although there have been difficulties using the dashboard on the incident reporting system so this has been removed and reports are run instead.

PSIM: INSIGHT

Progress with external commissioned / homicide reports updated 7th May 2026

These reports are presented in detail as require additional management by the PISM team and are high profile.

Ref	Incident date	Directorate	Investigating Lead (PSI)	Current Status (PSI)	PSI Team Incident Notes
E311357 (Homicide)	20/102025	Mid and South	EPUT	Learning response review is underway	Factual accuracy and wider stakeholder feedback 6th May, then share with family back to CIRG 20th May for sign off
E261724	13/02/2024	Inpatient and Urgent Care	Independent - FM - 26/02/2025 this has now been recommissioned to Independent - Anne Richardson Consultancy.	Learning response review is underway	In process of approving report and developing Safety Action plan scheduled.
E261694 (Homicide)	02/01/2024	Mid and South Essex	Independent Domestic Homicide Review	External Organisation Leading investigation/review	NHSE commissioning an independent review
E227825	01/08/2023	Specialist Services	Independent - FM - 26/02/2025 this has now been recommissioned to NICHE Health and Social Care Consulting Ltd.	Learning response review is underway	Final report received and action plan being developed.

PSIM: INSIGHT

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Patient Safety Alerts

Reference	Alert Title	Originated By	Issue date	Status	Response	Deadline
UKHSA2026/002PH	Outbreak of Invasive Meningococcal Disease, South East England	Department of Health	19/03/26	Issued	Assessed - relevant to organisation's services	09/04/26

INTERNAL ALERTS

Reference	Alert Title	Originated By	Issue date	Status	Response	Deadline
INT LIG 26 001	Safety Alert – all matrons and service managers at Linden/Crystal Centre	Internal Alert from H&S Team	18/02/26	Issued	5 responses still required	20/02/26
INT GEN 26 003 – Incident Reporting	Incident Reporting	Internal Alert from Safeguarding Team	16/02/26	issued	17 responses still required	02/03/26
INT GEN 26 002 - Search Training	Search Training Safety Alert	Internal Alert from H&S Team	13/02/26	issued	9 responses still required	27/02/26

Notable development in this quarter is the re-establishment of the EPUT Safety Specialist Group that will review the safety alerts and the safety alert process. This review will test the current system to ensure a robust process is in place to manage safety alerts (both national and local/internal).

PSIM: INVOLVEMENT

NHS
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Statutory Duty of Candour

Legal Basis: Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, this duty mandates that healthcare providers regulated by the CQC must be open and transparent with patients (or their representatives) when care results in significant harm. It applies to registered providers, (NHS trusts, primary care, private practice, social care), with NHS bodies bound since November 2014.

The duty is triggered when a "notifiable safety incident" occurs, defined as an unintended or unexpected event which causes, or could cause, any of the following:

- Death directly caused by the incident
- Severe harm (e.g., permanent disability or major organ/brain damage)
- Moderate harm (e.g., requiring extra care like unplanned surgery or hospital stay)
- Moderate or above psychological harm

What EPUT must do when Duty applies:

- Notify the patient or representative
- As soon as reasonably practicable, the provider must inform the patient or next of kin
- Must deliver both a verbal notification and a written apology which is meaningful
- Provide a clear, jargon-free explanation of what happened factually, whatever is remembered or known, with transparency about any ongoing investigations
- Offer reasonable support (e.g., emotional or psychological aid, interpreting services, guidance on next steps) throughout the process
- Record details of the notification, apology, support offered, and any subsequent actions or investigations

A Statutory Duty of Candour letter has been introduced since December 2025:

- Changes to Datix to allow electronic reporting is undergoing further refinement, manual review of Incidents will need to happen for previous data for 2025/2026
- This will apply to all incidents of the relevant harm levels not just the incidents reviewed under PSIRP
- There is the risk that we have not been compliant in some cases previously, and this work is being undertaken so we can understand the extent and to ensure we are compliant going forward
- An improvement program has commenced – further details on next slide

PSIM: INVOLVEMENT

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Patient Safety Partners Update

The Patient Safety Partners (PSPs) are a recommendation from the NHS Patient Safety Strategy (2019).

PSPs serve as **knowledge brokers and critical advocates**, ensuring NHS safety strategies remain grounded in real patient experiences. Through structured roles, formal governance involvement, and national support systems they:

- Ensure the patient voice is central to safety strategies
- Act as “critical friends” to challenge assumptions and promote safer care
- Support the NHS Patient Safety Strategy and PSIRF from boardrooms to policy workshops, helping NHS services become measurably safer and more responsive to patient needs

PSPs are patients, carers, or members of the public who work with NHS organisations.

EPUT initially had several PSPs working within the Trust in a variety of ways, but more recently, that activity has ceased whilst renumeration issues are resolved. We will now proceed with PSPs being volunteers and this process has commenced.

PSIM: LEARNING & INVOLVEMENT

Themes identified across submissions into Learning Collaborative Partnership (LCP Q4)

Communication Quality & Information Flow (including inconsistent or unclear handover and overuse of jargon & acronyms): Gaps in information sharing between teams, wards, GPs, AMHPs, and families. Inadequate justification of decisions in risk-based scenarios. Challenges with timely notifications.

Documentation & Record-Keeping Quality: One of the strongest consistent themes throughout Q4 including missing or incomplete clinical records. Poor rationale recorded for prescribing, care reductions, or risk decisions. Variability in documentation of assessments, falls, post-incident reviews, and safety plans.

Workforce Capability & Capacity Repeatedly Drive Variation: Skills, training, staffing pressures, and role clarity underpin many issues. Need for more consistent up-skilling, including medication safety and risk assessment. Variation in supervision, training, and appraisal completion.

Risk Recognition Needs Earlier, Clearer, & More Consistent Action: From deterioration to safeguarding to crisis calls. Early signs of deterioration missed or not escalated. Crisis calls not always escalated or documented properly. Over-reliance on parental self-reporting in safeguarding. Inconsistent application of DNA Policy and follow-up.

Patient & Carer Involvement Directly Affects Safety & Outcomes: Highlighted both as a strength (particularly in community mental health services) and a gap (notably in safeguarding and risk documentation).

PSIM: LEARNING & INVOLVEMENT

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EPUT Quarterly Learning Event

On 18 February 2026, the Trust brought together representation from ICB, NHSE, other providers, peer workers, frontline staff and managers at a stakeholder event to consider the most important opportunities to improve care. Key safety intelligence was reviewed, including:

- Prevention of Future Deaths reports and Trust responses
- Patient safety reviews
- Patient safety review action plans

The analysis of data shows that while the Trust is learning and improvement is visible, it is variable and largely driven by low to medium-level transactional actions. As a result, improvements are not consistently embedded, and sustainable, cross-organisational change is not yet achieved. The action taken forward is to embed consistent, person-centred Fundamentals of Care across all services by strengthening five core Safety Improvement Plans (SIPs), ensuring care is reliable, coordinated, and grounded in lived experience:

Policy and Standard Operating Procedures (SOP) Application (continuing work to ensure policies/guidelines/SOPs are fit for practice)
What this is: A systematic approach to ensure policies, guidelines and SOPs are clear, current, usable at the point of care, and applied reliably in practice.

Carers and Families (engaging with and listening to families and carers)
What this is: A consistent approach that recognises carers and families as partners in care, with structured involvement and feedback at key points in the pathway.

Record-Keeping (ensuring clinical records keep patients and staff safe)
What this is: Making sure clinical records contain the right information, in the right place, at the right time, supporting safe decisions, handovers, and continuity.

Communication (within and between teams)
What this is: Reliable communication standards (e.g., handovers, referrals, transfers, escalations, MDT continuity) that reduce error and improve coordination.

Physical Health Care for People with Mental Health Needs
What this is: An integrated approach to meeting the physical health needs of people using mental health services, to reduce avoidable harm and inequalities.

SAFETY IMPROVEMENT PLANS (SIPs)

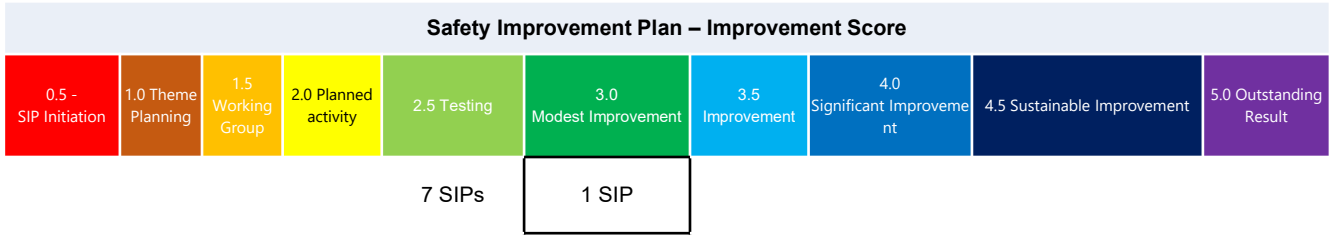
Overview

A comprehensive review of the SIPs and quality priorities have been completed with both internal and external stakeholders. This work has informed the Board-approved quality approach for 2026/28, summarised below.

The overarching quality priority for 2026/28 is the implementation of the Fundamentals of Care, which will be supported by five key SIPs:

1. Policies/guidelines
2. Family and carer involvement
3. Record-keeping
4. Communication within and outside teams and EPUT
5. Physical health care

Safety Improvement Plan	Progress
Ligature Risk Reduction	3.0
Falls Risk Reduction	2.5
MDT Communication Gap Risk Reduction	2.5
Transition of Children and Young People Risk Reduction	2.5
Patient and Service User Disengagement Risk Reduction	2.5
Record Keeping Risk Reduction	2.5
Clinical Handover Risk Reduction	2.5
Discharge and Transfer Risk Reduction	2.5



Each SIP is driven by a dedicated improvement group and monitored by the SIP Oversight Group.

SIP closure reports are submitted to Learning Oversight Sub-Committee (LOSC) upon completion of improvement objectives.

LOSC serves as the approving authority for SIPs and validates assurance and governance before approving it as embedded into Business as Usual (BAU).

Key achievements and current status:

- Policy and SOP Application risk progressed to work as we do/BAU
- Facilitated the Carradale AI project to support thematic review
- SIP internal Intranet page established
- SIP Oversight Group held an extraordinary meeting in March to support care co-ordination as a key area supporting multiple SIPs
- Completion of review and approved quality priority and SIPs plan for 2026/28

What's next:

Work will now commence to develop the detailed work plans for delivering the 2026/28 SIPs. For the 2023/26 SIPs, any outstanding improvement actions will be transitioned into the relevant existing workstreams. This will ensure continuity, maintained oversight, and sustained monitoring of all remaining improvement pathways, including those SIPs not included within the new five priorities for 2026/28.

PSIRF RELATED TRAINING
QUARTERLY PROGRESS REPORT

Jan to Mar 2026

EPUT Lessons Team
Be the driving force for true learning

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TRAINING SESSIONS
Human Factors MDP 2 sessions 14 attended
SEIPS 5 sessions (5 staff)
Trust ECOL Induction 6 sessions 180 attendees
SWARM Huddle Training 2 sessions 9 attended

PSIM: LEARNING & IMPROVEMENT

NHS Essex Partnership University NHS Foundation Trust

Summary of issues raised at weekly Emerging Incident Review Group (January – March 2026)

Area	Key Points Raised	Actions / Assurance
Patient Safety & Risk Management	- High use of 1:1 observations - Delayed discharges and CTO recall risks - Extreme system pressure (OPEL 4) - Risks linked to safeguarding placements, disengagement, medication delays/stockpiling and environmental safety	- Strengthened care unit leadership and executive oversight - Need for enhanced operational dashboards (observations, discharges, risks) - Clear escalation during periods of extreme pressure
Incidents, Reporting & Learning	- Increasing number of overdue incidents and historic backlogs - Datix limitations affecting timeliness - Variable reporting confidence, particularly in community services	- Trust-wide focus on reducing overdue incidents - Improved monitoring of Safety Action Plan completion - Clearer expectations on learning translation into action
Documentation, Duty of Candour & Legal Readiness	- Ongoing issues with documentation quality (shorthand, missing records) - Variable upload of Duty of Candour letters - Rising coroner, inquest and tribunal pressures	- Targeted documentation and Duty of Candour awareness - Reinforcement of defensible record-keeping standards - Improved coordination of evidence and records
Workforce & Capacity	- Staffing fragility (AHP gaps, district nursing pressures) - Bank staff conduct and supervision variation - Training gaps (CPA, Oxevision, records) impacting assurance	- Review and prioritisation of mandatory and risk-critical training - Executive visibility of workforce risk - Focus on supervision and professional oversight
Complaints, PALS & Experience	- Delays in PALS responses - Increase in ADHD-related complaints - Need for earlier senior input in complex cases	- Earlier escalation and senior oversight - Focus on response timeliness and learning from themes

Jan - Feb 2026

KPI ECOL COMMUNICATION CHANNELS

EPUT Lessons Team
Be the driving force for true learning

Lessons identified newsletter & 5 Key Messages

Channel	January	Open rate	February	Open rate
Lessons identified newsletter SWAY	20 - Jan	1334(Currently1497)	18 - Feb	1416
Beyond the Uniform SWAY	20 - Jan	1222(Currently1352)	18 - Feb	1416
Wednesday Weekly	21 - Jan	577	18 - Feb	1439
5 key messages PDF	20 - Jan	156	24 - Feb	119
Lessons identified newsletter PDF	28 - Jan	122	24 - Feb	90
All Staff email invite to SWAY newsletter	29 - Jan	1334	24 - Feb	1416
ECOL landing page	1 - 31	592	1 - 28	669
Learning Matters page	1 - 31	12	1 - 28	27/Highest 73
Safety Action Learning Alert	1 - 31	19	1 - 28	/24Highest 126
PSIM landing page	1 - 31	52	1 - 28	72
SIPs landing page	1 - 31	105	1 - 28	72
LinkTree	1 - 31	23	1 - 28	14
Learning Matters session	28 - Jan	35	N/A	

Data collected on 10/03/2026. Please note that figures are subject to change. Channels containing multiple messages, such as the Weekly Newsletters, reflect the total open rate and do not account for individual views of specific articles.

QUESTIONS TAKEN FROM THE GENERAL PUBLIC

9. STRATEGIC INITIATIVES

9.1 OPERATIONAL PLAN 2026/27-2028/9

Information Item

ZT/AG/ AM/TS

REFERENCES

Only PDFs are attached

Operational Plan 2026-27-2028-9 03.06.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	3 June 2026

Report Title:	**Operational Plan 2026/27-2028/9**					
Executive/ Non-Executive Lead:	Zephan Trent, Executive Director Strategy, Digital & Transformation Alex Green, Executive Chief Operating Officer Trevor Smith, Executive Chief Finance Officer Andrew McMenemy, Executive Chief People Officer					
Report Author(s):	Anna Bokobza, Director of Strategy Simon Covill, Director of Operational Finance Jenny Davis, Director of Finance – Strategy & Commercial Rob Thorton, Associate Director of Business Analysis & Reporting Kelly Gibbs, Associate Director of People - Resourcing					
Report discussed previously at:	Finance & Performance Committee 9th February, 26th February, 19th March and 30th April Private Board meeting – April 2026					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

Purpose of the Report		
This report provides the Board with Trust's Operational Plan as previously agreed alongside the feedback received from the NHS England regional team in April.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to note:

- The final plan submitted
- The conditional acceptance and summary feedback received from NHS England dated 17 April
- Note the Trust's response to the feedback (not formally sent).

Summary of Key Issues

Medium term integrated delivery plan

- The NHSE Medium Term Planning framework specifies that providers are required to produce 5-year Integrated Delivery Plans as part of their final submissions. The Integrated Delivery Plan will be refreshed annually
- The MTIDP describes EPUT's planning principles and strategic context, linking the narrative to the core components of the Strategic Plan 2023/4-2027/8 and the review of this that was completed in summer 2025. It sets out key planning assumptions and evidence of an aligned vision for health and care in Essex with Essex ICB, including EPUT's role in driving the shift from hospital to community and delivering neighbourhood health
- The MTIDP summarises commitments for key operational enablers including workforce, digital and data, estates and finance and sets links agreed transformational priorities back to the current operating challenges
- Each Clinical Care Unit has developed its own MTIDP structured around its role in delivering the Trust's strategic objectives over the next five years. Care Unit plans have been approved through the Accountability Framework.

Operational planning process 2026/27

- The planning process was executed at an accelerated pace this year, driven by nationally mandated timescales. This enabled the organisation to gain earlier visibility of activity trends and forecasting assumptions than in previous years, strengthening preparedness for contract negotiations
- A strong foundation for this year's planning cycle was established through the Strategic Plan Review conducted over summer 2025. This provided clear organisational direction, underpinned by three bold strategic shifts that guide priorities for the next three to five years
- Clinical and operational leadership was highly engaged throughout, supported by coordinated input from corporate teams
- The overall approach remained firmly anchored in quality and safety principles. We maintained a consistent commitment to improvement, with finance positioned as an enabling function alongside workforce, digital, estates and other corporate enablers. Plans clearly articulate the links between service developments or efficiency schemes and their impacts on activity, workforce and financial outcomes
- The Executive Team played a central role in shaping, challenging and refining emerging plans. This included three dedicated deep-dive sessions between December and February, ensuring robust scrutiny and collective ownership
- There has been significant complexity in aligning planning assumptions with the ICB. This reflects the ongoing evolution of commissioning structures, the ICB's role in the planning process, and the need for coordinated assumptions among partners across the Mid and South Essex Community Collaborative (MSECC)

- All Board Directors were invited to attend extra-ordinary meetings of the Finance & Performance Committee on 9 February for delegated scrutiny and approval of planning submissions on 12 February
- The Finance & Performance Committee were notified on 13 March of changes agreed to the Year 1 financial plan ahead of a resubmission of fully triangulated plans to NHS England on 18 March. The Committee was additionally notified on 17 March of an agreed amendment to community health growth assumptions in a revised activity plan which was also submitted on 18 March.

Activity & performance plans

- The plan demonstrates a plan to eliminate inappropriate out of area placements by March 2028 and a strong focus on reducing adult and older adult average length of stay in line with national targets
- Delivery of flow improvement plans and length of stay reductions are heavily dependent on system partners and community capacity
- Oversight controls include weekly monitoring of flow metrics and grip on delivery of neighbourhood models that will enable the desired shift from hospital to community over time.

Workforce plans

	Workforce - Forecast Out-turn			
	31/03/2026	31/03/2027	31/03/2028	31/03/2029
	Year Ending	Year Ending	Year Ending	Year Ending
Summary Staff Detail	WTE	WTE	WTE	WTE
Substantive staff	6,424.34	6,190.77	6,166.93	6,166.93
Bank staff	907.24	733.00	629.00	554.00
Agency staff	99.81	44.00	25.00	0.00
Total staff	7,431.39	6,967.77	6,820.93	6,720.93
Total Establishment	7,045.02	6,799.62	6,567.97	6,439.63

- Assumes 10% substantive reduction to non-clinical roles in Y1 and decrease of an additional 50 non-clinical roles through MARS. Flat line of non-clinical roles for Y2 & Y3
- Flat line of clinical roles with the exception of known contract changes across the full period for Y1 through to Y3
- Assumes cessation of Inquiry staffing costs in Y2
- Temporary Staffing Reduction 26/27: 174 WTE reduction bank staff (15% spend reduction) and 53 WTE reduction in Agency Staff (30% spend reduction) in 26/27 aligning to national reduction targets and moving to a position of eliminating all agency by Q3 28/29
- This plan increases exposure to quality, access and staff experience risks but controls are in place to monitor and manage this risk through the Accountability Framework and Integrated Performance Reporting.

Financial plans

- The FY2627 plan submission is breakeven, as agreed under delegated authority from the Board at Extraordinary Finance & Performance Committee 26th February.
- Capital investments planned for FY2627 total £24.1m FY2728 £32.9m.

Oversight of delivery

- Delivery of Care Unit workforce, finance, activity and quality plans are routinely monitored via the monthly Accountability Framework process (quarterly for corporate functions)
- A sub-set of the metrics reported through the Accountability Framework is reviewed by the Board in the bi-monthly Integrated Performance Report

- Assurance of delivery against EPUT's suite of enabling strategies is provided to their "home" Board committee twice per year and to the Board by exception. In 2026/27 this cycle will include a sharper focus on the agreed inputs, measurable outcomes and time-bound milestones
- This is supplemented by the Strategic Impact report presented to the Board twice per year to provide assurance of delivery against the Strategic Plan
- Over the next two years, we plan to develop a board to ward framework for "actionable analytics" built on the adoption of modern technologies to provide clear visualisation of quality and performance measures as enablers for change across all levels of the trust.

Response from NHS England East of England Region

- The regional team has confirmed acceptance of EPUT's plans which are deemed partially compliant
- Full compliance is conditional on the full achievement of the developments set out in Appendix One to the letter received on 17 April
- EPUT's response to the requirements in Appendix One is presented for noting.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
EPUT Medium Term Delivery Plan Appendix 1 – EPUT Closedown Letter 17.04.26 Appendix 2 – Response to Operational Planning close down letter

Lead

Zephan Trent
Executive Director of Strategy, Transformation & Digital

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NHS Foundation Trust

Medium term integrated delivery plan

2026/27 to 2030/31

Version FINAL

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Executive Summary

Essex Partnership University NHS Foundation Trust (EPUT) enters the next five years with a clear ambition: fewer people in Essex should experience illness, and those who do must receive faster, safer, more personalised and compassionate care—close to home and supported by strong community networks. Our Medium-Term Integrated Delivery Plan (MTIDP) sets out how we will deliver this ambition between 2026/27 and 2030/31, in line with NHS England's national planning framework, the needs of our local population and in support of delivery of the 10 Year Health Plan.

Essex faces growing and changing population needs, with rising acuity in mental health presentations, increasing frailty, persistent inequalities, and pressure across inpatient and community pathways. EPUT has made progress, including reductions in long waits and improvements in inpatient flow, but continues to face significant challenges in workforce supply, sustained financial pressure, system fragmentation, and the cultural impact of the Lampard Inquiry. The Trust's recent Strategic Plan Review confirmed that our vision and objectives remain the right ones—but delivery requires deeper integration, greater digital maturity and a shift in how we work with communities and partners to **meet people where they are** in EPUT's next chapter.

By 2030/31, EPUT aims to be recognised as the leading provider of integrated mental health and community care across Essex, underpinned by:

- Neighbourhood-based, proactive, preventative models of care – supporting the shifts from hospital to community and from prevention to cure
- Being a fully trauma-informed organisation, in how we care, lead and work
- AI-enabled clinical pathways and operational processes, improving access, safety, productivity and personalisation – supporting the shift from analogue to digital
- Systems of care built around partnership, not organisational boundaries
- A more stable, skilled, and supported workforce
- Financial sustainability and the ability to reinvest in frontline care.

Five-Year Logic Model: Towards Standardised Community and MH Provision for Essex

INPUTS	• Workforce: staffing baseline, operating model changes, leadership development, cultural development to curiosity beyond risk • Digital: EPR implementation, integrated system data platform, AI enablement • Finance & estates: DSF recovery actions, efficiency programme, demand and capacity modelling, estates consolidation, neighbourhood hubs • Partnerships: Local communities, ICB, local authorities, PCNs, acute providers, VCSFE		
ACTIVITIES	• Deliver three bold moves • Become a trauma-informed organisation • Deliver neighbourhood health and accountable care • Adopt AI for personalised and preventative care models • Operational transformation programmes • Improving patient flow • Community First (community mental health transformation)	**SHORT TERM OUTCOMES** • Integrated frailty, dementia and INT models • Reduced LoS and OOA placements • Improved patient and carer experience • Fewer crisis presentations • More timely access to community MH services • Earlier intervention • Embedding personalised and preventative pathways • Actionable analytics	**LONG TERM IMPACT** • Fewer people experiencing severe illness in Essex • Those who do receive faster, safer and more personalised treatment • Neighbourhood teams deliver holistic physical and mental healthcare • Sustainable, highly engaged workforce and financial resilience • Improved equity in access, experience and outcomes for all communities
OUTPUTS	• Standardised neighbourhood model • Integrated MDTs around local populations • Virtual wards with maximised occupancy • Consolidation of specialist mental health services • Increased digital maturity, improved data quality • Reduction in temporary staff costs • Improved staff engagement, satisfaction and leadership capability		

Planning Principles

EPUT's integrated delivery planning process has been underpinned by the following principles:

Quality & Safety

- Keeping **quality of care** (**experience, effectiveness** and **safety**) **as defining priorities**. Despite the exceptionally challenging financial context, EPUT retains its commitment to planning driven by quality, safety, improvement and population need, with finance positioned as an enabler alongside workforce transformation, digital solutions, data and estates
- Promoting clarity on prioritisation and trade-offs, **balancing ambition with realism and feasibility of delivery**
- Creating **clear links between service development / efficiency / improvement plans** and the **effects on activity, workforce** and **financial plans**

Cultural & Learning

- Being **clinically** and **operationally led**, and **corporately enabled**, cascading through the Accountability Framework
- **Creating alignment** between Care Units' commitments and our corporate, enabling strategies
- Being a cornerstone of the Essex health and care system and play a driving role in the **delivery of system priorities**
- Collective responsibility to ensure that **all enablers are supporting delivery of committed priorities**
- Being based, wherever possible, on **data evidencing changes** in activity, demand or acuity

Summary of Planning Assumptions

- Population growth of 0.53% per year as per ONS projections
- Demand and acuity trends continue in line with those seen during 2025/26 unless otherwise specified
- Mental Health LoS reduction to max 45 days in 26/27 and elimination of inappropriate OOA placements by March 2028
- 10% substantive reduction to non-clinical roles in 2026/27
- Reduction of 15% in bank WTEs and 30% in agency WTE in 2026/27
- MHOST impact not included; assume MHIS funded in 2027/28 onwards
- NOVA go-live in October 2027 with release of large numbers of staff for training in 2027/28 and assumed cost alignment in 2026/27 to offset some investment as per business case
- Reforms to the Mental Health Act drive greater focus on choice and autonomy, least restriction, therapeutic benefit and individualised care and will bring in tightened detention criteria and statutory treatment plans with increased patient involvement

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02. EPUT's Strategic Plan

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EPUT's Strategic Plan 2023/4-2027/28

OUR VISION

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

Strategic objectives

We have four strategic objectives to achieve our vision:

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

EPUT's Medium Term Integrated Delivery Plan (MTIDP) for 2026/27-2030/31 sets out the commitments and priorities for the final two years of delivery against its Strategic Plan for 2023/24-27/28 and its ambitions for the three years beyond that, although it is acknowledged that these may change in response to internal and external factors.

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

Strategic Plan Review

The development of the MTIDP has been closely informed by the conclusions of the organisation's Strategic Plan Review that took place Q2-3 2025/26. This review was conducted to evaluate the ongoing relevance and feasibility of the Trust's stated vision, values and strategic objectives in an operating environment that has shifted significantly since the development of its Strategic Plan in 2022. It concluded that:

- EPUT's vision, values and strategic objectives remain relevant in the new context
- Deep capacity, performance and financial pressures remain
- Over two thirds of staff understand the Trust's strategic objectives and see their relevance to their role
- Quantitative evidence of delivery against all four strategic objectives is not yet consistently available from across the Trust, though considerable progress is demonstrable across all domains
- Enabling strategies need a consistent delivery roadmap for coherence and impact
- Adoption of AI offers significant potential to rapidly improve quality of care, improved access and address inequalities but requires focus and investment
- Impact on the social determinants of health (anchors work) will likely be better delivered by local neighbourhood partnerships than by sovereign organisations going forward
- Intelligence from patients and families tells us that our organisation needs to become truly trauma-informed to transform culture and quality of care
- A stronger and more influential position for EPUT as a System, Place, and Neighbourhood leader is within reach and desirable.

Delivery Approach for a New Chapter: Meeting People Where They Are

To achieve its vision of being the leading health and wellbeing service in the provision of health and community care in its current context, EPUT is planning to make three bold moves over the next three years. This will require reprioritisation of existing resources.

1

As a disruptive set of technologies, **AI** has the potential to:

- Unlock the step change **quality of care** necessary to deliver the level of service that local communities deserve
- Turn **patient experience into intelligence** that drives change
- **Personalise pathways**, automate referrals, enhance diagnostics and **reduce delays**
- Make big data the engine of **prevention** and support agile developments tailored to address inequalities
- Automate routine work and increase job satisfaction.

2

Becoming **a trauma-informed organisation** means recognising the impact of the incidents in people's lives on their day-to-day experience of working at, or receiving care from, EPUT. Accelerating this work will bring:

- Better outcomes for people receiving care
- Improved quality and safety
- Stronger workforce wellbeing and resilience.

3

Accountable Care is about taking a lead on integrated delivery of healthcare for a defined population, working in a different way with partners. This will support achievement of EPUT's strategic objectives to deliver safe, high quality integrated care and improving services with its partners. For local communities, this will bring:

- **More joined-up care** – reducing duplication and gaps so people experience seamless support
- **Better health outcomes** – by focusing on prevention, early intervention and coordinated management of long-term conditions
- **Improved use of resources** – funding follows need across the system rather than individual organisations, meaning local people benefit from more efficient services that can reinvest savings into frontline care.

This combined approach will enable EPUT not just to put **people at the heart of everything it does**, but to **meet people where they are**: through an individualised and culturally sensitive approach to care and organisational management and focusing integrated care delivery in the local communities where people live. Meeting people where they are recognises the fluid nature of lived experience and is equally applicable to physical and mental health service delivery as well as the variation of personal and professional experiences of our staff.

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03. Strategic Context

EPUT

Population Health Needs in Essex

- Population of approximately 2 million(1) which has grown by an average of 0.9% per year since 2011 and is predicted to continue growing(2). Growth is largely driven by migration, 2/3 from within the UK and 1/3 from abroad(3)
- Population is older than national average, with 20% aged over 65 compared to 18.7% for England(4) and has a smaller than average working age population of 56.5% compared to 58.1% for England(5)
- The following annual growth projections from ONS have been factored into EPUT's activity plans by age group

Essex Local Authorities	2026	2027	2028	2029	2030	Average
CYP: 0-17yrs	-0.30%	-0.31%	-0.42%	-0.49%	-0.51%	-0.41%
Adult: 18-64yrs	0.46%	0.38%	0.42%	0.43%	0.42%	0.42%
Older: 65+	1.65%	1.78%	1.74%	1.80%	1.80%	1.75%
Total	0.54%	0.52%	0.52%	0.53%	0.53%	0.53%

- Essex is becoming more ethnically diverse, though it remains less so than England overall. 83% of residents identify as White British, compared to 74.4% nationally. Thurrock (66.2%) and Harlow (72.8%) have the most diverse populations. The largest minority group is Other White (including Eastern European, Irish, Gypsy and Roma) at 5.9%, Asian (4.2%) and Black (3.4%)
- The population is roughly 1/3 urban, 1/3 rural and 1/3 coastal with different health needs in each
- 10.3% of Essex's population live in neighborhoods ranked amongst the 20% most deprived nationally(5). Most deprived areas include coastal towns of Southend, Canvey Island, Harwich and Clacton, larger towns of Colchester and Tilbury and new towns of Basildon and Harlow. These areas face poorer health outcomes, higher premature mortality and challenges such as more widespread unemployment, poor housing and digital exclusion
- The last five years have shown increasing demand and acuity in mental health need across Essex e.g. significant increase in referrals for ADHD/ASD assessments and increased in mental health disability reported by Local Authorities

Sources
(1) Population estimates 2024, Office for National Statistics (ONS)
(2) and (4) Population projections for local authorities 2022, ONS
(3) Greater Essex Trends 2024, Essex County Council
(4) 2019 Index of Multiple Deprivation

Current Challenges

EPUT's three immediate transformation priorities are designed to address its current operational challenges.

EPUT is currently ranked in the National Oversight Framework segment 3, 40th out of 60 Mental Health and Learning Disability Trusts nationally (Q2 results). In comparison to other Trusts, EPUT performs well in the following domains:

- Percentage of patient waiting >52 weeks for community services (Sept 2025)
- Percentage of patients aged 18-65 with >60 days length of stay (Q2 2025/26)
- Percentage of patients in mental health crisis to receive face to face contact within 24 hours (Q1 2025/26).

The domains where EPUT performs less well in comparison to peer Trusts are:

- Planned surplus/deficit for 2025/26
- NHS staff survey – engagement and raising concerns (2024)
- Urgent Community Response 2-hour performance (Q2 2025/26)

- We are **transforming mental health inpatient and community care** to improving inpatient flow, reduce average length of stay and patients inappropriately placed out of area
- We will **implement a new, first of its kind EPR** by 2027 across EPUT and Mid & South Essex NHS Foundation Trust, transforming how acute, mental health and community care is delivered and removing barriers between providers
- We will make a **step change in operational and corporate productivity** to create financially stable services for the future.

The transformation priorities will be supported by further embedding our approach to patient and carer involvement and investing in leadership development and cultural change across the Trust.

Financial Context

Overview
- Current financial pressures are driving progressive transformation across clinical and corporate services
- Operating context including wholesale change in commissioning architecture
- Impact of the Lampard Inquiry on resources, finances and risk appetite
- Implementation of major transformational programmes e.g. Time to Care mental health inpatient operating model and risk to realisation of associated benefits

Key drivers of financial pressures
- Mental Health Length of Stay, inpatient flow and Out of Area Placements
- Efficiency requirements and non-recurrent cost improvements
- Impact of inflation on operating costs
- Lampard Inquiry

Efficiency plans
- TTC benefits realisation and further flow interventions
- Temporary staffing reductions
- Local programmes and Corporate Services Review
- Flow improvements
- Use of technology

Capital programme
- NOVA focus for Y1-2
- Strategic bids for Return to Constitutional Standards and Safety priorities

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04. Delivery Approach

EPUT

Shared Vision with Essex ICB

EPUT and Essex ICB share a common vision for neighbourhood-based, preventative, high-quality care.

The ICB's draft commissioning intentions emphasise:

- Prevention
- Equitable access
- Local delivery
- Standardisation.

EPUT is positioning itself to be fully aligned with this direction. Together with the ICB and system partners, EPUT will be seeking to improve outcomes for priority groups across Essex, particularly those who are more currently more intensive users of health services, those living with frailty and long-term conditions.

Implementing a single EPR in partnership with MSEFT represents a significant and exciting opportunity to transform and integrate care, make safety improvements and drive value through improved data quality, streamlined data utilisation and creating potential for research and innovation.

Making Neighbourhood Health a Reality

EPUT is uniquely positioned to lead the delivery of a population health model, anchored in neighbourhoods, adding years of quality life for an agreed cohort of people of Essex and delivering consistent outcomes for all communities

- With a stable leadership team and improving financial position
- As the only provider delivering services focussed on Greater Essex
- Bringing experience delivering integrated mental and physical healthcare
- Through ongoing efforts to build trust with acute partners
- Bringing a track record of high-quality co-production and partnership with service users, families and carers.

The offer includes:

- Neighbourhood health service development delivered in partnership with primary care at scale
- Standardised and consistent community/MH core offers
- Strengthened population health capability.

Key features of the model would include:

- Whole population approach
- Patient led and co-produced
- Central role of GPs
- Maximal use of community assets and capital investment in neighbourhood health hubs
- Proactive screening
- A dynamic feedback loop for continuous improvement
- Early risk detection
- Variable definition of “population” as needed, but consistent ability to count and track and screen
- Enabled by AI and “big data”
- Aligned incentives and value shared between parties
- Application of actuarial techniques to aggregate health risk exposure

Leading into Neighbourhoods

Strategic partnerships and clinical relationships

Integration and Connectivity within a System

Peer support in all senses

Not everything will happen at neighbourhood level. We work across four nested tiers:

Hyper-local (practice / micro-area) — Continuity, local MDT huddles, social prescribing, VCSE.

Neighbourhood (50k+) — Integrated MDTs, proactive care, PHM, shared workforce.

Place/multi-neighbourhood (150k+) — Urgent care, diagnostics, community mental health, estates, digital.

System (ICB, County) — Acute, specialist services, major programmes.

Quality Priorities

In setting out our quality priorities for 25/26, we held a Quality Conversation workshop in February 2025 to ensure we continue with our commitment of a co-produced approach. We will continue to follow our Quality Assurance Framework (QAF) providing a structure and measures for success to understand what works best to make our services better for our service users and staff.

Quality Priority Overarching: Culture and Competence

- Quality Priority 1: Reducing Health Inequalities
- Quality Priority 2: Patient Experience with PSIRF
- Quality Priority 3: Experiences of Neurodivergent People, Families and Carers in Inpatient Care
- Quality Priority 4: Suicide Prevention
- Quality Priority 5: Reducing Inpatient Falls
- Quality Priority 6: The Management of the Deteriorating Patient
- Quality Priority 7: The Development of a Patient Safety Culture
- Quality Priority 8: Transformation of Community Mental Health Teams
- Quality Priority 9: Reducing Restrictive Practices

Our quality priorities are informed, overseen and delivered through co-production and partnership with those that have lived experience of EPUT's services.

What is Quality Planning?
•Uses existing data to define quality priorities
•Builds on issues that are important to people we care for, their loved ones and supporters, our staff, Board and system partners
•Aligns with the Trust strategic objectives, legal frameworks, national, regulatory and best practice
•Uses recommendations and learning from quality improvement to date

What is Quality Control?
•A set of tools, processes and checks to monitor impact against agreed standards
•A marker for following best practices and indicators of quality from a day-to-day perspective
•Are conducted by those who are doing the work

What is Quality Assurance?
•Are processes used to ensure and provide confidence through various evidence sources
•Quality Assurance includes assessment, triangulated evidence and reflection on quality
•Informs quality improvement areas across the Trust

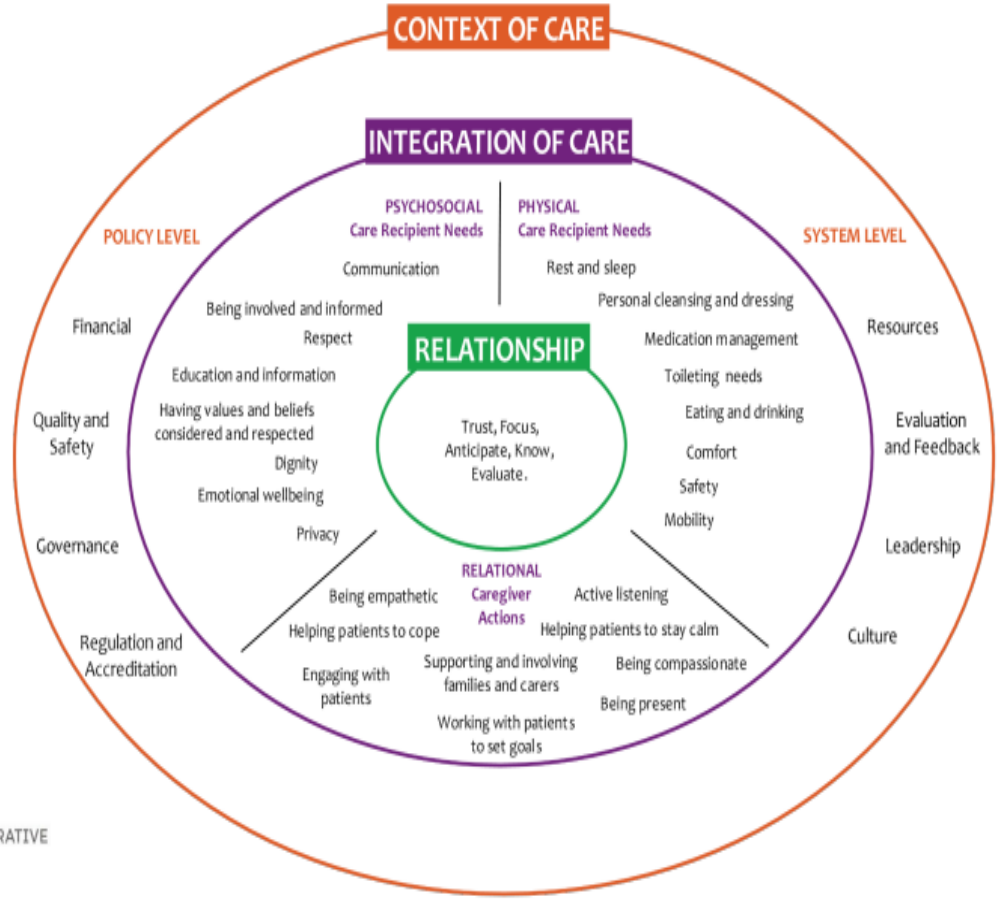
What is Quality Improvement (QI)?
•Is the systematic use of tools to continuously improve quality of care and outcomes for patients
•Includes key principles such as training staff in QI approach, using data to understand areas for improvement and empowering staff to act on ideas for improvement
•QI methods can work in discrete projects, as well as organisation-wide to ensure continuous quality improvement at scale

Fundamentals of Care

EPUT has adopted the Fundamentals of Care Framework that outlines what is involved in the delivery of safe, effective, high-quality fundamental care, and what this care should look like in any healthcare setting and for any care recipient.

The Framework emphasises the importance of nurses and other healthcare professionals developing trusting therapeutic relationships with care recipients and their families/carers. It also emphasises the need to integrate people's different fundamental needs; namely their physical (e.g., nutrition, mobility) and psychosocial needs (e.g., communication, privacy, dignity), which are mediated through the nurses' relational actions (e.g., active listening, being empathic).

EPUT has adopted this framework as it focuses first on the relationship, then the integration of care and the context of where that care is delivered. It is therefore meaningful and relatable to individual care settings, whilst providing a framework to support the care we provide to our patients



INTERNATIONAL LEARNING COLLABORATIVE
CONNECTED TO CARE

Digital, Data and Technology Priorities – 5-year View

- **Digitally enable unified care pathways** – The delivery and optimisation of the NOVA programme to drive efficiencies in the delivery of safe care and a higher quality of care delivery for our clinicians, our partners and our patients.

- **Continue the journey as a data insight driven trust -** Development of a board to ward framework for "actionable analytics". Build upon the adoption of modern technologies to provide clear visualisation of quality and performance measures as enablers for change across all levels of the trust.

- **Establish EPUT as a centre of excellence for digital innovation –** Embed AI into the fabric of EPUT and establish a culture of change as an AI enabled trust. Leverage tried and tested AI tools (Copilot and AVT) to drive efficiency and productivity. Explore innovation opportunities and partnerships with the private sector though co-production.

- **Enhance record sharing –** Continue to evolve the quality and value of the shared care record and patient portal with system partners to enhance clinical and social care decision support and patient interaction with their care. Step forward as the lead organisation for share care records on behalf of the Essex care system.

- **Maintain our digital sustainability** – Ensure that our digital and technology systems are sustainable to maintain safe and uninterrupted clinical and corporate operations, drive forward our cloud-first agenda to right size our infrastructure and reduce our technical department.

Workforce Context 2025/26

- In 2025/26 the Trust successfully worked within the ambitious targets set for both and agency consistently throughout the year
- This has led to a significant reduction in bank and agency usage with an emphasis on maintaining and enhancing patient quality. A reduction in bank usage from approximately 1,300 to 850 WTE has led to efficiencies by reducing pay spend on temporary staff from £83m to £46m
- The plan for 2026/27 is to enhance these efficiencies further. However, support on our nursing substantive model based on the MHOST safer staffing tool will be important to realise this continued trend of patient safety and appropriate clinical staffing
- Temporary staffing reduction plans will also need to accommodate release of staff for EPR training in 2027/28 to support successful delivery of NOVA. Reduction plans are predicated on changes in clinical and operational practices, reinforcement and compliance with clinical policies and safe implementation of AI solutions
- The Trust also effectively ran a MARS programme in 2025/26 with a reduction of 30 WTE while using this opportunity to enhance innovative working practices. It is expected that this will be repeated in early 2026/27
- The Trust has demonstrated improvement in key workforce indicators relating to vacancy levels and turnover. In 2026/27 we will prioritise enhanced staff support that will improve staff attendance and reduce cost.
- In 2025/26 we have delivered a reduction in consultant vacancies, and it is expected that 2026/27 will create further opportunity for improvements with reduced consultant and medical vacancies that will therefore support both the quality agenda as well as creating further efficiencies.

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Workforce Strategy – 2025 - 2030

Rationale for Change

Workforce supply pressures - National shortages and local challenges require innovative approaches to recruitment and retention.

Changing generational aspirations A new generation of staff seeking flexibility, inclusion, and meaningful career development.

AI and digitisation Technology is reshaping roles and creating opportunities for innovation in care delivery.

Economic and immigration shifts A challenging financial climate and reduced international recruitment highlight the need to strengthen domestic pipelines.

NHS financial position The drive for productivity and efficiency requires us to support our people to work differently, with the right skills and resources.

Shift to Community Care – Aligning workforce models to neighbourhood health centres to shift care from hospitals to community

The Path to Success

Assessing and understanding our workforce today We will undertake a comprehensive assessment of our current workforce, linking workforce to activity, finance, and service demand. By enhancing our use of workforce data and analytics, we will gain sharper insights into where pressures exist and where opportunities for improvement lie.

Forecasting and planning for the future We will develop improved insight into future workforce and skill requirements, using modelling to anticipate the roles, skills, and capacity needed to deliver our strategic aims. This will ensure we are proactive in shaping our workforce rather than reactive to short term pressures.

Attracting and developing talent from within our local communities, widening participation and creating meaningful employment opportunities. At the same time, we will invest in our existing people enhancing skills, supporting career progression, and creating structured pathways that enable staff to grow and thrive.

Partnering for success We will work closely with partners in further and higher education, as well as with system partners across the Greater Essex ICS. These partnerships will help us build sustainable pipelines of talent and ensure our workforce is equipped for the future.

Workforce Priority Aims

COMPASSION

- Trauma Informed Care – Creating psychologically safe environments
- Leadership Development Programme – Equip current& future leaders with skills to lead compassionately, manage change effectively & foster a culture if accountability
- Compassionate and Inclusive Leadership – developing in both people & thought leadership development, ensuring they are equipped to shave the future of health & so
- Professional fulfilment and Wellbeing Culture – compassionate care for patients begins with compassionate care for staff, prioritizing worklife balance, recognition and support
- Leadership Behavioral Framework – expectations for compassionate and accountable leadership

ATTAIN

- Improved Workforce Modeling – 5 year plans with annual professional specific planning, informed by data and analytics and trend analysis. Ensuring our workforce sup aligned with service demand and activity, financial sustainability and delivers the requirements of the 10 year health pan and greater ICS strategy
- Proactive, Locally focused recruitment – target under utilized and hard to reach talent pools, supported by improved employer branding & marketing.
- Widening Participation – Expanding partnerships with further and higher education providers to shape workforce skills and create sustainable employment pipelines

RETAIN

- Career development – clear career pathway and support for development aligned to workforce priority and delivery plans
- Flexible working – Expand opportunities to meet the diverse needs of workforce, enabling digital technologies to support with rostering and job planning requirements
- Priortising Equality, Diversity & Inclusion – Embedding EDI into everything we do
- Staff Engagement - Strengthen the staff voice by creating more opportunities for open dialogue, co production and feedback
- Reward & Recognition – enhanced programme to celebrate achievements and contributions of our people

EMPOWER

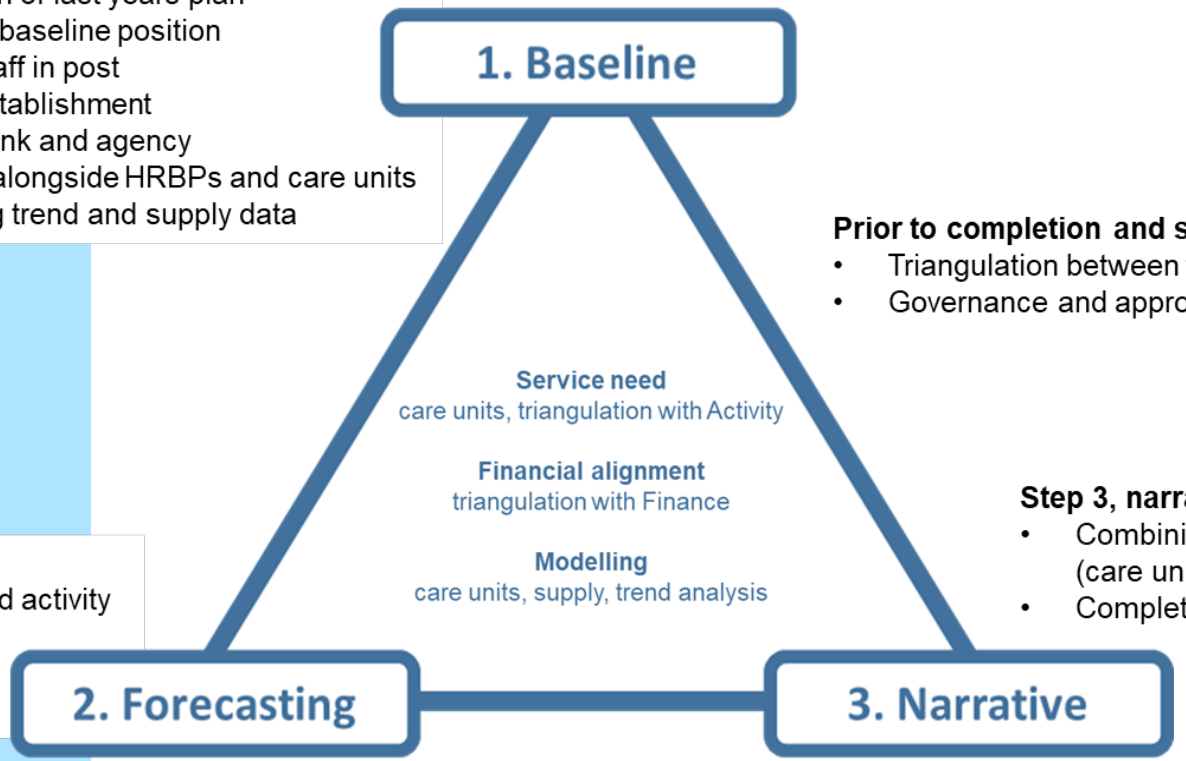
- Demonstrating University Status in Education Provision - Strengthen our reputation as a centre of excellence for education and training, working in partnership with universities and highe institutions. To become a leader in clinical education, research 7 workforce development
- Career Pathway Development – clear and accessible pathways for all staff groups and creating opportunities for development, and enhancing entry level routes
- Talent Mapping and Succession Planning – implement and expand processes to ensure the workforce is practicing at the top of professional capability and supported with progression into and leadership roles
- Innovation & Research Opportunities – expand opportunities for staff to engage in research, innovation and quality improvement projects. T foster a culture of curiosity and continuous in
- Technology & Digitalisation – enabling staff to embrace digital tools & AI to support learning, development and service delivery, with a view to improve productivity and release time for p

Activate Win
Go to Settings to

Workforce Planning

Methodology

Step 1, building the baseline
- Evaluation of last years plan
- Populate baseline position
  - Staff in post
  - Establishment
  - Bank and agency
- Working alongside HRBPs and care units
- Gathering trend and supply data



Prior to completion and submission
- Triangulation between finance, workforce and activity plans
- Governance and approval

Step 2, forecasting
- Full understanding of service need and activity
- Financial triangulation
- Extensive workforce modelling
- Modelling bank & agency projections

Step 3, narrative
- Combining information from various sources (care units, HRBPs, strategic plans, data…)
- Completion of narrative template

Forecasted Year End Position 25/26

Forecasted substantive staffing position based on the following modelling:

- M7 and M8 baseline
- 2023/24 and 2024/25 trends
- 2025/26 trend to date
- Remaining NQ pipeline
- Reviewed against M9 position

	2025-26 M12 31/03/2026				
	Establishment	Total Staffing	Substantive	Bank	Agency
Registered Nursing	**2,237.81**	**2,273.42**	**1,964.66**	**255.57**	**53.19**
Scientific, Therapeutic and Technical	**1,240.36**	**1,240.96**	**1,210.87**	**19.84**	**10.25**
Allied Health Professionals	455.15	438.12	423.29	6.58	8.25
Psychological Professions	595.20	597.82	595.95	1.87	0.00
Pharmacy	83.44	70.82	67.53	1.29	2.00
Other ST&T	106.57	134.20	124.10	10.10	0.00
Support to Clinical	**1,488.91**	**1,941.27**	**1,381.58**	**546.80**	**12.89**
Support to nursing	1,190.32	1,659.22	1,102.00	544.33	12.89
Support to AHPs	188.14	171.12	169.35	1.77	0.00
Other support roles	110.45	110.93	110.23	0.70	0.00
Total NHS Infrastructure support	**1,662.41**	**1,639.70**	**1,548.33**	**85.03**	**6.34**
Digital, Data and Technology	178.29	190.09	174.36	15.73	0.00
Estates and Facilities, central functions, property	361.80	298.79	283.28	15.51	0.00
Other Infrastructure & Support Staff	1,122.32	1,150.82	1,090.69	53.79	6.34
Other	**8.00**	**7.00**	**7.00**	**0.00**	**0.00**
Medical and Dental	**407.53**	**329.04**	**311.90**	**0.00**	**17.14**
Substantive Total	**7,045.02**	**7,431.39**	**6,424.34**	**907.24**	**99.81**

Forecasted Year End Position 26/27

Forecasted substantive staffing position based on the following modelling:

- Known contract changes
- Flat line to clinical roles (other than above changes)
- 10% substantive reduction to all non-clinical roles
- Decrease of 50 non-clinical roles due to MARS

	2026-27 M12 31/03/2027				
	Establishment	Total Staffing	Substantive	Bank	Agency
Registered Nursing	**2,150.14**	**2,181.77**	**1,957.81**	**205.64**	**18.32**
Scientific, Therapeutic and Technical	**1,176.25**	**1,230.37**	**1,210.47**	**14.12**	**5.78**
Allied Health Professionals	434.69	426.91	419.36	3.77	3.78
Psychological Professions	562.14	599.22	597.78	1.44	0.00
Pharmacy	84.46	71.18	68.23	0.95	2.00
Other ST&T	94.96	133.06	125.10	7.96	0.00
Support to Clinical	**1,518.57**	**1,821.19**	**1,371.73**	**445.87**	**3.59**
Support to nursing	1,203.72	1,524.84	1,077.35	443.90	3.59
Support to AHPs	182.93	170.59	169.15	1.44	0.00
Other support roles	131.92	125.76	125.23	0.53	0.00
Total NHS Infrastructure support	**1,562.87**	**1,402.90**	**1,331.93**	**67.37**	**3.60**
Digital, Data and Technology	158.84	161.14	147.36	13.78	0.00
Estates and Facilities, central functions, property	345.55	267.87	256.28	11.59	0.00
Other Infrastructure & Support Staff	1,058.48	973.89	928.29	42.00	3.60
Other	**8.00**	**7.00**	**7.00**	**0.00**	**0.00**
Medical and Dental	**383.80**	**324.54**	**311.83**	**0.00**	**12.71**
Substantive Total	**6,799.63**	**6,967.77**	**6,190.77**	**733.00**	**44.00**

Forecasted Year End Position 27/28

Forecasted substantive staffing position based on the following modelling:

- Flat line to all roles except those related to inquiry
- Removal of inquiry related staff

	2027-28 M12 31/03/2028				
	Establishment	Total Staffing	Substantive	Bank	Agency
Registered Nursing	**2,044.29**	**2,141.17**	**1,957.81**	**176.85**	**6.51**
Scientific, Therapeutic and Technical	**1,151.92**	**1,228.39**	**1,210.47**	**12.14**	**5.78**
Allied Health Professionals	414.21	426.38	419.36	3.24	3.78
Psychological Professions	562.14	599.01	597.78	1.23	0.00
Pharmacy	89.44	71.05	68.23	0.82	2.00
Other ST&T	86.13	131.95	125.10	6.85	0.00
Support to Clinical	**1,463.89**	**1,755.16**	**1,371.73**	**383.43**	**0.00**
Support to nursing	1,151.37	1,459.10	1,077.35	381.75	0.00
Support to AHPs	182.93	170.38	169.15	1.23	0.00
Other support roles	129.59	125.68	125.23	0.45	0.00
Total NHS Infrastructure support	**1,556.53**	**1,364.65**	**1,308.09**	**56.56**	**0.00**
Digital, Data and Technology	156.84	159.21	147.36	11.85	0.00
Estates and Facilities, central functions, property	353.80	266.25	256.28	9.97	0.00
Other Infrastructure & Support Staff	1,045.89	939.19	904.45	34.74	0.00
Other	**8.00**	**7.00**	**7.00**	**0.00**	**0.00**
Medical and Dental	**343.34**	**324.54**	**311.83**	**0.00**	**12.71**
Substantive Total	**6,567.97**	**6,820.91**	**6,166.93**	**628.98**	**25.00**

Forecasted Year End Position 28/29

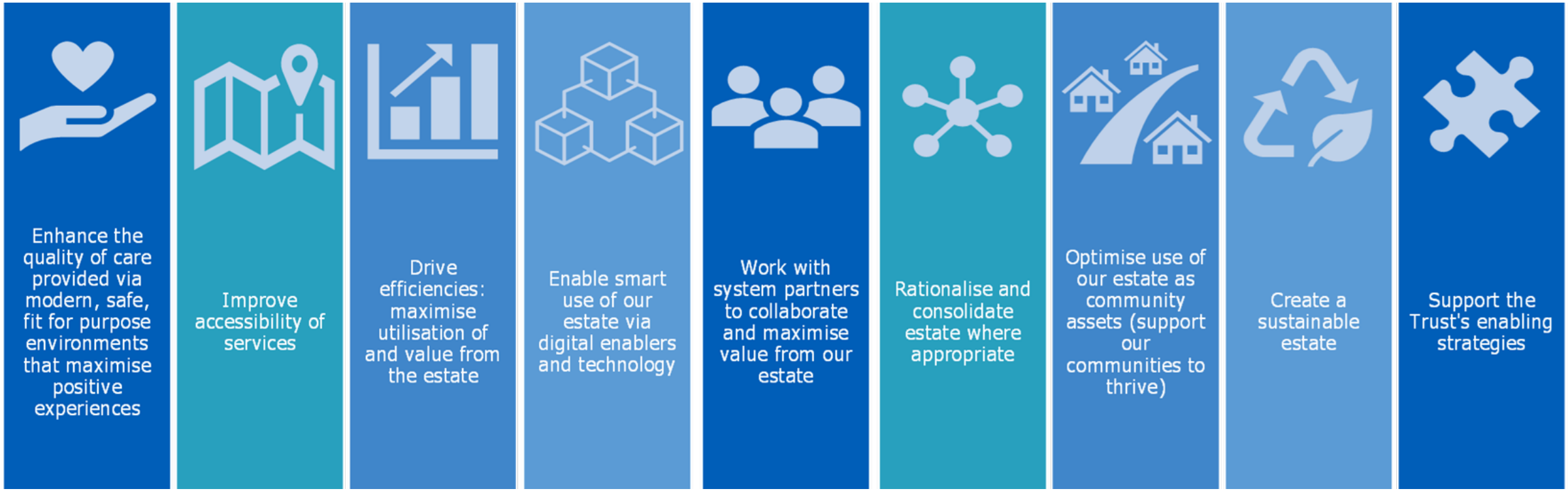
Forecasted substantive staffing position based on the following modelling:

- Flat line to all roles

	2028-29 M12 31/03/2029				
	Establishment	Total Staffing	Substantive	Bank	Agency
Registered Nursing	**1,998.59**	**2,132.47**	**1,957.81**	**174.66**	**0.00**
Scientific, Therapeutic and Technical	**1,143.10**	**1,222.61**	**1,210.47**	**12.14**	**0.00**
Allied Health Professionals	405.39	422.60	419.36	3.24	0.00
Psychological Professions	562.14	599.01	597.78	1.23	0.00
Pharmacy	89.44	69.05	68.23	0.82	0.00
Other ST&T	86.13	131.95	125.10	6.85	0.00
Support to Clinical	**1,463.85**	**1,699.16**	**1,371.73**	**327.43**	**0.00**
Support to nursing	1,151.25	1,403.29	1,077.35	325.94	0.00
Support to AHPs	181.11	170.24	169.15	1.09	0.00
Other support roles	131.49	125.63	125.23	0.40	0.00
Total NHS Infrastructure support	**1,499.76**	**1,347.86**	**1,308.09**	**39.77**	**0.00**
Digital, Data and Technology	142.96	152.79	147.36	5.43	0.00
Estates and Facilities, central functions, property	351.80	265.05	256.28	8.77	0.00
Other Infrastructure & Support Staff	1,005.00	930.02	904.45	25.57	0.00
Other	**8.00**	**7.00**	**7.00**	**0.00**	**0.00**
Medical and Dental	**326.33**	**311.83**	**311.83**	**0.00**	**0.00**
Substantive Total	**6,439.63**	**6,720.93**	**6,166.93**	**554.00**	**0.00**

Estates

Estates Strategy Key Objectives



Estates – 5 Year Prioritisation

Core Element	Delivery plan
Utilisation of core Estate	• Undertake space utilisation surveys • Invest in technical solutions for space monitoring • Develop agile working spaces
Rationalisation of surplus Estate	• Develop disposal plan and timeline • Review utilisation data
Reduction in Backlog maintenance and Investment in critical infrastructure	• Develop programme of high-risk backlog maintenance • Develop programme of critical infrastructure requirements • Preparation for submission to Estates safety fund • Ring fence funding through capital programme
Develop fit for purpose Estate	• Develop programme of works for key sites • Investment through disposal of surplus estate • Review of community assets and condition appraisals • Develop programme of works for key sites • Investment through disposal of surplus estate • Review of community assets and condition appraisals • Commission six-facet surveys
Transformation of Estates and Facilities services	• Review of current structures • Market testing and benchmarking of services • Align services to clinical units • Value for money service • Eliminate temporary staffing
Sustainable Estate	• Review and complete actions from Green plan • Investment in sustainable solutions • Prepare schemes in readiness for external funding submission • Review energy usage • Benchmark against peer groups

Research

- EPUT has an established track record of research delivery in mental health, dementia and neurodegeneration and is strongly committed to building on this to increase the impact of the research it delivers to local communities across Essex
- Since the launch of its Research Strategy in 2023, EPUT has made demonstrable progress building research partnerships, raising awareness of research across the Trust, building multi-disciplinary clinical capacity and capability to run trials, and rebalancing its research portfolio to deliver more complex, interventional research
- To fulfil EPUT's potential in research, support the advancement of care and drive improved and more equitable participation in research for more of the people we look after, our priorities for the next period are to:
    - Grow our research portfolio and enable more people to participate in a wider range of studies
    - Continue to build clinical capacity and capability across all professions
    - Grow our commercial research profile and portfolio
    - Support delivery of the national 150-day target for study set up
    - Develop and strengthen our academic, industry and research delivery collaborations
    - Attract maximum grant funding for reinvestment in capability and delivery.
- In 2026/27, we are planning to adapt our Target Operating Model for Research to enable these priorities and reposition research as a core part of care delivery.

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05. Finance and productivity

EPUT

Summary Revenue & Capital Plan

Summary Revenue (3 yrs) & Capital Plan (5 yrs)	FY2627 £m	FY2728 £m	FY2829 £m	FY2930 £m	FY3031 £m
Revenue Plan					
Revenue Plan (Surplus Yr 3)	0.0	0.0	2.8		
Deficit Support Funding (DSF)	(6.3)	0.0	0.0		
Financial Plan (Excluding DSF)	**(6.3)**	**0.0**	**2.8**		
Efficiency Plan					
Plan	47.1	37.6	24.4		
%	6.8%	5.6%	5.4%		
Temporary Staffing Targets					
Agency	5.3	3.4	1.5		
Bank	32.8	28.2	24.2		
Total Temporary Staffing	**38.2**	**31.6**	**25.7**		
Capital & Cash Plan					
Local					
Operational Capital	8.9	4.9	16.2	16.5	16.7
EPR match funding	6.5	11.0	0.0	0.0	0.0
National					
EPR external funding	0.0	0.0	0.0	0.0	0.0
Estates Safety & Sustainability	2.5	15.5	0.0	0.0	0.0
Constitutional	6.2	1.5	7.0	0.0	0.0
Capital Plan	**24.1**	**32.9**	**23.2**	**16.5**	**16.7**
Cash					
Closing Cash Balances Plan	**13.1**	**11.4**	**8.4**		

Capital

	2026/27 £m	2027/28 £m	2028/29 £m	2029/30 £m	2030/31 £m
EPR	6.5	11.0	0.0	0.0	0.0
Leases	2.5	2.5	2.5	2.5	2.5
Brockfield Capital Lifecycle	0.8	0.4	0.6	0.3	0.0
MH UEC Cfwd	1.5	0.0	0.0	0.0	0.0
Critical Infrastructure Cfwd	0.5	0.0	0.0	0.0	0.0
BLM	1.7	1.7	2.2	2.2	2.2
Digital	0.8	0.0	4.0	4.0	4.0
Estates Strategic Schemes	1.8	0.6	4.6	4.8	4.8
MEMS	0.4	0.3	1.0	1.0	1.2
Contingency/PDC Support	1.0	1.1	3.2	3.2	3.2
Technical CDEL Adjustments Lease & PFI	-2.2	-1.8	-2.0	-1.7	-1.5
Operational Capital	**15.4**	**15.9**	**16.1**	**16.3**	**16.6**
External Capital Bids					
Equipment	0.6	0.0	0.0	0.0	0.0
Neighbourhood Mental Health	3.0	1.5	7.0	0.0	0.0
Digital	1.1	0.0	0.0	0.0	0.0
Community	1.5	0.0	0.0	0.0	0.0
Total Constitutional Standards Bid (RtCS)	**6.2**	**1.5**	**7.0**	**-**	**-**
Estates Safety	**2.5**	**15.5**	**0.0**	**0.0**	**0.0**
PFI Lifecycle Residual Interest	0.1	0.1	0.1	0.1	0.1
Total CDEL	**24.1**	**32.9**	**23.2**	**16.5**	**16.7**

- Total CDEL for FY2627 of £24.1m, including external capital of £8.7m, this includes development of a Neighbourhood MH at Landermere, Ambient AI investment, Psynomics, Estates Safety funding and Community Equipment
- FY2728 Total CDEL increases to £32.9m including £17m external capital funding, including Neighbourhood MH in Thurrock, and a decant ward facility development
- FY2829 Total CDEL £23.2m, of which £7m is external capital toward Neighbourhood MH in localities
- All external capital included in the plan, has regional agreement following a prioritisation process. This includes £14.7m Return to Constitutional Standards and £18m Estates Safety Funding
- Estates Safety funding for FY2829 and FY2930 has not been included whilst there is ongoing prioritisation by regional team
- Brockfield Capital Lifecycle costs are now included in the operational capital plan following the change in accounting treatment in FY2526. These do not hit CDEL as they reverse as a technical adjustment
- Work is ongoing to look at our Estate Disposal profile, to support CDEL and cash pressure in FY2627 and FY2728

Transformation and Productivity

The Trust recognises that the Medium Term Planning Framework places a clear expectation on organisations to maintain and improve productivity throughout the planning period. While the 2026/27 implied productivity position shows an early year dip, this reflects a conscious decision to prioritise patient safety and stabilisation during the first six months—particularly for inpatient mental health services facing acuity and demand pressures.
To ensure alignment with national expectations, EPUT is implementing a productivity recovery programme, which includes:

- Reduced reliance on temporary staffing through enhanced recruitment pipelines
- Redesign of community pathways to support the hospital to community shift
- Targeted LoS reduction workstreams supported by flow analytics

Collectively, these actions provide a credible and deliverable improvement curve across the remainder of the year and strong alignment with the framework's expected year on year trajectory.

The Transformation Team enables delivery of the Trust's strategic transformation agenda through a disciplined, portfolio-led approach that ensures alignment to organisational priorities, effective governance, and measurable benefits. The transformation portfolio supports the Trust's alignment to the CQC Key Lines of Enquiry particularly Well-Led, Effective and Responsive through strengthened governance (TDSG, Prioritisation Framework), clear accountability (Executive Team assurance reporting) and measurable improvement (impact analysis and benefits tracking).

The focus areas for the team are on the following priority programmes:

- Time to Care
- Community First
- NOVA (Electronic Patient Record)
- Lampard Inquiry
- Improving Patient Flow
- Medium-Term Plan
- Efficiencies and Operational Planning (inc. Corporate Services Review)

Transformation and Productivity

Over the next five years, Transformation will focus on strategic priorities designed to improve patient outcomes, enhance workforce wellbeing, and ensure financial sustainability, all underpinned and enabled by the NOVA EPR transformation.

Productivity Area	Opportunity Identified	EPUT High-Level Response
Workforce Efficiency	High agency spend; low substantive fill levels	Deploy 'Train, Retain, Reform' to reduce agency. Expand bank staff and recruitment drives.
Service Activity & Throughput	Underperformance in community contacts/output	Scale up Community First and refresher of Time-to-Care standards to boost throughput.
Bed Days & Length of Stay	Extended inpatient stays	Embed 'Improving Patient Flow' initiative to reduce LOS and repurpose bed days.
Outpatient & Clinical Pathways	Multiple follow-ups & low use of digital tools	Integrate NOVA EPR and patient-facing tools to cut unnecessary follow-ups and streamline clinics.
Non-elective / Urgent Care Use	High MH A&E attendance rates	Expand safe havens and MH urgent care, capitalizing on Basildon model for diversion.
Community Contact & Caseloads	Inconsistent clinician contact rate	Apply demand segmentation, standardise contact frequency aligned to caseload capacity.
Demand vs Capacity Gaps	Rising MH referrals ahead of staffing growth	Use targeted recruitments + perinatal and CYP prevention programme to manage demand.
Cost per Episode of Care	High variation in unit costs	Conduct deep-dive into inpatient vs community cost profiles; shift resources accordingly.

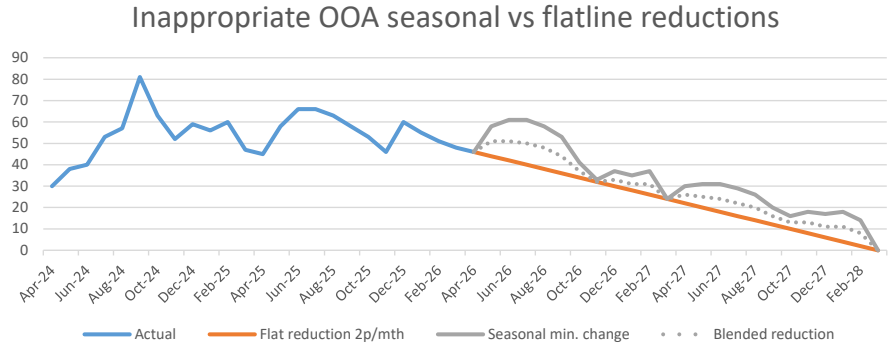
The team sets standards for delivery through consistent tools, templates, and guidance, ensuring a common approach to change across the organisation. This model provides clear accountability for delivery within agreed tolerances of time, cost, quality, scope, benefits, and risk, with regular reporting to the Executive Team and Board.

Mental Health Performance: OAPs and Length of Stay

- EPUT recognises the requirement within the Medium Term Planning Framework to deliver sustained improvements in mental health flow, including the elimination of inappropriate Out of Area Placements (OAPs) and year on year reductions in adult and older adult length of stay
- Although 2026/27 presents a number of operational pressures, the Trust has implemented a detailed inpatient flow and community capacity programme designed to ensure delivery of the national ambitions across the planning period
- For OAPs, the Trust has strengthened clinical oversight, increased daily operational review points, and committed ring fenced community capacity to support repatriation and prevent new placements. A revised escalation protocol, jointly agreed with Essex ICB, is now in place to ensure that any deviation from plan triggers immediate senior clinical intervention. Strategic workforce actions, such as enhanced crisis response, provide additional resilience to deliver a trajectory towards zero by increasing local alternatives to admission
- For Older Adult average LOS, the Trust acknowledges that baseline volatility and complexity of need create early year pressures. However, we have established a comprehensive improvement plan with targeted actions including: enhanced discharge co ordination, improved liaison with local authority partners, and investment in frailty aware multidisciplinary models aligned with neighbourhood care developments set out in the planning framework. These actions support a credible reduction in LOS across the three-year horizon.

Transforming Inpatient Mental Health Flow

- Continuing to transform flow through EPUT's inpatient mental health units is key to EPUT's plans to improve access for those that require a therapeutic admission, support shift of activity and resource from hospital to community and unlocking clinical productivity
- The commitment to eliminate inappropriate out of area placements by March 2028 is firmly underpinned by our Flow Transformation and Community First programmes as well as realising the full benefits of the Time to Care operating model.



Inappropriate Placed Remain OOA	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	Jun-27	Sep-27	Dec-27	Mar-28
Mid and South Essex	23	25	25	25	24	22	18	16	16	15	15	12	12	8	5	0
North East Essex	16	18	18	18	17	15	13	11	12	11	11	8	8	6	4	0
West Essex	7	8	8	7	7	7	6	5	5	5	5	4	4	2	2	0
EPUT Total	**46**	**51**	**51**	**50**	**48**	**44**	**37**	**32**	**33**	**31**	**31**	**24**	**24**	**16**	**11**	**0**

	Q4 25/26	Q1 26/27	Q2 26/27	Q3 26/27	Q4 26/27
Demand, Flow & Capacity	• Review s.136/MHA referral/demand • Implement flow roadshows • Agree actions from 2nd system discharge workshop • Medically review all patients staying >60 days	• 2 x new ED Diversion units operational • Prioritise HIUG and OOA discharges • Launch community asset log in each locality • s.117 refresh training	• Increase safe discharges at weekends • Redefine inpatient PD pathway for shorter stays and more community involvement		
Community First	• Data collection • Demand & Capacity • Core Functions	• Workforce analysis • Bottleneck analysis • Team structure • Future demand forecast • Adults implementation	• Demand & capacity management and optimisation • Define clinic flow and transfer pathways • Care pathway & SOP agreed • Referral, assessment and Care-Co standards set	• Standardised community model • Workforce optimisation recommendation • Models of care recommendation	• Older Adults implementation
Target Operating Model	Implementation complete – moves to BAU				

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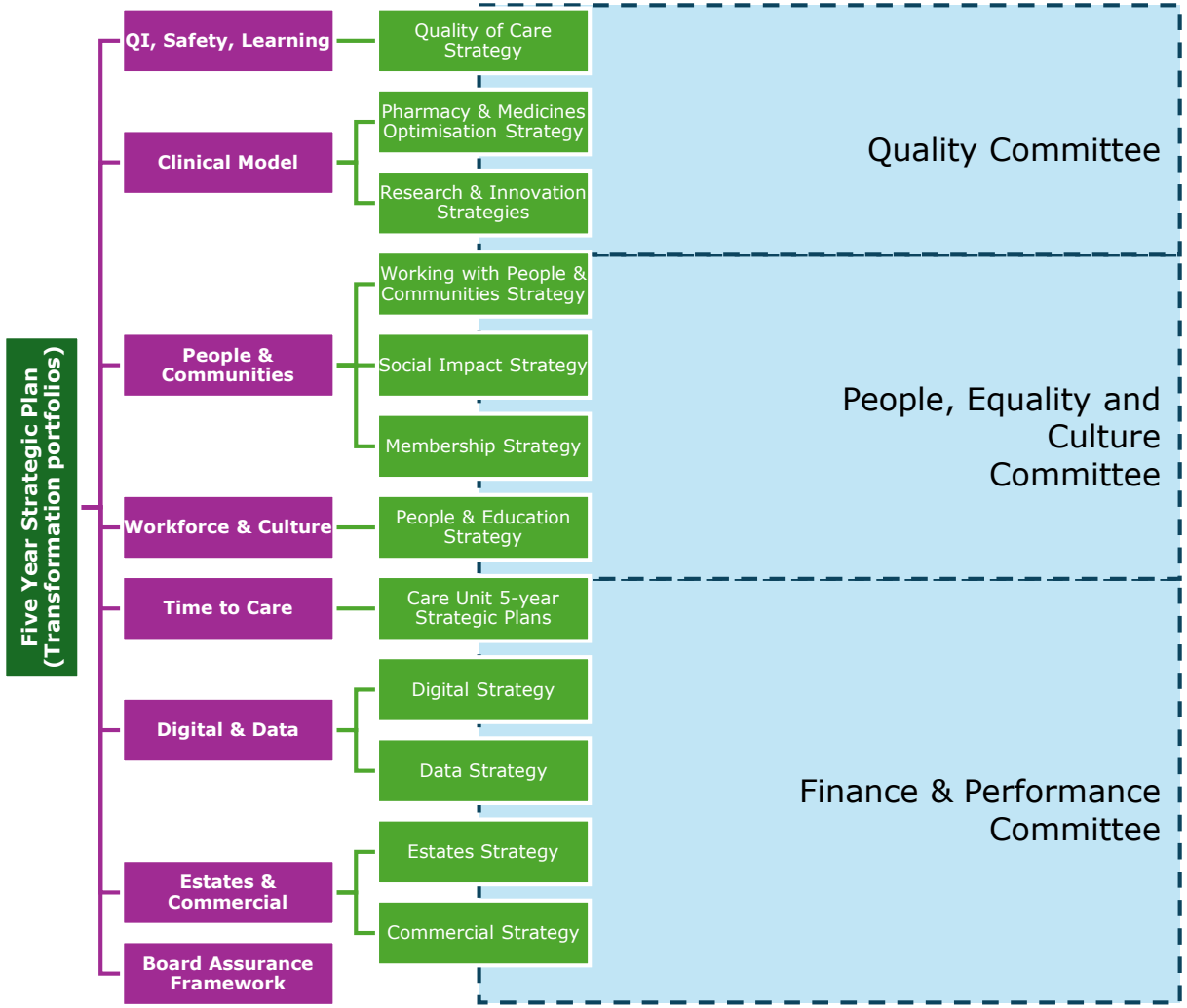
06. Oversight and Risks

EPUT

Enabling Strategies

- The Strategic Plan is underpinned by a streamlined suite of enabling strategies that are corporately owned and support operational delivery
- The Board receives twice yearly reports to provide assurance on the delivery of each of EPUT's enabling strategies via the relevant Board committee
- The annual operational planning process provides the opportunity for each Clinical and Corporate Care Unit to refresh and recommit to its priorities for the year
- During 2026/27, we will be exploring the application of Quality Improvement methodology and design of logic models to support robust implementation planning for all enabling strategies and demonstration of impact for the communities we serve from the changes we are making.



Monitoring and Reporting

- Delivery of Care Unit workforce, finance, activity and quality plans are routinely monitored via the monthly Accountability Framework process (quarterly for corporate functions)
- A sub-set of the metrics reported through the Accountability Framework is reviewed by the Board in the bi-monthly Integrated Performance Report
- Assurance of delivery against EPUT's suite of enabling strategies is provided to their "home" Board committee twice per year and to the Board by exception. In 2025/26 this cycle will include a sharper focus on the agreed inputs, measurable outcomes and time-bound milestones
- This is supplemented by the Strategic Impact report presented to the Board twice per year to provide assurance of delivery against the Strategic Plan
- Over the next two years, we plan to development a board to ward framework for "actionable analytics" built on the adoption of modern technologies to provide clear visualisation of quality and performance measures as enablers for change across all levels of the trust.

Trust Strategic Objective	Accountability Framework Domains
1. We will deliver safe, high quality, integrated care services	Quality & Safety Operational Performance
2. We will enable each other to be the best we can be	Workforce and culture Strategy, Transformation & External Relations
3. We will work together with our partners to make our services better	Quality & Safety Operational Performance Finance Strategy, Transformation & External Relations
4. We will support our communities to thrive	Strategy, Transformation & External Relations

Risks and Mitigations

- EPUT's risk model is set out in its Risk Management and Assurance Framework which describes how the Trust leads, directs and controls the risks to its key functions
- Our Board Assurance Framework (BAF) is designed to identify, evaluate, manage, monitor and oversee the movement in risks to delivery of our strategic objectives
- The MTIDP plan has been developed in alignment with the agreed mitigations for the 11 strategic risks and one corporate risks described in the BAF report of February 2026
- Our planned priorities address the strategic and corporate risks for 26/27 and beyond
- Reporting monthly against the BAF provides the opportunity to continually review operational plan throughout the year and make adjustments as necessary to support risk management and reduction
- Care unit priorities for 2026/27 have been agreed in direct response to local risks on which progress is reported monthly through the Accountability Framework.

Appendix 1
Paul Scott
Chief Executive Officer
Essex Partnership University NHS
Foundation Trust

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

17 April 2026

Dear Paul,

Essex Partnership University NHS Foundation Trust
Acceptance Status: Conditional

I am writing in response to the submission **of your final medium-term plan for 2026/27–2028/29** and your **five-year Integrated Delivery Plan**, and to set out next steps. Thank you for the extensive work across your organisation that has contributed to the development of these plans. Annex One of this letter summarises the key commitments your organisation has set out for delivery and any supporting actions to address key issues that have been agreed.

As you implement your plans our shared focus moves firmly toward delivering the strategic shifts and long-term transformation required to reset NHS performance and build a sustainable, modern health and care service. The Medium-Term Planning Framework set a clear expectation that organisations will work over multiple years to restore constitutional standards, strengthen community-based care, and accelerate prevention and digital transformation. Planning over multiple years means that planning does not end with submission of your plan; the focus on delivery will also be accompanied by ongoing foundational work as you continue to work on understanding any changes in the demand and capacity of your services and population health needs.

Transforming our services remains essential to achieving the required outcomes for patients as well as productivity and efficiency improvements to ensure sustainability. We will continue to work with you to ensure your organisation has in place the development and improvement support needed to strengthen capability and capacity, drawing on national resources where available.

Your submitted plan has been reviewed against the expectations set out in the national guidance and has been assessed as:

Partially Compliant; conditions to achieve full compliance are set out in Annex One.

Effective oversight of the delivery of these plans will be important to ensure that the ambitious trajectories are met. Primary responsibility for this sits with your Board. NHSE will review progress against these plans through our regional governance arrangements to ensure that there is continuous oversight, alignment across organisations, and transparent governance.

The region will operate a risk-based escalation process, from routine oversight through enhanced monitoring to full regional executive escalation, with clear triggers for senior involvement at each stage to ensure timely intervention. Organisations are expected to monitor performance routinely, pro-actively identifying and escalating issues.

We recognise the importance that you, as an NHS provider, play in improving population health outcomes and reducing health inequalities, including the essential work to deliver the NHS health inequalities legal duties and requirements outlined in the NHS England statement on information on health inequalities, and the shift to prevention. Providers play a key role in our collective work to halve the gap in healthy life expectancy to ensure more people live in good health for longer, thereby reducing demand on health and care services. As a region, we will continue to with work you and other partners, including ICBs and local authorities, to support delivery of population health improvement.

Please share this letter with your full Board and let me know if you wish to discuss any of the above.

Yours sincerely,

Clare Panniker
Regional Director
NHS England – East of England

Annex One

The table below shows your full submission and compliance against the key ambitions within the three years until 2028/29.

- The Trust must deliver in line with its planned performance commitments.
- For CYP 104 week waits, the regional team are aware of the variance between the November 2025 position (20) and M1 26/27 planned position (0). The team will connect with EPUT to understand how this reduction has been achieved during Q4, as this may provide helpful learning for others.
- For both adult and older people's LoS the plan is agreed for Y1 at this stage. As there is no planned reduction to LoS in subsequent years the forward plan is not in line with requirements. The regional team will continue to engage with EPUT regarding the plan for Y2/3 reductions.
- The Trust is expected to report on its progress towards compliance over the year. The Trust should focus on continuing progress in developing efficiency plans with the aim of seeing a reduction in the % of high-risk schemes by month 3 reporting.
- The Trust to review misalignment between workforce and expenditure movements during 2026/27. Provider to share basis being used to assess whether temporary staffing levels are in line with internal plans (as financial budgets not included in line with WTE).
- The Trust should continue to focus on delivering a minimum of 2% productivity growth, supported by fully developed, recurrent schemes that are aligned across finance, workforce and activity plans, with clear ownership and in-year monitoring.
- Providers should ensure that they comply with all national MHMDS, Community Sitrep and FDF reporting requirements for RTT and 52 weeks waits for community and mental health referrals (as relevant to the services they provide), continuing to review and improve data completeness and quality. Providers are expected to build on progress made in 2025/26 reducing the number of patients with excessive waiting times over 52 weeks, achieving 78% of patients waiting less than 18 weeks in 2026/27, 79% in 2027/28 and 80% in 2028/29. The region will continue targeted work with providers reducing the longest waits with a focus from April 2026 on patients waiting more than 40 weeks for assessment and treatment.

Headline metrics

		2026/27				2027/28				2028/29			
Document Section	Planning Metric	Time point	Baseline /Target	Plan	Variance	Time point	Baseline /Target	Plan	Variance	Time point	Baseline /Target	Plan	Variance
3.5 Mental Health	Number of active inappropriate adult acute out of areas placements (OAPs) at the end of the reporting period	Mar-27	10	24	14	Mar-28	24	0	-24	Mar-29	0	0	0

Supporting metrics

		2026/27				2027/28				2028/29			
Document Section	Planning Metric	Time point	Baseline /Target	Plan	Variance	Time point	Baseline /Target	Plan	Variance	Time point	Baseline /Target	Plan	Variance
3.5 Mental Health	Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period	Mar-27	0	0	0.0								
	Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 month rolling metric)	Mar-27	51.6	40.0	-11.6	Mar-28	40.0	40.0	0.0	Mar-29	40.0	35.7	0.0
	Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 month rolling metric)	Mar-27	105.2	75.0	-30.2	Mar-28	75.0	75.0	0.0	Mar-29	75.0	60.0	0.0

APPENDIX 2

Response to Operational Planning close down letter

The Executive note the conditional acceptance status of the plans it submitted in March 2026 and has reviewed in detail the areas of partial compliance set out in Annex One. It recognises the importance of addressing these at pace and has strengthened both delivery plans and governance arrangements to ensure full compliance within expected timescales.

1. Delivery against planned performance commitments

The Executive recognise its accountability for delivery of the plan and has further enhanced and strengthened oversight accordingly.

A refreshed Transformation and Efficiency Group (TEG) has been established as the single forum for delivery of efficiency, workforce, activity and financial commitments, with:

- collective, senior operational, clinical and corporate ownership of the challenge
- clear delivery accountability for all major programmes
- structured escalation of risks and underperformance
- aligned reporting across all delivery areas

This is supported by:

- Executive-led governance and oversight of each major efficiency programme
- Executive, Finance & Performance and Board review of performance and any remedial/improvement plans via the Integrated Performance Report
- Accountability Framework for Clinical and Corporate Care Units to report on delivery and escalate risks or needs for corporate support.

2. CYP 104-week waits

In terms of the query regarding CYP 104-week waits and the variance identified between the reported November 2025 position and the planned trajectory. Initial review indicates that this metric may relate to services delivered outside of EPUT direct service provision. The Trust is working with system partners and the regional team to confirm the data source and ensure consistent interpretation of MHSDS submissions. We will validate the position and provide clarification to the region, including any implications for how waiting time performance is represented within the Trust's plan.

3. Average length of stay trajectory

It is recognised and acknowledged that ALOS trajectories beyond year one were not sufficiently developed at the point of submission.

Following clinical and operational review, trajectories have been reset to deliver progressive improvement over the planning period:

- Adult acute ALOS reducing from 60 days in 2026/27 to 50 days in 2027/28 and 40 days in 2028/29
- Older adult ALOS reducing from 90 days to 80 days and then 70 days over the same period

Delivery will be driven through a strengthened flow and capacity programme, including:

- targeted work on long stay patients and delayed discharges
- development of step-down pathways and alternatives to admission
- strengthened system partnership to improve discharge flow

This programme includes a continued reduction in inappropriate out of area placements to zero by the end of 2028/29 as part of improving system flow.

4. Efficiency and productivity improvement plans

The requirement to strengthen efficiency plans and reduce reliance on high-risk schemes has been progressing following the planning round. In particular, through the relaunched TEG, the Trust is:

- accelerating the development of recurrent efficiency schemes
- ensuring clear ownership and accountability for delivery
- improving in-year monitoring and early identification of delivery risk
- developing the pipeline of proposals and programmes going forwards

A key priority is to reduce the proportion of high-risk schemes over the course of the year and increase delivery confidence.

5. Workforce and expenditure alignment

The Trust monitors workforce and expenditure plans at an aggregate level which ensures alignment. As part of budget setting and efficiency planning process temporary staffing targets have been set at Care Unit / Corporate levels. Performance is monitored at Accountability meetings and monitored weekly with an escalation process in place. Safer staffing business cases follow governance requirements including clinical input into cases prior to approval recommendation.

The Trust has taken the decision to base all staff budgets at a substantive level. This includes 19% absence cover and a central reserve for maternity leave in clinical areas. The Trust has adopted this approach to incentivise recruitment to substantive posts, recognising the quality and financial benefits of a substantive workforce. This approach forms part of our intentional strategy to further reduce reliance on temporary workforce. Unfortunately, the

PWR return does not allow this approach and requires WTE to be split by Substantive, Bank and Agency, resulting in a known difference between financial and workforce plans.

To support the delivery of the workforce plan, the Trust is implementing a strengthened approach to workforce control and delivery including:

- a programme to reduce temporary staffing, with Care Groups accountable for delivery
- weekly and monthly reporting supported by Executive oversight
- daily staffing controls in inpatient services aligned to safer staffing requirements
- weekly Establishment Control Panels and quarterly workforce reviews to maintain discipline.

These actions are supported by targeted initiatives to improve productivity and reduce cost pressures, including reducing medical vacancies and sickness absence.

Further detail will be provided on the methodology used to align workforce, temporary staffing and financial plans, including how variance is identified and managed.

6. Data quality, reporting and waiting times

The Trust acknowledges the need to ensure full compliance with national reporting requirements and continued improvement in waiting time performance.

The Trust confirms:

- ongoing compliance with MHMDS and community sitrep submissions
- continued work with the regional team to progress FDF requirements
- targeted action to reduce the longest waits, including those over 40 weeks.

9.2 PEOPLE STRATEGY

Decision Item AM

REFERENCES

Only PDFs are attached

People Strategy 03.06.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	3 June 2026

Report Title:	**People Strategy**					
Executive/ Non-Executive Lead:	Andrew McMenemy, Executive Chief People Officer					
Report Author(s):	Andrew McMenemy, Executive Chief People Officer					
Report discussed previously at:	People Committee and Executive Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	The production of the revised People Strategy has been identified as a mitigation to the BAF risks associated to workforce. These are primarily SR10,11 & 12 but also extend to SR5 and SR8.	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Statutory Public Inquiry	✓
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	✓
	SR9 Digital and Data	
	SR10 Workforce Sustainability	✓
	SR11 Staff Retention	✓
	SR12 Organisational Development	✓
	SR13 Quality Governance	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/a	
Describe what measures will you use to monitor mitigation of the risk	N/a	

Purpose of the Report		
This report provides the Board with the final version of the Trust 5 year People Strategy. The strategy has been developed over a number of months and taken consideration of many EPUT staff alongside external stakeholders.	**Approval**	✓
	Discussion	✓
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Provide approval for the publication and implementation of the new Trust People Strategy 2026-2031.

Summary of Key Issues
The attached report provides the Board of Directors with the new Trust People Strategy 2026-2031. In addition, the report includes an associated implementation plan that outlines the objectives that will support delivery of the strategy. It also includes a one page strategy summary that will be used and adapted to support effective implementation and communication to the wider staff group at EPUT. The development of the new People Strategy has been overseen by the Executive Committee and the People Committee, both of which have previously received iterations of the strategy while it was being developed. The development of the strategy also included extensive consultation in order to receive feedback on the content and identify priority areas. This included feedback from Care Unit teams, Corporate teams, wider staff using on line opportunities and significant support from our staff side colleagues. We commissioned the Trust marketing team to develop an enhanced format for the strategy. The format includes pictures and stories from our own staff in order to enhance the context of the strategy document and make it more relevant to all of our people working at EPUT. It is expected that, following ratification, the Executive Committee will receive an annual review of the strategy that will focus on delivery and any proposed amendments, taking consideration changes to national or local strategies. In addition, the People Committee will receive regular updates of progress aligned to the supporting implementation plan in order to provide assurance in respect of delivery.

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

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

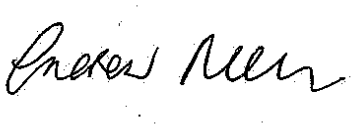
Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Appendix 1 – People Strategy. Appendix 2 – People Strategy – Implementation Plan.

Appendix 3 – People Strategy Summary.

Lead



Andrew McMenemy
Executive Chief People Officer

NHS
Essex Partnership University
NHS Foundation Trust

People Strategy

2026 - 2031

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Foreword

Why our people matter

At Essex Partnership University NHS Foundation Trust (EPUT), our people are at the heart of everything we do. The quality and safety of our clinical care depend on the compassion, skill, and commitment of our workforce. Without them, our ambitions for excellence in patient-centred care cannot be realised.

Drivers for change

We are operating in a period of significant transformation. The merger that created EPUT, the lessons learned from national and local inquiries, and the profound impact of the COVID-19 pandemic have reshaped the way we deliver care and support our staff. In addition we have the introduction of the 10 year plan demonstrating a fundamental shift of service provision that will impact capacity and skills of our future workforce. These experiences highlight the urgent need to nurture, value, and invest in our people-today and for the future.

Our commitment

We are committed to creating an environment where our workforce feels supported, recognised, and empowered. By doing so, we will attract, retain, support, and grow a compassionate and committed workforce that can deliver safe, high-quality, and patient-focused care. This commitment reflects the ambitions of the NHS People Plan, the NHS Long Term Workforce Plan, and the Greater Essex Integrated Care System (ICS), ensuring our local strategy is aligned with national priorities.

Rationale for change

The case for a refreshed People Strategy is clear:

- Workforce supply pressures – National shortages and local challenges require innovative approaches to recruitment and retention.
- Changing generational aspirations – A new generation of staff seek flexibility, inclusion, and meaningful career development.
- AI and digitisation – Technology is reshaping roles and creating opportunities for innovation in care delivery.
- Economic and immigration shifts – A challenging financial climate and reduced international recruitment highlight the need to strengthen domestic pipelines.
- NHS financial position – The drive for productivity and efficiency requires us to support our people to work differently, with the right skills and resources.

Looking ahead

This strategy is not just about responding to challenges-it is about seizing opportunities. By valuing and investing in our people, we will build a workforce that is resilient, inclusive, and future-ready. Together, we will deliver on our promise of safe, high-quality, and compassionate care for the communities we serve.

Executive summary

Our people strategy sets out how we will develop, support, and grow our workforce to deliver EPUT's strategic aims, with a clear emphasis on clinical quality, safety, and patient-centred care. It recognises that our people are our greatest asset and that investing in them is essential to achieving sustainable, high-quality services for the communities we serve.

This strategy is designed to respond to both national drivers-including the NHS People Plan, the NHS Long Term Workforce Plan, and the People Promise-and to the priorities of the Greater Essex Integrated Care System (ICS). It also reflects the lessons learned from recent challenges such as the pandemic, workforce shortages, and the increasing demand for more flexible, inclusive, and digitally enabled ways of working.

How will we achieve this?

Assessing and understanding our workforce today
We will undertake a comprehensive assessment of our current workforce, linking staffing levels to activity, finance, and service demand. By enhancing our use of workforce data and analytics, we will gain sharper insights into where pressures exist and where opportunities for improvement lie.

Forecasting and planning for the future
We will develop improved insight into future workforce and skill requirements, using modelling to anticipate the roles, skills, and capacity needed to deliver our strategic aims. This will ensure we are proactive in shaping our workforce rather than reactive to short-term pressures.

Attracting and developing talent
We will implement a clear plan to attract talent from within our local communities, widening participation and creating meaningful employment opportunities. At the same time, we will invest in our existing people-enhancing skills, supporting career progression, and creating structured pathways that enable staff to grow and thrive.

Partnering for success
We will work closely with partners in further and higher education, as well as with system partners across the Greater Essex ICS, to map out future skills requirements and capacity needs. These partnerships will help us build sustainable pipelines of talent and ensure our workforce is equipped for the future of health and care.

Our ambition

Through this strategy, we will create a workforce that is:

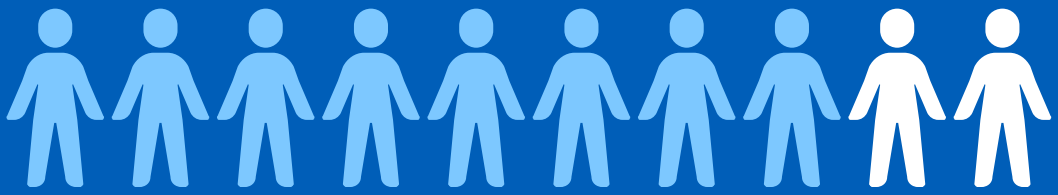
Compassionate and inclusive	Reflecting the diversity of our communities and ensuring every member of staff feels they belong.
Skilled and future-ready	Equipped with the knowledge, innovation, and digital capability to deliver modern healthcare.
Resilient and supported	With wellbeing, recognition, and compassionate leadership at the heart of our culture.

By delivering on these commitments, EPUT will not only meet its clinical quality and safety ambitions but also play a leading role in shaping a sustainable, system-wide workforce for the future.

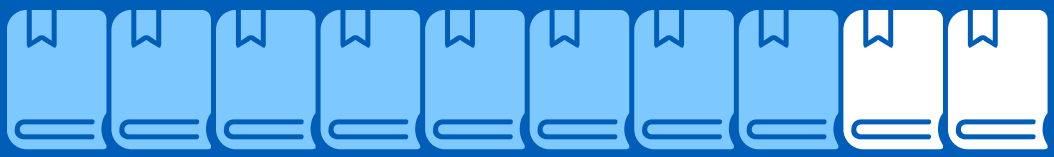
The current view and progress

Workforce Key Performance Indicators (KPIs) – overview

8.8% Vacancy rate in 2026 vs 9.3% in 2022



85% appraisal compliance in 2026 vs 80.2% % in 2022



89% mandatory training in 2026 vs 73.3% in 2022

Overall EPUT performance

	Jan 2022	Jan 2024	Jan 2026	Trend
Budget establishment (wte)	5694.19	6631.51	7061.23	▲
Staff in post (wte)	5164.75	6059.35	6439.6	▲
Vacancy rate (%)	9.3%	8.6%	8.8%	▲
Turnover rate (%)	11.1%	9.0%	8.9%	▼
Sickness rate (%)	6.4%	6.1%	5.9%	▼
Appraisal compliance (%)	80.2%	80.5%	85.0%	▲
Mandatory training compliance (%)	73.3%	79.0%	89.1%	▲

Please see appendix 1 for a breakdown of the KPIs by staff group data.

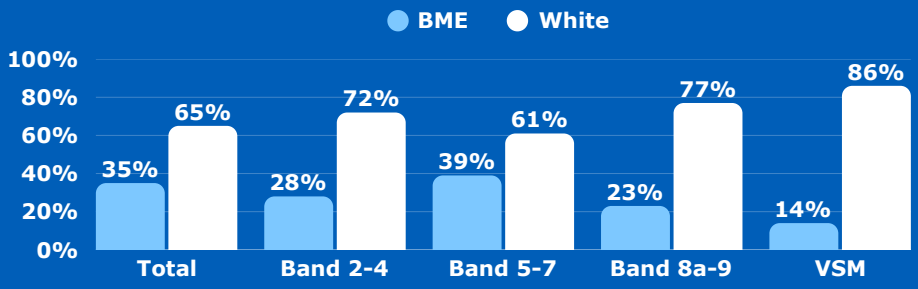
Equality, Diversity and Inclusion (EDI)

35% of workforce is black, minority ethnic with 65% white

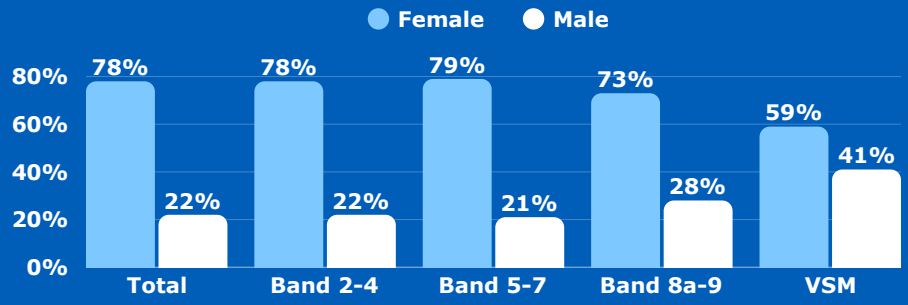
78% of workforce is female, with 22% male

19% of workforce is disabled or did not say, with 81% non-disabled

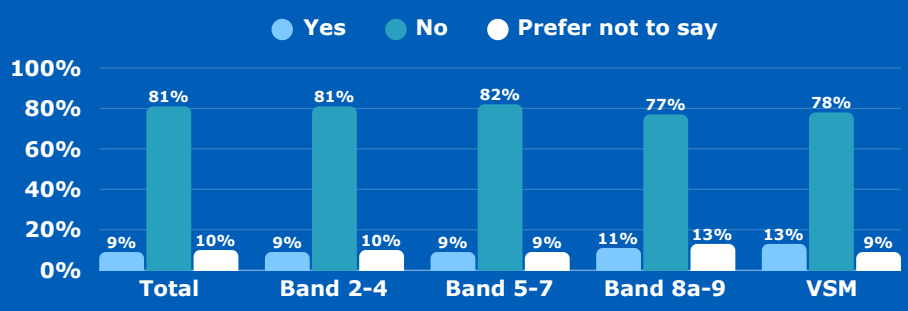
Ethnicity by banding



Gender by banding



Disability by banding



Our priority aims

Compassion | Attract | Retain | Empower

"CARE for our people, CARE for our future"
Our overarching people strategy is framed around CARE. This reflects our ambition to be an employer of choice, to nurture and grow our workforce, and to deliver compassionate, inclusive care.

C
Compassion

Looking after our people by supporting wellbeing, enhancing recognition, and developing compassionate leaders.

- Embedding Trauma-Informed Care principles across leadership and management.
- Prioritising staff wellbeing in line with the NHS People Promise commitment to "we are safe and healthy."
- Developing leaders who are compassionate, accountable, and collaborative, reflecting the Greater Essex ICS ambition for a culture of care.

A
Attract

Creating meaningful employment opportunities in our local communities while driving social responsibility.

- Strengthening entry routes into health and care careers through apprenticeships, volunteering, and partnerships with schools, colleges, and universities.
- Supporting the Greater Essex ICS goal of widening participation and tackling health inequalities through employment.
- Contributing to the national ambition of making the NHS the employer of choice, offering flexible, modern, and socially responsible roles.

R
Retain

Embedding equality, diversity & inclusion at every level of the Trust, ensuring staff experience is rewarding and fair.

- Delivering on the NHS People Plan commitment to "belonging in the NHS" by tackling discrimination and ensuring equity of opportunity.
- Building a culture of engagement, recognition, and fairness that reflects the diversity of our communities.
- Working with ICS partners to create consistent approaches to staff wellbeing, retention, and inclusion across Greater Essex.

E
Empower

Creating an environment of opportunity that allows staff to realise their potential through learning, innovation, and development.

- Investing in continuous professional development, leadership pathways, and innovation hubs.
- Supporting the NHS Long Term Workforce Plan by expanding training capacity and developing new roles to meet future service needs.
- Partnering with the Greater Essex ICS to deliver system-wide workforce development programmes, enabling staff to grow and move across organisations.

Key areas of focus which form our priority aims

1 Compassion — Looking after our people

We are committed to creating a culture where compassion is at the heart of leadership, decision-making, and everyday practice. This means supporting staff wellbeing, recognising their contribution, and developing leaders who are accountable, inclusive, and trauma informed.

Key areas of focus

Trauma-informed care - We will embed trauma-informed principles across our organisation, ensuring leaders and managers understand the impact of trauma on staff and patients. This approach will shape how we support colleagues, resolve conflict, and create psychologically safe environments.

Leadership Development Programme - We will design and deliver a refreshed leadership development programme that equips current and future leaders with the skills to lead compassionately, manage change effectively, and foster a culture of accountability and trust.

People and thought leadership development - We will invest in developing both people leadership (supporting teams, coaching, mentoring) and thought leadership (innovation, system influence, and strategic thinking), ensuring our leaders are equipped to shape the future of health and care within the Greater Essex ICS.

Compassionate and inclusive leadership - We will champion leadership that is inclusive, fair, and reflective of the diversity of our workforce and communities. Leaders will be expected to model behaviours that promote belonging, equity, and respect.

Professional fulfilment and wellbeing culture - We will privilege staff wellbeing and professional fulfilment, recognising that compassionate care for patients begins with compassionate care for staff. This includes prioritising workload balance, recognition, and access to wellbeing support.

Leadership behavioural framework - We will implement a clear behavioural framework that sets expectations for compassionate, accountable leadership. This framework will be embedded in recruitment, appraisal, and development processes to ensure consistency and accountability.

Measures of success

Enhanced engagement with the new leadership development programme, evidenced by uptake and positive feedback.

Reduction in staff grievances and concerns, reflecting improved trust, fairness, and psychological safety.

Improved staff survey results, particularly in areas relating to leadership, wellbeing, and feeling valued.

Increased representation of diverse leaders across all levels of the organisation.

Positive cultural indicators, such as higher appraisal completion rates and improved retention linked to leadership quality.

2 Attract

Creating meaningful employment opportunities in our local communities while driving social responsibility

We are committed to creating meaningful employment opportunities in our local communities, while driving social responsibility and widening participation. By attracting people into health and care careers, we will not only strengthen our workforce but also contribute to reducing inequalities and improving the health and wellbeing of the communities we serve.

Key areas of focus

Workforce modelling - We will develop robust workforce plans over a five-year horizon, supported by annual profession-specific planning. This will be informed by accurate workforce data, analytics, and trend analysis, ensuring that our workforce supply is aligned with service demand, financial sustainability, and the ambitions of the NHS Long Term Workforce Plan and the Greater Essex ICS workforce strategy.

Proactive, locally focused recruitment - We will strengthen our recruitment approach by targeting under-utilised and hard-to-reach talent pools, supported by improved employer branding and marketing. This will ensure that our recruitment campaigns resonate with local communities and highlight EPUT as a socially responsible, inclusive, and forward-thinking employer.

Widening participation - We will expand partnerships with further and higher education providers to shape future workforce skills and create sustainable employment pipelines.
This includes:

- Offering work experience, volunteering, and direct entry routes to support career development.
- Providing placements to support T-levels and apprenticeships.
- Extending partnerships with local businesses, chambers of commerce, community groups, the third sector and local councils to maximise opportunities for local people.
- Supporting the ICS ambition to widen participation and reduce inequalities by creating accessible pathways into health and care careers.

Digitisation of workforce processes - We will harness the potential of AI and digital technologies to streamline recruitment, onboarding, and workforce planning. This will improve efficiency, enhance candidate and staff experience, and support learning and development opportunities through digital platforms.

Measures of success

Improved workforce metrics – measurable reductions in vacancy levels, turnover, and reliance on bank and agency staff.

Enhanced employer brand – stronger presence and awareness in local communities, with improved perception of EPUT as an employer of choice.

Increased participation – higher uptake of apprenticeships, T-level placements, and other entry routes into health and care careers.

Sustainable pipelines – evidence of stronger local recruitment pathways and reduced reliance on international recruitment.

> **Best career move I have ever made was getting a role with EPUT – have never been happier and more secure.**

> **Make recruitment packages more desirable to entice more people to work for the NHS.**

3 Retain

Embedding equality, diversity & inclusion and demonstrating staff experience and engagement that is rewarding and fair

We are committed to creating a workplace where every member of staff feels valued, supported, and able to thrive. Retention is not simply about keeping people in post, it is about ensuring that their experience of working at EPUT is rewarding, fair, and inclusive. By embedding equality, diversity, and inclusion (EDI) at every level of the Trust, we will create a culture where people want to stay, grow, and contribute to delivering safe, high-quality, and compassionate care.

Key areas of focus

Enhanced induction and onboarding - We will strengthen induction and onboarding processes to ensure new staff feel welcomed, supported, and connected to our values from day one. This will include early career pathway discussions, embedding our culture and behaviours, and ensuring a positive first impression that supports long-term retention.

Flexible working - We will expand flexible working options to meet the diverse needs of our workforce. This includes improved rostering systems, flexible shift patterns, self-rostering, clarity on hybrid working arrangements, and opportunities for protected secondments, career breaks, and sabbaticals. These measures will support work-life balance and professional fulfilment.

Prioritising Equality, Diversity & Inclusion (EDI) - We will embed EDI into everything we do by:

- Extending the role and influence of staff networks.
- Embedding EDI objectives into leadership and team goals.
- Reviewing recruitment and employee relations practices to ensure fairness and remove bias.
- Delivering cultural awareness and inclusive leadership training for all staff.
- Working with community groups and ICS partners to eliminate discrimination and ensure our workforce reflects the communities we serve.

Staff engagement - We will strengthen staff voice by creating more opportunities for open dialogue, co-production, and feedback. This includes regular engagement forums, improved visibility of leaders, and acting on staff survey results to demonstrate that staff views drive real change.

Reward and recognition - We will enhance recognition programmes to celebrate the achievements and contributions of our people. This will include both formal recognition schemes and everyday appreciation, ensuring staff feel valued for their work and commitment.

Enhanced recruitment - To consider enhanced methods of recruitment for certain roles looking at competency tests where this is relevant to the role in addition to the traditional interview. In addition to consider protected secondments for existing staff in order to promote and encourage career development.

Measures of success

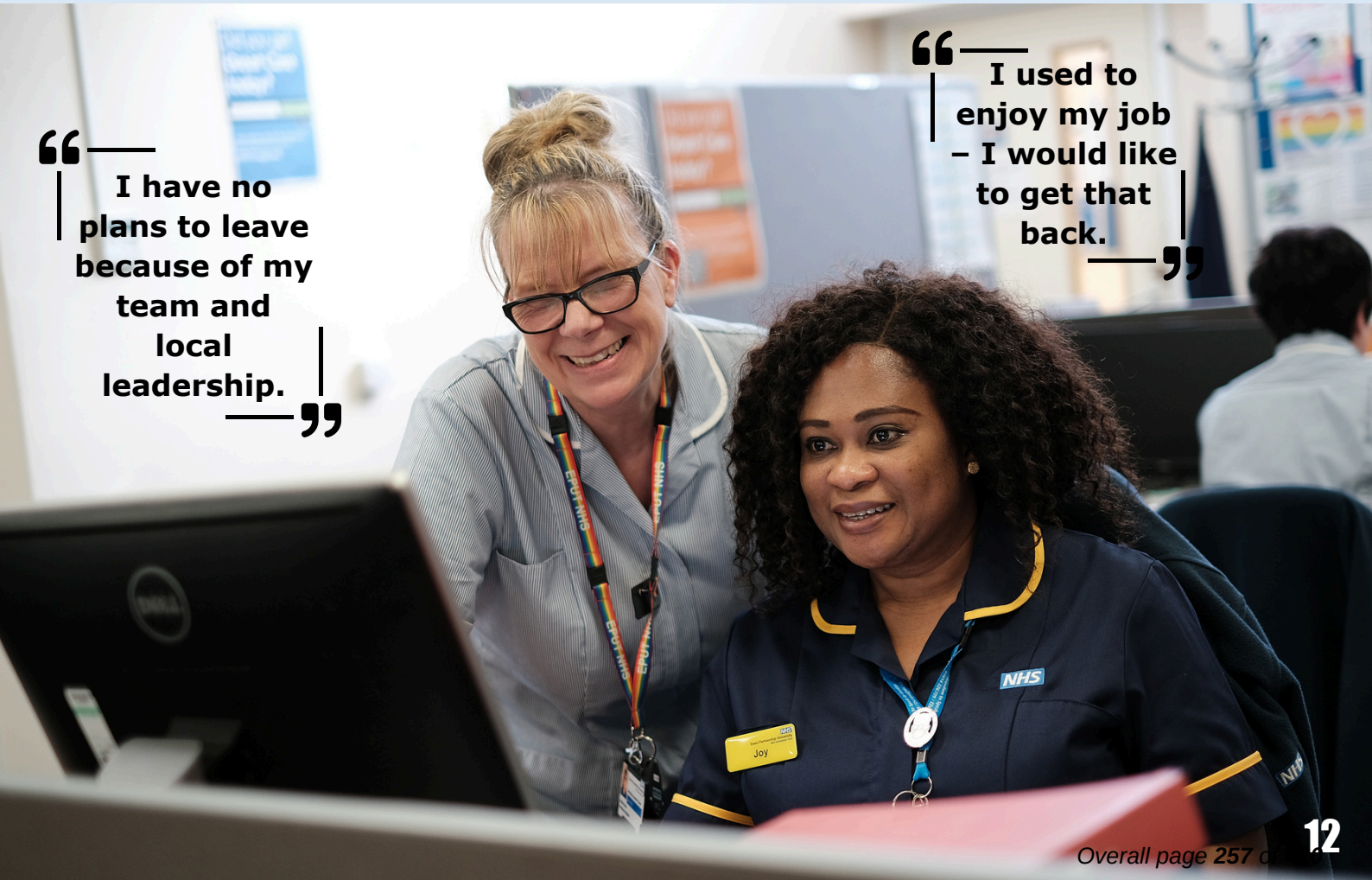
Improved WRES and WDES outcomes, demonstrating progress in equality, diversity, and inclusion.

Improved staff survey scores, particularly in areas relating to belonging, engagement, and feeling valued.

Reduced turnover and absence rates, reflecting a more engaged, supported, and resilient workforce.

Higher uptake of flexible working options, showing that staff feel empowered to balance work and life.

Increased participation in staff networks and engagement forums, evidencing stronger staff voice and influence.



4 Empower

Creating an environment of opportunity that allow staff to realise their potential through learning, innovation and development.

We are committed to building an environment where every member of staff can realise their full potential through learning, innovation, and development. Growth is not only about individual progression but also about strengthening our organisation's ability to deliver safe, high-quality, and future-ready care. By investing in education, career pathways, and innovation, we will create a workforce that is skilled, resilient, and equipped for the challenges of tomorrow.

Key areas of focus

Demonstrating university status in education provision - We will strengthen our reputation as a centre of excellence for education and training, working in partnership with universities and higher education institutions. This will position EPUT as a leader in clinical education, research, and workforce development, aligned with the ambitions of the NHS Long Term Workforce Plan.

Career pathway development for all staff - We will create clear and accessible career pathways across all staff groups, ensuring that every individual has opportunities to progress. This includes structured development routes, mentoring, and access to apprenticeships, T-levels, and advanced practice roles.

Revised appraisal framework - We will redesign our appraisal process to focus on innovation, growth, and personal development. Appraisals will become a meaningful tool for career planning, skills development, and recognition, rather than a compliance exercise.

Talent mapping - We will introduce systematic talent mapping to identify high-potential staff and ensure they are supported to progress into leadership and specialist roles. This will help us build a strong internal pipeline of future leaders.

Succession planning - We will implement succession planning across all key roles, ensuring continuity of leadership and expertise. This will reduce reliance on external recruitment and strengthen organisational resilience.

Innovation and research opportunities - We will expand opportunities for staff to engage in research, innovation, and quality improvement projects. This will foster a culture of curiosity and continuous improvement, while also enhancing our reputation as a learning organisation.

Technology and digitisation - We will enable staff to embrace digital tools and AI to support learning, development, and service delivery. This includes digital learning platforms, simulation-based training, and the use of technology to streamline processes and free up time for patient care.

Measures of success

Increased uptake of apprenticeships, T-level placements, and other entry-level development opportunities.

Improved staff survey scores, particularly in areas relating to belonging, engagement, and feeling valued.

Reduced turnover and absence rates, reflecting a more engaged, supported, and resilient workforce.

Higher uptake of flexible working options, showing that staff feel empowered to balance work and life.

Increased participation in staff networks and engagement forums, evidencing stronger staff voice and influence.

How we will deliver together

To truly empower our workforce, this strategy must be a living, shared commitment. Our People & Culture team has been structured to provide the right expertise to guide this journey, but real change will be driven through genuine collaboration with our care units and corporate teams across EPUT.

A strategy is only as meaningful as the actions behind it. To ensure we build an environment that attracts brilliant people and retains the invaluable experience already within our teams, this document is supported by a practical Implementation Plan (included as an appendix). Rather than rushing for short-term fixes, this plan outlines a sensible, prioritised approach, which breaks down our journey into achievable phases over 1 year, 2-3 years, and 4-5 years.

We owe it to our colleagues to follow through on these promises. To ensure we stay on track and remain responsive to our teams' needs, we have established clear and supportive checkpoints:

- The Executive Committee will review our progress yearly, ensuring that our actions consistently support our ambitions for our people.
- The People Committee will lead an annual reflection on the strategy, supported by quarterly check-ins on our implementation plan. This is not just about reporting data but an opportunity to listen, adapt and ensure our governance drives meaningful improvements.

Ultimately, by holding ourselves accountable and leading with compassion, we create the strongest possible foundation for our staff to thrive. When we support and value our people, we directly improve the care, services, and outcomes we deliver to our patients.

People Strategy Implementation Plan – 2026-2031

Compassion – Looking after our people -Year One Objectives

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
To complete and publish cultural review outcome and initiate pilot leadership programme from these findings.	OD & Culture	May 2026	Clear understanding of areas to develop culture.	
To commence senior leaders programme in partnership with Kings Fund & BRAP.	OD & Culture	March 2027	Initiate year one of the programme by June 2026 with diverse uptake.	
To use feedback from cultural review to publish new Leadership Behavioural framework.	OD & Culture	June 2026	Published and promoted leadership behavioural framework with clear line of measured improvements.	
Implementation of resolution strategy for	Operational Human Resources	June 2026 for publication and	50% reduction in formal investigations	

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
conduct concerns and grievance.		December 2026 for measuring impact.	and 50% reduction in employment tribunal claims.	
Strengthen the wellbeing offer and create a healthier, more resilient workforce through proactive, preventative, and responsive support systems	Operational Human Resources & OD & Culture	December 2026	Improved wellbeing scores in NHS Staff Survey. Reduction in stress-related sickness. Increased staff perception of psychological safety. Improved retention and sickness absence rates. Line manager capability to support staff wellbeing. Sickness absence reduction to 4.9%.	

Attract – Creating meaningful employment opportunities in our local communities while driving social responsibility - Year One Objectives

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
Working with colleagues in Information to develop plans that support EPR implementation and other digital initiatives.	Resourcing & Operational HR	December 2026	Training plans in place to support effective implementation. Workforce models prepared for digital transformation and EPR launch readiness.	
Implement year one of recruitment plan in order to reduce levels of vacancies.	Resourcing	December 2026	Reduced vacancy rates of <3% for band 5 nursing and HCAs and improved recruitment pipelines from local community for priority roles. Implementation of year one of safer staffing business case.	
To introduce protected secondments of 6-12 months from within the Trust to develop	Resourcing/OD & Culture	December 2026	Identify staff who are not confident pursuing roles through traditional recruitment and	

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
career and talent mapping.			promote career development.	
Commence Trust wide work experience programme and T-Level placements.	Education	September 2026	Multi-disciplinary opportunities for students from FE colleges and schools.	
Implementation of new partnership agreement with ARU.	Education	April 2026	Established outcomes based on agreed priorities. Enhanced academic collaboration strengthen workforce pipelines and development.	

Retain – Embedding, equality, diversity & inclusion and demonstrating staff experience and engagement that is rewarding and fair - Year One Objectives

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
Review and refresh staff induction and on-boarding to align with values.	Resourcing/Operational HR/OD & Culture	September 2026	A new programme aligned with September intake and measured for impact.	
Review flexible working for all staff and agile working practices for non-clinical staff ensuring equity.	Operational Human Resources.	September2026	Revised policy and aligned to cultural review with measurable impact.	
Prioritising equality, diversity and inclusion with initial focus on cultural awareness training, anti-racist practice and completing sexual safety training across the Trust.	OD & Culture	September 2026	All staff to have had the opportunity to participate in cultural awareness training with those recruiting and leading having this as a requirement.	

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
Enhancing staff recognition and engagement using staff survey to prioritise.	OD & Culture	October 2026	60% staff survey engagement in 2026. Clear and effective 'You said, We did' campaign. To initiate in-person long service and leadership awards.	
Implement Apprentice First roles	Education and Resourcing	March 2027	Apprentice only roles introduced to create opportunities for staff to join, learn and progress, increasing retention rates.	

Empower – Creating an environment of opportunity that allow staff to realise their potential through learning, innovation and development - Year One Objectives

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
Implement new appraisal framework aligned to National	Education	September 2026	New online framework with relevant communication/training.	

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
Management & Leadership Framework.				
3 year talent plans for each care unit and corporate service.	Education and OD & Culture	June 2026	Clear plans for Trust/Care Units and Corporate services.	
Confirm 3 areas of AI implementation for People & Culture.	Operational HR/Resourcing & Education.	December 2026.	Chat bot for operational HR queries. Support for recruitment and linking appraisal with education priority areas.	
Prepare the organisation and for the successful implementation of a new workforce system (ESR Replacement).	Resourcing	March 2027	Establish a Workforce System Readiness Programme Organisation achieves formal readiness sign-off to transition to new workforce system.	

Compassion – Looking after our people - Years 2–3 Objectives

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
Mid management leadership development programme funded by apprenticeship levy.	OD & Culture/Education	September 2027	Fulfilment of 3 year leadership development plans. Improvement in safety and quality indicators. Strengthened leadership capacity pipeline and improved management confidence across care units.	
Reflect on Kings Fund/BRAP programme and revise and improve for year 2 &3.	OD & Culture	September 2027	To inform OD priorities and the curriculum for the leadership development programmes.	

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
Strengthen system-wide leadership capability by leading cross-organisational improvement initiatives, embedding compassionate, inclusive leadership behaviours across teams and pathways.	Education & OD & Culture	March 2027	Moving towards areas of collaboration with system partners for leadership development and talent mapping.	

Attract – Creating meaningful employment opportunities in our local communities while driving social responsibility - Years 2–3 Objectives

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
Expand roles such as peer support workers, nursing associates, and advanced clinical practitioners.	Resourcing and Education	September 2028	Pipeline of future workforce in place, and support to deliver clinical workforce models, supporting	

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
			potential efficiencies and improved safety and quality indicators.	
Develop system-wide workforce pipelines in partnership with ICS, local authorities, and education providers.	Resourcing and Education	January 2028	Integrated workforce pipeline sustaining long term recruitment and retention. Collaborating with an Inclusive Employment programme to encourage a wide range of talent to join our Trust.	
Develop opportunities to provide training to local providers, creating income generation for the Trust	Education	March 2029	Support local organisations to be able to train their own staff (statutory and apprenticeships)	
Achieve a sustainable workforce model	Resourcing and Education	January 2027	Creating opportunities from the local	

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
aligned to long-term mental health and community service demand.			population; strengthened relationships with our local education providers, and implementation of new clinical working models.	

Retain – Embedding, equality, diversity & inclusion and demonstrating staff experience and engagement that is rewarding and fair - Years 2-3 Objectives

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
Implement digital workforce solutions to support flexible working, e-rostering, and workforce productivity.	Resourcing & Operational HR	March 2029	Improved rostering efficiency and workforce productivity.	

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
Embed consistent performance development reviews linked to wellbeing, career aspirations, and service improvement.	Education	September 2028	New online framework with relevant communication/training.	
Develop reciprocal mentoring programme for colleagues with protected characteristics and senior leaders across EPUT & Essex ICS system.	OD & Culture	May 2027	To achieve at least 50% of designated leaders' actively practicing feedback with reciprocal mentor.	

Empower – Creating an environment of opportunity that allow staff to realise their potential through learning, innovation and development - Years 2-3 Objectives

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
Develop inclusive leadership capability across all bands, aligned to EDI priorities and the Advancing Mental Health Equalities framework.	OD & Culture	March 2028	Increased opportunities for career development with greater levels of diversity across all professions and levels of seniority.	
Expand apprenticeship, return-to-practice, and widening participation programmes.	Education	March 2029	Local organisations able to train and retain their own staff through our apprenticeship programme. Opportunities created to support professionals to return to practice utilising their previous	

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
			experience to better patient outcomes.	

Years 4-5 Objectives - Compassion – Looking after our people

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
Provide structured coaching or mentoring to emerging leaders.	Education / OD and Culture	March 2028	High performing individuals noted in appraisals to be matched to a mentor or coach	

Years 4-5 Objectives - Attract – Creating meaningful employment opportunities in our local communities while driving social responsibility.

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
Deliver a mature, data-driven HR operating model	Resourcing	2030	Triangulation of data that is easily accessed and available to all	

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
supporting population health and system priorities.			staff and leaders. Predicative workforce analytics informing workforce planning and improved decision making.	

Years 4-5 Objectives - Retain – Embedding, equality, diversity & inclusion and demonstrating staff experience and engagement that is rewarding and fair.

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
Establish the Trust as a learning organisation and employer of choice for mental health and community careers.	OD and Culture and Education	September 2030	Improved safety and quality indicators, better outcomes and improved experience for patients, improved staff morale and retention.	

Years 4-5 Objectives - Empower – Creating an environment of opportunity that allow staff to realise their potential through learning, innovation and development.

Objective	Owner(s)	Timescale for Completion	Expected Outcome/Impact	Rag Rating based on completion and Impact.
Sustain a values-led, high-performing culture that supports continuous improvement and system working.	All	2030	Highest quartile for staff survey and engagement scores. Low levels of turnover and absence.	

People Strategy

NHS
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NHS Foundation Trust

2026 - 2031

Our commitment

Our five year people strategy sets out how we will **develop, support, and grow our workforce** to deliver EPUT's strategic aims, with a clear emphasis on clinical quality, safety, and patient-centred care. It recognises that our people are our greatest asset and that investing in them is essential to achieving sustainable, high-quality services for the communities we serve.

Our people strategy has four priority aims

C
Compassion

Looking after our people by supporting wellbeing, enhancing recognition, and developing compassionate leaders.

- Embedding Trauma-Informed Care principles across leadership and management.
- Prioritising staff wellbeing in line with the NHS People Promise commitment to "we are safe and healthy."
- Developing leaders who are compassionate, accountable, and collaborative, reflecting the Greater Essex ICS ambition for a culture of care.

A
Attract

Creating meaningful employment opportunities in our local communities while driving social responsibility.

- Strengthening entry routes into health and care careers through apprenticeships, volunteering, and partnerships with schools, colleges, and universities.
- Supporting the Greater Essex ICS goal of widening participation and tackling health inequalities through employment.
- Contributing to the national ambition of making the NHS the employer of choice, offering flexible, modern, and socially responsible roles.

R
Retain

Embedding equality, diversity & inclusion at every level of the Trust, ensuring staff experience is rewarding and fair.

- Delivering on the NHS People Plan commitment to "belonging in the NHS" by tackling discrimination and ensuring equity of opportunity.
- Building a culture of engagement, recognition, and fairness that reflects the diversity of our communities.
- Working with ICS partners to create consistent approaches to staff wellbeing, retention, and inclusion across Greater Essex.

E
Empower

Creating an environment of opportunity that allows staff to realise their potential through learning, innovation, and development.

- Investing in continuous professional development, leadership pathways, and innovation hubs.
- Supporting the NHS Long Term Workforce Plan by expanding training capacity and developing new roles to meet future service needs.
- Partnering with the Greater Essex ICS to deliver system-wide workforce development programmes, enabling staff to grow and move across organisations.

To truly empower our workforce, this strategy must be a living, shared commitment. Our People & Culture team has been structured to provide the right expertise to guide this journey, but real change will be driven through genuine collaboration with our care units and corporate teams across EPUT.

For more information about how we will implement this strategy, read the full 2026 - 2031 People Strategy on the intranet.

9.3 STRATEGIC IMPACT REPORT

Information Item ZT

REFERENCES

Only PDFs are attached

Strategic Impact Report 2025-26 03.06.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	3 June 2026

Report Title:	**Strategic Impact Report 2025/26 Month 12 (M12)**					
Executive/ Non-Executive Lead:	Zephan Trent, Executive Director of Strategy, Transformation & Digital					
Report Author(s):	Anna Bokobza, Director of Strategy					
Report discussed previously at:	Executive Committee 21 April 2026 People Committee 30 April 2026 Quality Committee 13 May 2026 Finance & Performance Committee 21 May 2026					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
This report provides the Committee with an update on the implementation of the Trust's Strategic Plan at M12 of 2025/26, the end of the third year of the five year planning period. This is prefaced by a recap of the conclusions from the Strategic Plan Review presented to the private Board meeting in October 2025. It also provides updates on the impact of the Transformation function in	**Approval**	
	Discussion	
	Information	✓

the last year. Finally, the report provides a high level summary on the 2026/27 operational planning cycle.		

Recommendations/Action Required

The Board of Directors is asked to:

1. Note and take assurance from report.

Summary of Key Issues

The Strategic Impact Report presents medium to longer term delivery trends to illustrate progress in delivery of our Strategic Plan, complimenting the faster cycle of monthly performance reporting. The report is prepared and presented to the Board twice per year. Since the last report, further work has taken place to align reporting metrics and timescales with those that feature in the Integrated Performance Report and other Board or Committee reports as far as possible. Trends are presented up to M12 to align with data already validated through the IPR and reported to Board committees.

At the end of Y3 of our Strategic Plan, we continue to evidence steady progress against aspects of each strategic objective in the last six months, although measurable medium-term trends remain mixed. Any risks to delivery against the strategic objectives, controls, mitigations and system dependencies are addressed through the Board Assurance Framework.

1. **We will delivery safe, high quality integrated care**
    - The Trust encourages high incident reporting rates as part of its learning and improvement culture. Incident reporting rates have been consistently above target over the last three years.
    - We expect a large proportion of incidents to have no/low rates of harm. This proportion has very slightly decreased over three years but increasing positively in the last 10 months towards the 93.7% target.
    - Over three years an average of 94.4% of patients and families report feeling safe in EPUT's care, with many months above the 95% target and relative consistent monthly results.

2. **We will work with our partners to make our services better**
    - Time to Care programme has now reached completion and has introduced a new inpatient model built around purposeful admission, therapeutic and trauma-informed care and safe and effective discharge.
    - System flow in Mental Health services has been and remains challenged. Out of Area placements reduced significantly in from 35 in M2 to 15 in M8 despite ongoing wider challenges with system flow have contributed to another increase over the last three months.
    - In the six months, an inpatient flow improvement programme has been designed and launched. Work to manage Length of Stay on adult wards has shown positive impact in recent months with increased admissions not driving up occupancy. National Oversight Framework league tables for Q3 25/26 ranked EPUT as 9th out of 47 for percentage of inpatients aged 18-65 with length of stay > 60 days, an improvement from 14th out of 47 in the previous quarter.
    - Monthly average Length of Stay on Older Adult wards has reduced during 2025/26 through remains outside of the national 90-day target.

3. **We will enable each other to be the best we can be**
    - Conducted review of People Strategy (published January 2024) and agreed revised priorities : "CARE for our people, CARE for our future" – Compassion, Attract, Retain, Empower. Revised strategy and five-year implementation plan will be launched during Q1 2026/27.
    - Key People indicators e.g. turnover and supervision rates show sustained improvement over three years. Sickness rates have remained above 5% target in 2025 and into 2026 with current rate at 5.4% against a target of 5%. A comprehensive review is underway to identify services and areas where sickness absence exceeds target.

- Year on year comparison of National Staff Survey results shows growing engagement and morale and improved staff experience against all seven themes of the People Promise.
- We have made significant progress since 2021 on the development of our lived experience and volunteers workforce, particularly with >50 new peer support roles as part of the new inpatient operating model.

4. We will help our communities thrive

- Conducted mid-point review of EPUT's Social Impact Strategy (published September 2023) and agreed revised governance embedding social impact in emerging neighbourhood models, whilst maintaining internal delivery on local recruitment, procurement and use of estates alongside a system-aligned approach for wider determinants and population-level initiatives.
- Active participation in Wave 1 National Neighbourhood Programme in North East and West Essex, enabling stronger focus on inequalities, community assets, and grassroots VCSE collaboration.We are progressing the development of a theory of change and outcome measures as part of ongoing strategic and medium-term planning across the Trust and with partners at system and neighbourhood level.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Strategic Impact Report M12 2025/26

Lead
 Zephan Trent **Executive Director of Strategy, Transformation & Digital**

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Essex Partnership University
NHS Foundation Trust

STRATEGIC IMPACT REPORT

M12 2025/26

EPUT

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02 DELIVERY HIGHLIGHTS

03 DELIVERY AGAINST STRATEGIC OBJECTIVES

04 TRANSFORMATION DELIVERY FRAMEWORK UDPATE

05 OPERATIONAL PLANNING 2026/27 and beyond

Note: Where possible, data is taken from the April Integrated Performance Report (M12) and the two reports are best read in conjunction for synthesis of shorter and longer term trends in delivery.

The Strategic Impact Report presents medium to longer term delivery trends to illustrate progress in delivery of our Strategic Plan, complimenting the faster cycle of monthly performance reporting

Executive summary

1. We will delivery safe, high quality integrated care
   - The Trust encourages high incident reporting rates as part of its learning and improvement culture. Incident reporting rates have been consistently above target over the last three years
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   - Over three years an average of 94.4% of patients and families report feeling safe in EPUT's care, with many months above the 95% target and relative consistent monthly results.

2. We will work with our partners to make our services better
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Executive summary

3. We will enable each other to be the best we can be
   - Conducted review of People Strategy (published January 2024) and agreed revised priorities : “CARE for our people, CARE for our future” – Compassion, Attract, Retain, Empower. Revised strategy and five-year implementation plan will be launched during Q1 2026/27
   - Key People indicators e.g. turnover and supervision rates show sustained improvement over three years. Sickness rates have remained above 5% target in 2025 and into 2026 with current rate at 5.4% against a target of 5%. A comprehensive review is underway to identify services and areas where sickness absence exceeds target
   - Year on year comparison of National Staff Survey results shows growing engagement and morale and improved staff experience against all seven themes of the People Promise
   - We have made significant progress since 2021 on the development of our lived experience and volunteers workforce, particularly with >50 new peer support roles as part of the new inpatient operating model.

4. We will help our communities thrive
   - Conducted mid-point review of EPUT’s Social Impact Strategy (published September 2023) and agreed revised governance embedding social impact in emerging neighbourhood models, whilst maintaining internal delivery on local recruitment, procurement and use of estates alongside a system-aligned approach for wider determinants and population-level initiatives
   - Active participation in Wave 1 National Neighbourhood Programme in North East and West Essex, enabling stronger focus on inequalities, community assets, and grassroots VCSE collaboration.

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INTRODUCTION

EPUT

EPUT'S STRATEGIC PLAN 2023/24-2027/28

Risks to delivery against the strategic objectives, controls, mitigations and system dependencies are addressed through the Board Assurance Framework.

OUR VISION

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

OUR VALUES

Strategic objectives

We have four strategic objectives to achieve our vision:

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

Delivered through our target operating model

Strategic Plan Review

We are now at the end of the third year of our five-year Strategic Plan. During Q2 2025/26, we reviewed the Plan to check that it is still relevant and feasible and that it reflects our vision, values and strategic objectives and also the significant changes in the wider health and care system that have taken place since we launched the Strategic Plan.

Our review was based on a range of views and firmly concluded that our vision, values and strategic objectives are still relevant. It also surfaced three bold shifts that EPUT now plans to make over the next three years so retain its strategic edge.

Operational planning for 2026/27 onwards have been informed by the priorities set by the Board – these priorities build on our existing plans to deliver our strategic objectives and provide the quality of care our local communities deserve.

Many enabling strategies are also reaching their mid-point with reviews in progress or planning which will inform the next chapter of focussed delivery, in alignment with system partners.

A new chapter for EPUT: meeting people where they are

We want to be **the leading health and wellbeing service for mental health and community care**. To help us achieve that aim in a rapidly changing world, **we're planning three big changes in the next two years**, using our existing resources.

1

We will explore and develop the potential of AI so we can:

- **Make lasting improvements to quality of care**, so we deliver the service our communities deserve
- **Learn directly from our patients' experience** to drive the changes we make
- **Personalise the care we give,** improve the way we diagnose and treat people, automate referrals and reduce delays
- **Use data and information to prevent ill health,** address inequalities and develop new services faster
- **Automate routine work,** increase time staff can spend with patients and increase job satisfaction

2

Becoming a trauma-informed organisation means recognising how traumatic events affect people's lives and their day-to-day experience of receiving care from, or working at, EPUT. Doing this more quickly will help us to:

- **Deliver better outcomes** for people receiving care
- **Improve quality and safety** in all our services
- **Strengthen wellbeing and resilience** for our workforce

3

Delivering accountable care is about how EPUT takes a lead on delivering integrated healthcare for a defined population, working in a different way with our partners. This supports our strategic objectives of providing safe, high quality integrated care and working with our partners to improve services. For local communities, this will bring:

- **More joined-up care** – reducing duplication and gaps so people have seamless support
- **Better health outcomes** – focusing on prevention, early intervention and coordinated management of long-term conditions to avoid people experiencing a crisis or serious ill health
- **Better use of resources** – ensuring funding follows people, not organisations, across the system, so local people benefit from more efficient services that reinvest savings into frontline care

This combined approach will enable us to continue to put **people at the heart of everything we do and to meet people where they are**: delivering integrated physical and mental health care in local communities which reflects people's individual needs and cultures and recognises the variety of personal and professional experiences of our staff.

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Our Year 3 commitments to deliver the strategic plan
Summary of 2025/26 operational plan

Trust overall	• **Progress implementation of digital and data strategic priorities – including the new unified electronic patient record (EPR)** • **Progress the implementation of our estates strategy and our research, innovation and commercial strategy - including developing an AI framework** • **Continue to work towards becoming a trauma-informed and psychologically-informed organisation**
We will deliver safe, high quality, integrated care services	• Progress the Community First programme to transform our community mental health services operating model • Co-produce and agree a plan to improve services for neurodivergent people with our voluntary and community sector partners
We will work together with our partners to make our services better	• Collaborate with partners in the SET All Age Mental Health Strategy Implementation Group to revise shared priorities • Complete alignment of community mental health teams to Primary Care Networks (PCNs) and integrated neighbourhood teams where possible • Roll out new family and carer ambassador roles to ensure patients' views are heard and families and carers are involved in care • Implement our Patient and Carer Race Equality Framework (PCREF) across all services
We will enable each other to be the best we can be	• Complete the implementation of the Time to Care programme to ensure mental health inpatient admissions are purposeful and therapeutic, reduce length of stay and improve system flow and are also less reliant on agency staff • Deliver our corporate services review and start implementing its recommendations • Fully implement the national sexual safety framework • Grow our substantive peer support workforce by 30% and increase our use of lived experience ambassadors by 20%
We will support our communities to thrive	• Bid for National Lottery grant to deliver major social impact intervention with voluntary sector partners via Enable East • Refresh our Green Plan for 2025 onwards to ensure services are environmentally sustainable • Agree our approach to delivering and monitoring social value through procurement • Create partnership arrangements with local colleges and schools across Essex to collaborate on local recruitment initiatives • Ensure our services are provided from the right locations to support patient access and new models of care

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DELIVERY HIGHLIGHTS

M12 2025/26

EPUT

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STRATEGIC IMPACT DASHBOARD – rolling 12 month averages show medium term trends

Strategic Objective 1: We will deliver safe, high quality integrated care services

Indicator	23/24	24/25	25/26	Movement in last year
Incident reporting rate (>44.33)	68.22	63.04	61.43	↓
No/low harm incident rate (>93.7%)	89.92	88.09	88.00	→
% patients/families feeling safe in EPUT's care*	95.42	94.16	93.82	→

Strategic Objective 2: We will work with our partners to make our services better

Indicator	23/24	24/25	25/26	Movement in last year
Adult Mental Health ALOS on discharge (<60)	61.43	76.48	59.15	↓
Out of Area Placements	19.25	26.50	36.25	↑
Virtual Ward Occupancy (>80%)	61.58	63.67	62.45	→
Weighted accruals to NIHR research studies (3200/yr)	N/A	314	96	↓

Strategic Objective 3: We will enable each other to be the best we can be

Indicator	23/24	24/25	25/26	Movement in last year
Staff turnover (<12%)	9.58	9.08	9.11	→
Manager+Leadership Dev Prog uptake	196	278	155	Changed methodology
LEA & volunteer hours	N/A	445	209	↓
Staff supervision/1-1 support (>90%)	73.29	72.93	76.82	↑

Strategic Objective 4: We will help our communities to thrive

Indicator	23/24	24/25	25/26	Movement in last year
% workforce from local communities	81	89	89	→
% BAME staff in roles >B7	21	22	22	→
% procurement spend with local suppliers	23	22	38	↑
Social Impact Grants (£k)	61	268	24	↓

Notes:

- Indicators for Strategic Objective 3 are to be revised to align with the relaunch of the People Strategy in Q1 26/27
- Safety of care and environment are not always relevant for people, particularly those who use our community services which are not specifically mental health related, and as such we have an average of 17% no-response rate for the 2 questions relating to safety, which when excluded from the percentage rating significantly increases the Trust's performance rating in the domain of safety within the friends and family test.
- Any data variance from the Integrated Performance Report is driven by live updates from Datix on incidents reported retrospectively

At the end of Y3 of our Strategic Plan, we continue to evidence steady progress against aspects of each strategic objective in the last six months, although measurable medium-term trends remain mixed

Strategic objective	Progress on key deliverables
We will deliver safe, high-quality integrated care	**Focus on high quality care** • In April 2024, EPUT launched its Quality of Care Strategy, supported by a three-year programme plan running to March 2027. The strategy, built around the three pillars of Experience, Effectiveness and Safety, establishes a clear golden thread of keeping quality at the centre of all services while enabling Trust-wide empowerment, learning and improvement. While all projects made progress, each was only partially able to achieve its intended outcomes in the first year due to competing operational priorities, the time required to establish steering groups, build consensus and confirm direction of travel. These foundations are now securely in place, enabling work to continue, strengthen and align to the 2026–2028 priority and our safety improvement plans • Quality Principles and five Safety Improvement Plans have been co-produced for 2026-28 and anchored in the Fundamentals of Care framework which is already embedded in several areas across the Trust • The Community First Programme moved into execute phase in M11 and is now focused on an accelerated timeline to produce a first draft of the service model and mental health pathway with a timeline for implementation. Community First will help to standardise processes and approaches, better align community teams with our inpatient mental health wards and reflect the national and local strategic shifts in health and care delivery which are set out in the NHS's Ten Year plan – in partnership moving more care from hospital settings to local communities. **Focus on safety** • EPUT's work on embedding the Patient Experience of the Patient Safety Incident Response Framework is now part of a wider NHS England supported initiative focused on restoring public trust in our patient safety processes. Feedback data has been collected and reviewed and project principles are being agreed before beginning Quality Improvement work on elements of the Patient Safety Process
We will work together with our partners to make our services better	**Working in partnership with people and communities** • Completed recruitment of to 14 new family and carer ambassador roles under TTC model to ensure patients' views are heard and families and carers are involved in care • Participants in the RISE (Resilience, Intelligence, Strength & Excellence) programme conceiving the initiative of developing Race Equity Champions and participated in early co-design of the role, overseen through the Reducing Health Inequalities sub-committee to strengthen PCREF delivery. Implementation will be planned during Q1 2026/27 • EPUT, in partnership with Start Change, will launch the COMPASS (Community Outreach Mentoring Pathway Advocacy Service Support) pilot programme in Q1 2026/7, rescheduled from 2025/26. This six-month initiative is designed to support men aged 18–35 from racialized communities with a history of repeated mental health hospitalisations **Delivering care in partnership** • Continuing to developing relationships with primary care leaders across Essex to level up primary care mental health provision and build foundations for an emerging neighbourhood health model as part of the implementation of the 10 Year Plan for Health • EPUT has worked in multi-agency collaboration with the East of England Ambulance Service to improve guidance and operational pathways for patients with PEACE plans. This ensures better coordinated responses, improved communication, and care that aligns with patient wishes at end of life

At the end of Y3 of our Strategic Plan, we continue to evidence steady progress against aspects of each strategic objective in the last six months, although measurable medium-term trends remain mixed

Strategic objective	Progress on key deliverables
We will enable each other to be the best we can be	**Focus on staff engagement, experience and organisational culture** • The Trust achieved a 52% response rate in the 2025 National Staff Survey, representing a 10% increase on 2024 and providing a stronger and more representative insight into staff experience as well as a general indication of improved engagement levels from staff. EPUT performed favourably when benchmarked against local trusts and those trusts facing similar levels of scrutiny and has seen improvements for most People Promise domains • We formed a partnership with BRAP and the Kings Fund to undertake a review of our organisational culture and develop a pilot leadership programme running from Q1 26/27 supporting leaders to navigate complexity, balance accountability with trust and create the conditions for learning and psychological safety **Supporting our staff and ensuring sustainable staffing** • Use of bank and agency staff continued to reduce through internal controls and focus on substantive workforce development • Corporate Services Review is designed to repurpose and revalidate our Trust Target Operating Model to ensure better support our Care Units, patients and families while delivering an ambitious efficiency saving. A large number of opportunities have been identified including preparation of a business case for adoption of AI to unlock clinical time and capacity
We will help our communities thrive	• In M9, following a mid-point review of delivery progress in a changing operating context, the Board endorsed changes to the governance of the Social Impact Programme to embed social impact through emerging neighbourhood and accountable care models, with maintained internal delivery and a system-aligned approach for wider determinants and population level work • Neighbourhood and accountable care delivery models for Essex continue to evolve, with EPUT consistently advocating for social impact contributions aligned to neighbourhood priorities • Active participation in Wave 1 National Neighbourhood Programme in North-East and West Essex, enabling stronger focus on inequalities, community assets, and grassroots collaboration with Voluntary and Community Sector partners • Enable East has completed its final contract and will pause operations from April 2026 to reduce financial risk exposure, in line with previous Executive Committee decisions • Social value procurement work is progressing, including exploration of CoPilot-enabled automation for supplier reporting and collaboration with MSEFT to maximise benefits from the Oracle partnership • EPUT has maintained its plans to send zero waste to landfill and secured £1.2m investment in carbon reduction infrastructure

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DELIVERY AGAINST STRATEGIC OBJECTIVES

M12 2025/26

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Delivery against strategic objective 1 – we will deliver safe, high quality integrated care

Trust overall	Care group specific
• Incident reporting rates sustained well above target for last three years • Increasing trend in proportion of low/no harm reports over last 12 months (average 88%), though still reporting below 93.7% target • Restraint incidents reported significant decrease in M10 and M11 with the lowest number of incidents in the preceding six months though still slightly outside target of <164 per month • Practice Nurse Educators are now in post across inpatient areas and are undertaking training to become Professional Advocates, strengthening clinical leadership and support for our workforce • Roots assessment tool data collection underway to understand the experience of neurodivergent people in inpatient care. The Trust baseline is due in Q2 2026/27 to support the transformation of services and settings in becoming trauma-informed building on the learning • Implementation of SafeWards has continued across inpatient services to embed work reduce restrictive practice, through a series of interventions designed by researchers at Kings College London to reduce conflict on wards	**Urgent Care and Inpatients** • Pilot re-alignment of Urgent Care to community teams in North East Essex launched in Q3 to test impact on flow, length of stay and complex case management. Leadership structure in place and pathway redesign in progress • PICU Mental Health Length of Stay on Discharge reduced significantly since peak of 137 days in M2 to 36 days in M12 against target of <50 days **Specialist Services** • Downward trend in self harm safety incidents from prior year average of 192 per month to 155 in 2026/27 • Maintained reduced level of restraints from prior year average of 99 per month throughout 2026/27 **Psychological Services** • Talking Therapies performance remains stable, with DTAC development underway and a 50% reduction in lost appointments since Sept 2023. Risk review calls completed for all patients waiting in 2025/26, providing assurance on safety • Personality Disorder & Complex Needs: Skills for Carers groups pilot completed in Linden Centre and extending to West Essex in March, outcome-measure project spanning PD&CN, Transitions Intensive Psychology Services and psychotherapy ready for pilot **North East Essex** • Sustained progress in reducing the number of outstanding incidents, the majority relating to section 42 enquiries that have required close working with safeguarding teams • Assertive Outreach peer support workers are embedded within both community teams with 50% of AOT caseload actively working with new peer support workers **West Essex** • Community Health Service KPIs performing outside contract target has reduced during Q4 • Early Intervention and Prevention Service rated as top performing for CBT and Family Interventions **Mid and South Essex** • Community Collaborative revisions to the Stroke Early Supported Discharge Service and actions taken by partners have addressed referral pressures and capacity constraints, with average response times reduced from 21 days in M1 to 2.1 days in M8-9 • Good progress made in Q4 to review and close overdue reported incidents

STRATEGIC OBJECTIVE 1:
WE WILL DELIVER SAFE, HIGH-QUALITY INTEGRATED CARE

Metric	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Trend
Incident Reporting Rates	>44.3	61.4	59.3	63.1	57.8	55	74.8	61.9	71.9	65.5	54.6	53.2	58.6	
No/low harm incident rates	>93.7%	86.2	84.0	84.8	84.5	88.5	88.0	90.7	89.7	90.3	88.8	89.3	91.4	
% of patients and families that say they feel safe in EPUT's care		93.5	96.5	93.5	96.1	93.2	93.9	95.6	90.6	93.6	92.9	94.2	92.2	

Note: Any data variance from the Integrated Performance Report is driven by live updates from Datix on incidents reported retrospectively

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Delivery against strategic objective 2 – we will work together with our partners to make our services better

Trust overall	Care group specific
• There continued to be challenges with patient flow through inpatient services. This has an impact on other areas such as accessibility, financial outcomes and out of area placements. A reset of the flow improvement plan and increased clinical engagement has been initiated to support delivery of the planned elimination of inappropriate Out of Area Placements by March 2028 • Over the last three years, following the success of the peer worker pilot as part of Time To Care in 2022/23, EPUT introduced >50 substantive new peer worker roles focussing on supporting families and carers of people in inpatient services • Last six months of research strategy have driven further capacity and capability expansion across professions to enable more clinicians to lead and support trials. The Trust has also secured strategic funding for a specialist clinical trials pharmacist post and capital funding for investment in mobile research infrastructure, both critical enablers to the delivery of commercial and interventional portfolio research • EPUT is actively participating in the national NHS England Culture of Care Programme, working alongside CPFT, NSFT, CNWL, OMHP and BHFT. Shared learning events, joint improvement cycles and thematic webinars support consistent, evidence-based improvements across inpatient mental health services, with four EPUT wards taking part	**Urgent Care and Inpatients** • Development of new Mental Health Emergency Department Diversion Spaces at Colchester and Princess Alexandra Hospitals progressing well with construction commenced on both sites • Adult MH average length of stay on discharge has reduced from 71 days in M1 to 50 days in M12 well within national target of 60 • Older Adult Length of Stay has reduced steadily during 25/26 but remains outside the national target of 90 **Specialist Services** • Held away day in February attended by six partner organisations in the delivery of Op Courage with excellent attendee feedback on reflective space and psychological safety of the event • All secure wards will be going live with electronic handovers in April this is following a delay due to technical reasons **Psychological Services** • Delivered successful pilot integrating advanced psychological support into drug and alcohol services in Thurrock • Co-leadership of Schwartz rounds for the Trust **North East Essex** • In Early Intervention & Prevention Services, the 24% target has been surpassed for the percentage of service users taking up family interventions and for the percentage of carers that have taken up education and support offers • Implementation of Urgent Care Triage Nurse has been met with positive feedback **West Essex** • Funding secured from Essex County Council for further 12 months of the Transfer of Care Hub placement team • Proactive care acceleration through additional matron post with Better Care Funding extended for 12 months to enable holistic assessment and personalised planning for those with long term conditions and at risk of acute admission **Mid and South Essex** • Community Collaborative working with General Practice Provider Collaborative who will take a leading role in the creation of a Neighbourhood Health Delivery Unit with plans in place for the establishment of joint strategic oversight • Work continues in support of the INT model development, coordinated by working group where partners come together to support its development and identify and resolve issues • Further increase in the utilisation of the FrEDA template across MSE community services and across all organisations, with more service coming onboard

STRATEGIC OBJECTIVE 2: WE WILL WORK TOGETHER WITH OUR PARTNERS TO MAKE OUR SERVICES BETTER

Metric	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Trend
Adult Mental Health ALOS on discharge (inc assessment units)	60	70.6	86.8	66.8	59.8	48.0	96.8	44.0	52.7	50.1	45.5	36.7	52.0	
Out of Area Placements	0	21	36	34	34	25	22	26	15	36	36	41	109	
Virtual Ward Occupancy	>80.0%	66.7	75.8	75	61.4	72	53.9	53.8	53.7	70.4	58.7	45.6	Data not yet available	
Weighted accruals to NIHR research studies (3200/yr)	>267	157	116.5	112.5	54	33.5	43.5	185	120	83.5	81.5	81.5	82.5	

Note: In September 2025, OOA placement reporting was changed to re-categorise spot purchased placements at Cygnet Colchester as inappropriate, driving an increase in reported OOA placements

Delivery against strategic objective 3 – we will enable each other to be the best we can be

Trust overall	Care group specific
• 2025 Staff Survey results show an increase in overall morale and engagement as well as advocacy, with more staff now recommending EPUT as a place to work • We have developed a new equality network model in collaboration with network leads and staff through co-design • Quarterly staff recognition events programme launched • Vacancy rate has continued to reduce throughout the last year and has remained below target threshold of <12% since M11 2024/25 • Continued reduction in temporary staffing utilisation across the Trust • Average staff turnover of 8.9% throughout the year against target <10% • Rising trend in staff supervision and appraisal rates throughout the year, achieving a peak of 81.1% in M11 against a target of 90% for supervision and 86.7% for appraisals against a target of 90% sustained to the end of the year • Rising trend in mandatory training rates through the year, achieving nearly 90% on all essential courses by the end of the year. The Trust is continuing to work with colleagues to increase compliance across all professions and subjects in order to protect our staff and patients	**Urgent Care and Inpatients** • Staff supervision rates improved from 71% in M1 to 79% by year end • Vacancies reduced and sustained below 13% target M9-11 through growing pipeline of recruits and reducing time to hire **Specialist Services** • Mandatory training rates above target all year • Vacancies reduced to 18% by year end since peak of 22% in M1 through maintaining pipeline of recruits and reducing time to hire **Psychological Services** • Mandatory training rates above target all year and steady progress on vacancy reduction throughout the year • Effective use of underspend to support fixed term recruitment and digital solutions: digital solutions, outsourced assessments • Delivered range of training to support improved provision to neurodiverse patients **North East Essex** • Staff appraisal target achieved and sustained since M10 • Vacancies reduced to 14% by year end since peak of 18% in M1 through maintaining pipeline of recruits and reducing time to hire • Incremental and sustained increase in mandatory training rates since beginning of year reaching a high of 94% in M11 against 90% target **West Essex** • Staff appraisal target achieved and sustained since M9 • Staff supervision rates improved from 76% in M7 to peak of 86% in M11 • Vacancy rate reducing and below 12% target all year with strong and growing recruitment pipeline **Mid and South Essex** • Staff appraisal target achieved and sustained since M9 • Mandatory training rates above target all year

STRATEGIC OBJECTIVE 3:
WE WILL ENABLE EACH OTHER TO BE THE BEST WE CAN BE

Metric	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Trend
Staff turnover	<12%	8.7	11.1	8.9	8.6	8.4	8.7	8.6	11.1	8.6	8.9	8.9	8.8	
Manager/Leadership Dev Programme uptake							25	19	49	33	13	3	13	
LEA hours/year		139.5	179	214	243.6	76	172	246.55	240.8	465.47	202.19	187.21	138.69	
Staff Supervision / 1-to-1 support	>90.0%	70.9	74.0	77.8	77.9	76.4	74.9	77.6	79.8	76.3	77.0	81.1	78.1	

Delivery against strategic objective 4 – we will help our communities to thrive

Trust overall

- 89% of EPUT staff live and work in same county, consistent with the prior year average
- 22% of band 7 and above roles held by BAME colleagues, consistent with the prior year average
- 38% of purchase order value was placed with suppliers in Essex, Bedfordshire or Suffolk, same as in the first half of the year, an increase of 16% on the prior year average
- Hosting >200 apprentices, using approximately 30% of apprenticeship levy with plans in development to increase usage further by supporting voluntary and community sector partners
- Green Plan has avoided 330,000 kg of CO2e emissions attributable to reduction in energy consumption (gas and electricity), which also improves internal/external air quality a direct link to the wider determinants of health
- Enable East successfully supported 35 Essex residents on their path towards employment in eight months on the Step Forward programme. 13 learners have successfully secured roles in health or social care, of which 10 have progressed into ICB-funded work placements with EPUT, NELFT or Forget Me Not care
- The Individual Placement Service (IPS) has celebrated its 300th support employment start under the Essex Connect to Work programme that started in October 2025. Impactful delivery has been enabled by widening the range of ill health conditions that IPS has traditionally worked with as well as broadening the range of settings for the team's operations.
- EPUT engaged in MSE Healthy Housing system diagnostic, with the inpatient flow team leading Trust input. Findings highlight links between housing conditions and discharge delays; improvement

Care group specific

Urgent Care and Inpatients

- Continued roll out of restorative supervision to support staff and teams during sustained periods of operational pressure
- Continued work with University of Essex and Anglia Ruskin University to train student nurses on the International Fundamentals of Care

Specialist Services

- Multiple teams working with vulnerable, disadvantaged or marginalised groups recognised for outstanding feedback in IWantGreatCare reports
- Proactive identification and Safe and effective management of two cases of diphtheria in wounds of homeless persons in Suffolk

Psychological Services

- Expanded service user network models to learning disability, adult community psychology and older people's mental health services
- Rolling out trauma buddy initiative as part of the Trust's move to become a trauma informed organisation

North East Essex

- Actively engaged in wave 1 pilot of National Neighbourhood Programme with focus on reducing inequalities through two test and learn sites that launched in Q4. EPUT is leading the people and culture work steam
- Plans approved in principle to develop Clacton Integrated Mental Health Hub on Bernard Ward with co-located VCSE services, pending development of full business case

West Essex

- Actively engaged in successful partnership bid for wave 1 of National Neighbourhood Programme with plan to scale existing Care Closer to Home and Integrated Neighbourhood Team model to neighbourhood health centres in Harlow and focus on proactive management of long term conditions, working alongside West Essex Citizen and Co-Production network

Mid and South Essex

- Successful local recruitment to trainee nurse and apprenticeship roles
- Influenced shape of Community First programme to transform mental health services to meet population

STRATEGIC OBJECTIVE 4:
WE WILL HELP OUR COMMUNITIES TO THRIVE

Metric	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Trend
% workforce from local communities							88.90%					89.00%	
% BAME staff in roles >B7		22%	23%	22%	22%	22%	22%	22%	22%	22%	22%	22%	
% procurement spend with local suppliers		46%	34%	32%	34%	39%	43%	33%	45%	41%	42%	38%	

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TRANSFORMATION DELIVERY FRAMEWORK UPDATE

MONTH 12 2025/26

EPUT

TRANSFORMATION TEAM OVERVIEW

The Transformation Team comprising portfolio, programme and project expertise continues to deliver impact across the Trust by enabling safe, well-governed and strategically aligned change.

The move to a focused approach of the Trust's priority transformation programmes has strengthened operational resilience, improved patient pathways and supported progress against key strategic outcomes.

The following large-scale priority programmes, all with Board or Executive Committee-approved Business Cases or Programme Initiation Documents, remain the primary focus of the team:

- Lampard Inquiry
- NOVA (Electronic Patient Record)
- Community First Programme
- Demand, Capacity and Patient Flow
- Efficiencies Programme, including the Corporate Services Review
- Adoption of Artificial Intelligence

Alongside programme and project management, the Transformation Portfolio Management Office (PfMO), comprising four WTE, plays a critical role in strengthening Trust-wide change governance by providing structure, oversight and assurance across not only the Executive-agreed priorities but also the wider Trust portfolio.

The team maintains portfolio management systems, promotes change methodologies and provides regular assurance reports for the Executive Team and wider System. This reporting provides clear visibility of progress, risks and issues, strengthening confidence in programme delivery and governance.

As custodians of the Single Front Door, the PfMO ensures all change activity is consistently triaged, strategically aligned and progressed through appropriate governance pathways. Working closely with Digital colleagues, a transparent, evidence-based prioritisation framework has been developed using a weighted model, ensuring limited organisational and digital capacity is directed to the highest-value activity at the right time and is supported by a streamlined intake process and enhanced request form incorporating automated prioritisation scoring.

This revised prioritisation approach enables care units to maintain a live, transparent view of their programmes and projects, with the flexibility to respond to emerging priorities. Oversight is embedded through the Transformation and Digital Steering Group, the Trust's primary forum for portfolio assurance, ensuring sustained organisational focus on delivering strategic objectives and measurable outcomes.

KEY PROJECTS AND PROGRAMMES

PROJECT/ PROGRAMME	PROGRAMME AIM	TRANSFORMATION INPUT	TRANSFORMATION OUTPUT	OVERALL IMPACT
Lampard Inquiry	To ensure the Trust provides responses to requests from the Inquiry in order to meet its statutory obligations and demonstrates transparency, accountability, and learning	Three WTE members of the team (Portfolio Lead, Programme Manager and Project Support) have been allocated from March 2026 in order to; • Strengthen process and programme management • Coordinate and manage Rule 9 requests including sourcing data, liaising with legal teams and subject matter experts	• Ensuring timely, accurate, high-quality, and fully assured responses to requests	• Improved practice and reduction of risk of inpatient deaths in Essex
NOVA (EPR)	The programme aims to deliver a joined-up, first-of-its-kind Electronic Patient Record system (EPR). Providing a single, integrated patient record, real-time access to information and to connect acute, mental health & community services	Since early 2025 a Project Manager has been allocated full time and this was further strengthened in January 2026 with additional support from the Associate Director of Transformation and Portfolio lead. Collectively they have; • Established a single programme governance route and business case across Provide, EPUT and NELFT • Standardised BI and SystmOne delivery approaches to enable collaborative working and a single sign-off process • Led service-wide design workshops across 22 services to develop a consistent SystmOne model, including clinical templates and reporting • Provided end-to-end governance oversight across all three organisations, recognising the collaborative is not a legal entity • Provide subject matter expertise and active support to the community NOVA build, ensuring alignment across the full Mid and South Essex footprint • Enabled coordinated delivery by sharing learning, reducing duplication, and aligning agreements across the three community providers • Support with contacts within Provide and NELFT helping to ensure the community build reflects the entire MSE community • Support strategic planning (sprint sessions, resource requirements) for the community health and mental health work stream/pillar • Provide programme leadership/change management/EPUT comms and engagement strategy and linking into to the Trust governance • Support alignment of the nova implementation with priority programmes/projects • Chairing/leading requirement sessions to support the community health and mental health build • Provide subject matter expertise on Community and Mental Health at EPUT	• A unified operating approach established across three community health providers • Improved performance insight enabling targeted improvement and transformation activity • Consistent, standardised care pathways implemented across services • Clear, auditable capture of benefits realisation and lessons learned • Aligned delivery timelines across the SystmOne integration, NOVA programme and contract realignment • Clinical risks identified and mitigated through redesign of SystmOne practices • Providing build data required by oracle health • Improved performance reporting to determine areas for improvement/transformation • Standardisation of care pathways • Accurate recording of benefits realisation • Improved performance reporting to determine areas for improvement/transformation • Standardisation of care pathways • Accurate recording of benefits realisation • A consistent model of working has been designed, including clinical templates and reporting requirements	• A single, system-wide view of safety, quality and performance across Mid and South Essex community services • Reduced unwarranted variation and improved patient equity through standardised assessments and care planning • Improved data quality and contract assurance, with automated reporting reducing reliance on manual clinical audits • Increased efficiency and productivity through reduced duplication, shared delivery and economies of scale • Simpler access and referral pathways for partners, improving patient access and experience • Future-ready community services, with modernised SystmOne units supporting NOVA delivery and contract alignment • Better patient experience, reducing need to repeat their story • Patients experience more integrated, joined up care that focuses on the individual, rather than requiring individuals to navigate the system themselves • Staff will focus on activities that call for their expertise, rather than navigating multiple complex systems • Joined-up care across services • More time for patient interaction

KEY PROJECTS AND PROGRAMMES

PROJECT/ PROGRAMME	PROGRAMME AIM	TRANSFORMATION INPUT	TRANSFORMATION OUTPUT	OVERALL IMPACT
Community First	Design, develop and implement a person-centred, sustainable, consistent and responsive model of care for adult community mental health services. The programme aims to ensure effective management of demand while delivering high-quality care that is safe, effective, and provides a positive experience for service users, their supporters, and staff	Dedicated expertise, (Programme Managers, Project Manager, and PfMO Analyst) provide structure and pace, along with subject matter expertise from the Director of Transformation and Associate Director of Transformation, in order to; • Coordinate overall programme delivery and specific workstreams (Older Adults & Dementia, Transforming Outpatients, Standardising CMHT, Demand & Capacity) • Provide end-to-end robust oversight and governance • Implement effective change control • Strengthen strategic alignment, support evidence-based decision making and ensure the programme is delivered in a consistent, sustainable way that maximises impact for services, staff and the communities we serve	• Development of a consistent MH community care model • Drafted reports suitable for Executive review, showing clear plans for future implementation of the MH community care model • Enabling improved access, reduced variation in practice and strengthen the management of demand across services. This will support more efficient service delivery, improved outcomes for service users, and better use of workforce and system resources	• Service users and their families will experience more coordinated, responsive and personalised care closer to home • Staff will benefit from clearer pathways, more consistent ways of working and improved support to deliver high-quality care • Communities will see services that are better aligned with local needs and more capable of meeting future demand
Demand, Capacity and Patient Flow	• Support the Trust to work with internal and external partners to reduce spend on out of area beds by improving the flow of patients who require a short-term admission to stabilise their mental health	A dedicated Programme Manager has been allocated in order to; • Support operational staff to understand the deliverables required to make meaningful change, and to plan appropriately to meet those deliverables • Combine 3 separate flow projects into one programme, reducing duplication of effort and ensuring a single plan works across multiple outcomes required by multiple stakeholders (patients, staff, executives, system partners and commissioners) • Guide staff members through appropriate governance to maintain good programme management processes and ensure success	• Better staff understanding of their role within flow processes • Standardisation of discharge processes across the system • Create and manage a clear programme plan that provides assurance and guidance to all staff on the required actions • Drive benefit's realisation against the stated in the programme plan	• Increased number of patients seen in ED Diversion services, including West & North East • OPEL reporting will show a decrease in level (60% OPEL3 or below in 6 months, 60% OPEL2/OPEL1 in 12 months) • Inappropriate OOA figures will show a downward trend to 0 in April 2027 • No patient will be delayed for more than 7 days • Decrease in the use of s.2/s.136/s.140 • Decrease in failed discharges (re-admitted within 28 days) • Decrease in sickness absence • Increase in staff retention • Patients with a length of stay of more than target (60 days adults, 90 days older adults) will decrease by 50% in 6 months and 85% in 12 months • Wellbeing results in the staff survey will improve from the previous year

KEY PROJECTS AND PROGRAMMES

PROJECT/ PROGRAMME	PROGRAMME AIM	TRANSFORMATION INPUT	TRANSFORMATION OUTPUT	OVERALL IMPACT
Trust Efficiencies inc. Corporate Services Review	• Support the delivery of the Trust Efficiency targets across both Corporate and Clinical Care Units. Overseeing the identification and management of savings schemes that achieve financial efficiencies, ensuring that care quality and safety remain uncompromised • The team leads the review of Corporate Services to ensure they provide high-quality, professional support that meets care unit needs while delivering efficiency savings	The PfMO team have been working alongside finance colleagues to; • Support clinical and corporate meetings to identify and shape efficiency opportunities • Work closely with Finance colleagues to validate schemes and ensure they are accurate, and realistic • Lead the coordination and quality assurance of PIDs and QIAs, ensuring all documentation meets the required standard and has Executive approval • Tracked scheme progress using the centralised Aspyre platform and finance tracker • Ensure scheme assurance and delivery are reported through the appropriate internal and external governance routes	• Enabled delivery of 46 local schemes and 20 Corporate Service Review schemes to date • Minimised avoidable running costs through better oversight and more efficient use of resources • Ensured a growing culture of continuous improvement is in place, encouraging teams to work more efficiently and make the best use of Trust resources	• Supporting more effective collaboration between operational and finance teams • Ensuring stronger governance, clearer reporting, and high-quality documentation • Contributed to a consistent approach to monitoring efficiencies, supporting better engagement across Care Units
AI	• Embed artificial intelligence into the core of our strategic, operational, and clinical delivery models, using AI to enhance care quality, support trauma-informed and personalised care and reduce administrative burden	A dedicated Programme Manager has been allocated in order to; • Bring together cross-Trust stakeholders (HR, Finance, Procurement, Digital, Patient Safety, Data/Analytics etc.) to shape requirements, workflow assessments and readiness • Lead the development and maintenance of programme action log • Coordinate discovery workshops, supplier demos, technical readiness sessions and engagement with suppliers • Provide structured governance through highlight reports, RAG ratings, milestone tracking, and risk escalation pathways • Coordinated communications to pilot users and leaders • Oversee licence allocation, training scheduling, and early user on boarding	• Accelerated Programme Readiness and Early Progress • Improved Quality of Decision-Making • Strengthened Assurance and Governance • Cross-System Learning and Alignment • Faster Movement from Discovery → Build → Adoption • Enhanced Organisational Engagement • Clear Line-of-Sight to Benefits • Improved credibility and visibility of the AI programme • Faster mobilisation and reduced organisational disruption	• Enhanced learning culture and system collaboration • improved speed, quality, safety, and accessibility of care, while enabling a more personalised and patient-centred experience • Improve communications between healthcare staff and patients to improve outcomes and productivity • Enhancing Data Handling and Reporting • Streamlining Meetings, meeting admin and Collaboration • Supporting the creation of reports and documentation • Improving Procurement, Finance, and Governance Processes • Enabling Workforce Productivity Gains • Reduce the time spent managing email

KEY PROJECTS AND PROGRAMMES

PROJECT/ PROGRAMME	AIM	INPUT	OUTPUT	IMPACT
ED Diversion	• Facilitation of two new Emergency Department Diversion centres in order to provide adults experiencing a mental health crisis with rapid assessment, care and support in a calm, therapeutic environment away from busy A&E departments. Their purpose is to ensure people get the right help at the right time, closer to home, delivered by specialist mental health staff who can understand the triggers of the crisis and direct individuals to the most appropriate care—whether that is hospital admission or support in the community	Allocation of 0.6WTE Programme Manager, with specific subject matter expertise to; • Ensure the programme is designed, governed, and implemented in a way that delivers the outcomes EPUT intends • Coordinate the redesign of crisis pathways • Align the workforce, digital systems, estates redevelopment, and community interfaces • Manage risks and issues and provide robust mitigations • Provide leadership, pathway redesign expertise, robust governance, and cross-system coordination	• Brings together clinical, operational, digital, estates and partner stakeholders to create a coherent end-to-end model • Facilities, staffing models, digital enablers, and community interfaces are all aligned • Strengthen delivery discipline • Reduces risks • Drives benefits realisation	• Dedicated crisis space • Designed to improve patient experience • Better support individuals with neurodiversity • Strengthen the overall mental health urgent care pathway • Ease pressure on local emergency departments across Essex
Portfolio Management Office	• Provide structure, governance and oversight to the Executive-agreed priority programmes, to support delivery • Prioritisation of the wider portfolio to ensure that capacity is allocated to the right activity at the right time • Provide assurance reporting on portfolio performance, ensuring Executive stakeholders have clear visibility of progress, risks and issues • Custodians of the Single Front Door	The Transformation Portfolio Management Office consists of one WTE Lead, one WTE Analyst, two WTE team support and administrators, they typically; • Prepare the assurance report each month to the Executive Team • Work with Digital PMO to develop a prioritisation methodology. Using a weighted model that consists of five questions and is in line with models used elsewhere in the organisation • Assurance review PM software to ensure best use and oversight of the Trust portfolio • Manage all single front door requests for change and progress via the weekly triage meeting	• Care units have a clear, prioritised view of their projects and programmes. This list will be live and transparent, with new projects prioritised as they arise, potentially shifting focus. This will also support Digital resource allocation which is in demand. • A streamlined Single Front Door process, form updated to incorporate the new prioritization questions, enabling an automatic score. • Providing an assurance report to Executives enables transparency and reinforces confidence in the effective delivery and governance of projects and programmes.	• Stronger governance and accountability • Better alignment • Smarter resource use • More efficient project intake process • Increased transparency • Standardisation of processes • Improved strategic focus • Enhanced governance

TRANSFORMATION DASHBOARD – APRIL 2026

Demand, Capacity and Patient Flow	Community First	NOVA	Efficiencies Inc. Corporate Services Review	AI	Lampard Inquiry
Executive Sponsor Alex Green	**Executive Sponsor** Ann Sheridan	**Executive Sponsor** Zephan Trent	**Executive Sponsor** Andrew McMenemy and Trevor Smith	**Executive Sponsor** Zephan Trent	**Executive Sponsor** Denver Greenhalgh
Overview Address issues with flow processes and procedures across the system. Incorporating the recent flow recovery plan and the external flow review recommendations	**Overview** To review and remodel secondary care community teams to meet the needs of the Essex population through the provision of a revised consistent, safe and therapeutic service model.	**Overview** The implementation of a unified Electronic Patient Record (EPR) across EPUT and MSEFT.	**Overview** Drive the Trust's efficiency agenda by overseeing the identification and delivery of financial savings across corporate and clinical services, while ensuring high-quality, safe care.	**Overview** Embed artificial intelligence into the core of our strategic, operational, and clinical delivery models, using AI to enhance care quality, support trauma-informed and personalised care and reduce administrative burden.	**Overview** Successful response to requests from the Lampard Inquiry team (Rule 9)
Status Initiate	**Status** Execute	**Status** Execute	**Status** Execute	**Status** Execute	**Status** Execute
Projects • Clozapine Clinic • Flow Review	**Projects** • Standardising CMHT • Demand and Capacity • Older Adults • Transforming Outpatients • Assertive Outreach	**Projects** N/A	**Projects** • 33 efficiency schemes • 11 Corporate Service Review schemes	**Projects** • Copilot • Ambient Voice Technology	**Projects** N/A
Transformation team Resource • 1 WTE Programme Manager	**Transformation team Resource** • 1 WTE Programme Manager • 1 WTE Project Manager • 1 WTE Director of Transformation (SME) • 0.2 WTE Associate Director of Transformation (SME)	**Transformation team Resource** • 0.6 WTE Portfolio Lead • 0.2 WTE Associate Director of Transformation • 1 WTE Project Manager	**Transformation team Resource** • 0.2 WTE Deputy Director of Transformation • 0.5 WTE Data and Analytics Lead • 0.2 WTE PfMO Lead	**Transformation team Resource** • 1 WTE Programme Manager • 0.5 WTE PMO Analyst • 0.4 WTE Project Manager	**Transformation team Resource** • 1 WTE Portfolio Lead • 1 WTE Programme Manager • 1 WTE Project Support

SIX MONTH FORWARD PLAN

Single Front Door (SFD)

Relaunch the SFD in order to introduce the streamlined intake process and enhanced request form which enables structured decision-making that will directly influence which projects which enter the portfolio, the order in which they progress, and the level of support allocated

Operating Model

1-3 months

Continuous review of the teams purpose and function to ensure we maintain a Transformation Team the organisation needs today and in the future

Review of Trust Change Governance processes

Review of the Transformation and Digital Steering Group to ensure that it fulfils its requirement to, be the gateway for new initiatives, oversee delivery performance and risks across the entire portfolio, and provide a unified space for agreeing standards, resolving cross-cutting issues, and escalating decisions

Resource Utilisation

3-6 months

Review and assess utilisation of team resources and capabilities to ensure they are deployed in the right way to fully support the priority transformation programmes and ensure successful delivery

Continuous Improvement (Reporting)

Further development of assurance reporting to ensure we maintain a consistent, gold standard product which captures key data in order to provide on-going assurance on delivery

NHS
Essex Partnership University
NHS Foundation Trust

OPERATIONAL PLANNING 2026/27

EPUT

2026/27 and medium term planning process

- The planning process has been executed at an accelerated pace this year, driven by nationally mandated timescales. This enabled the organisation to gain earlier visibility of activity trends and forecasting assumptions than in previous years, strengthening preparedness for contract negotiations
- A strong foundation for this year's planning cycle was established through the Strategic Plan Review conducted over summer 2025. This provided clear organisational direction, underpinned by three bold strategic shifts that guide priorities for the next three to five years
- Clinical and operational leadership have been highly engaged throughout, supported by coordinated input from corporate teams
- The overall approach has remained firmly anchored in quality and safety principles. We have maintained a consistent commitment to improvement, with finance positioned as an enabling function alongside workforce, digital, estates and other corporate enablers. Plans clearly articulate the links between service developments or efficiency schemes and their impacts on activity, workforce and financial outcomes
- Under the newly clustered Integrated Care Board, EPUT has aligned its plans as far as possible with Essex ICB as its strategic commissioner
- EPUT has developed a credible, integrated five-year plan joining up strategic and operational plans with robust triangulation between activity, workforce and financial plans to deliver on national and local priorities with strong clinical leadership
- All national submissions were approved by the Finance & Performance Committee with delegated authority from the Board
- The organisation is now focussed on delivery of Year 1 plans which is overseen through the Accountability Framework and a newly relaunched Transformation and Efficiency Group.

10. REGULATION AND COMPLIANCE

10.1 EPUT PROVIDER LICENSE (INCLUDING CODE OF GOVERNANCE AND GOVERNOR TRAINING)

Decision Item DG

REFERENCES

Only PDFs are attached

Provider Licence Review 03.06.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	3 June 2026

Report Title:	**EPUT Provider Licence Review (including Code of Governance and Governor Training)**					
Executive Lead:	Denver Greenhalgh, Executive Director of Corporate Governance					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:	Council of Governors (Code of Governance / Governor Training) Executive Operational Committee (Provider Licence / Code of Governance) Finance and Performance Committee (Provider Licence / Code of Governance)					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	Non-compliance with the Provider Licence could result in regulatory action.	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Statutory Public Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital and Data	
	SR10 Workforce Sustainability	
	SR11 Staff Retention	
	SR12 Organisational Development	
	SR13 Quality Governance	
Does this report mitigate the Strategic risk(s)?		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register?		
If yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk.		

Purpose of the Report		
This report presents the Trust's annual self-assessment against the NHS Provider Licence, NHS Code of Governance for Provider Trusts, and statutory Governor Training requirements. The review has been undertaken in line with NHS England expectations and has been subject to scrutiny through the Executive Operational Committee, Finance & Performance Committee, and the Council of Governors (where appropriate). The assessment indicates that the Trust is substantially compliant with relevant requirements, with no material issues requiring disclosure. The Board is therefore asked to approve the self-certifications and formally declare compliance, noting these statements will underpin disclosures within the Annual Report and Accounts 2025/26.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

- Confirm compliance with Sections G6, CoS7 and NHS2
- Approve the annual self-assessment of compliance with the NHS Provider Licence
- Declare compliance with the NHS Code of Governance for Provider Trusts
- Approve the Governor Training self -certification (Statement 3)

Summary of Key Points

Provider Licence Review

NHS Foundation Trusts are required to make annual self-certification under the NHS Provider Licence, Risk Assessment Framework and the Health and Social Care Act 2012, in addition to those made as part of the annual report submission. Self-certifications are not routinely submitted to NHS England, but must be approved by the Board, retained, and made available on request, with relevant disclosures included within the Annual Report.

The Provider Licence was amended in 2023; however, the certificates have not been updated and do not match the new requirements. Therefore, our internal process (as set out in Appendix 1) is provided as a substitute of the formal forms until these become available.

Self-certification is required against Section 3 (previously G6) and CoS7 by 31 May 2026. Self-certification is required against NHS2 (previously FT4) and Governor Training by 30 June 2026. The Governor Training self-certification has been taken forward with the Council of Governors.

The review process to be followed is as follows:

- Self-assessment against the Code of Governance
- Review by Executive Operational Committee (Completed)
- Assurance report to Finance & Performance Committee (Completed)
- Final annual report, including relevant statement to Board of Directors (3 June)

A detailed self-assessment review was undertaken against the requirements of Section 3: General Conditions (G6), CoS7 and NHS2 (FT4) by the Trust Secretary's Office.

The review indicates that the Trust is substantially compliant, with no material areas of non-compliance identified. Appendix 1 details a high level summary against each of the requirements, and any areas for improvement are set out and are subject to ongoing monitoring (for example through the CQC Improvement Plan). The Board of Directors is asked to confirm compliance with G6, CoS7 and FT4 and thereby approve the annual self-assessment of compliance with the NHS Provider Licence as recommended by the Finance & Performance Committee to the Board.

Code of Governance Review

The purpose of the Code is to provide guidance to help Trusts deliver effective and quality corporate governance, contribute to better organisational performance and discharge duties in the best interests of patients.

The Trust's Annual Report must include a statement as to how the Trust applies the Code and confirms that the Trust 'complies' with the provisions, or if not, provide an explanation as to why it has departed from the Code.

The review process to be followed is as follows:

- Self-assessment against the Code of Governance
- Internal independent assessment by the Council of Governors Governance Committee (Completed)
- Report to Council of Governors (Completed)
- Assurance report to Finance & Performance Committee (Completed)
- Final annual report, including relevant statement to Board of Directors (3 June)

The Assistant Trust Secretary undertook the self-assessment review of the Trust's position against the Code. The review indicates the Trust is substantially compliant against all provisions. The Board of Directors is asked to declare compliance with the provisions of the Code of Governance as recommended by the Finance & Performance Committee and Council of Governors.

Governor Training

NHS Foundation Trusts are required to make an annual self-certifications to NHSE under the requirements of the NHS Licence, Risk Assessment Framework and the Health and Social Care Act 2012. However, the Health Social Care Act, Section 151(5) states in paragraph 10BA:

- "Public benefit corporation must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such."

As above whilst NHS England has not reissued the formal certification statements following the 2023 Provider Licence amendments, the Trust continues to complete an equivalent declaration (aligned to the formed Statement 3) to evidence compliance. The Board is asked to formally confirm the statement below based on assurance provided by the Council of Governors

- *The Board is satisfied that during the financial year most recently ended the licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role. (Statement 3)*

The Trust developed a Learning and Development Plan, identifying key learning topics to support its Governors to undertake their role. The Council of Governors Training and Development Committee oversees the plan. The Committee receives assurance that the plan is being delivered and considers any new training requirements as the year progresses. The Council of Governors Training and Development Committee and Council of Governors reviewed the learning opportunities provided by the Trust and agreed to recommend to the Board of Directors that sufficient training was provided to Governors to undertake their role.

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

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	SFI(s)	Standing Financial Instructions
DHSC	Department of Health and Social Care	WDES	Workforce Disability Equality Standard
ICB	Integrated Care Board	WRES	Workforce Race Equality Standard
ICP	Integrated Care Partnership	VFM	Value for Money
BAF	Board Assurance Framework	SID	Senior Independent Director
SoRD	Scheme of Reservation & Delegation	VSM	Very Senior Managers
FPPT	Fit and Proper Persons Test	KPIs	Key Performance Indicators
MSEFT	Mid and South Essex Foundation Trust	HOSC	Health Overview and Scrutiny Committee
DSoD	Detailed Scheme of Delegation	ARM	Annual Report and Accounts Manual
EPR	Electronic Patient Record	AI	Artificial Intelligence
TTC	Time to Care (programme)	PICU	Psychiatric Intensive Care Unit

Supporting Reports and/or Appendices

Appendix 1: Provider Licence Review 2026

Appendix 2: Code of Governance Review 2026

Executive/ Non-Executive Lead / Committee Lead:

Denver Greenhalgh
Executive Director of Corporate Governance

EPUT REVIEW OF COMPLIANCE AGAINST THE PROVIDER LICENCE 2025/26 AS AT APRIL 2026

Board assurance statement

The Board of Directors has reviewed its compliance with the Provider Licence for the year ended 31 March 2026. Based on the evidence presented in this review, the Board is satisfied that the Trust is compliant with the provisions of the Provider Licence. To underpin this assurance, we have drawn on a range of triangulated sources such as, Board Committees oversight throughout the period; internal audit offering independent verification and highlighting good practice as well as area requiring attention; and feedback from the Care Quality Commission. Our Board Assurance Framework (BAF) has served as an effective tool, mapping risks and controls.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
SECTION 1: INTEGRATED CARE			
IC1: PROVISION OF INTEGRATED CARE			
IC1.1	The Licensee shall act in the interests of the people who use health care services by ensuring that its provision of health care services for the purposes of the NHS: i) is integrated with the provision of such services by others, and ii) is integrated with the provision of health-related services or social care services by others and iii) enables co-operation with other providers of health care services for the purposes of the NHS where this would achieve one or more of the objectives referred to in paragraph 2.	Compliant	• EPUT utilises integrated care models to provide a range of healthcare services. • EPUT actively works with its partners through both formal and informal mechanisms to foster and enable integrated care. • The Trust is actively involved with system working including Board members as members of Integrated Care Boards and the Mid & South Essex Community Collaborative, which is working together with providers of linked services to provide joined-up services. A summary of these partnerships is provided in the EPUT Annual Report. • EPUT has representation on local partnership boards feeding into system wide working and planning. • Stakeholders are involved in managing key shared risks through well-established contract management and partnership committee structures that oversee the operational delivery of and potential threats to services delivered in partnership.
IC1.2	The objectives are: a. improving the quality of health care services provided for the	Compliant	• The Trust Strategic Objectives are in-line with the objectives in the provider licence, such as the delivery

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	purposes of the NHS (including the outcomes that are achieved from their provision) or the efficiency of their provision, b. reducing inequalities between persons with respect to their ability to access those services, and c. reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services.		of safe, high quality integrated care services, working together with partners to make services better and helping our communities to thrive, which includes reducing health inequalities. • The Trust completed a review of its Strategic Objectives in October 2025 to ensure these remained relevant and continuing to deliver in line with changes to national policy. • The Trust has developed a number of enabling strategies to support the delivery of strategic objectives; including the Quality of Care Strategy, Working with People & Communities, which specifically supports this condition. • The Trust has developed and published a Social Impact Strategy and Charter, which aims to be the key driver behind the reducing health inequalities.
IC1.3	The Licensee shall have regard to guidance as may be issued by NHS England from time to time for the purposes of paragraphs 1 and 2 of this Condition.	Compliant	• The Chairs Report to the Board of Directors includes a Governance Review which identifies new guidance issued by a range of organisations, including NHS England. This is highlighted to the responsible Executive Director for consideration and reflection in any future developments. • A monthly Legal Update report is presented to the Executive Team, which would identify any new guidance.
IC1.4	Nothing in this licence condition requires the licensee to take action or share information with other providers of health care services for the purposes of the NHS if the action or disclosure of the information would materially prejudice its commercial or charitable interests	N/A	
IC2: PERSONALISED CARE & PATIENT CHOICE			
IC2.1	The Licensee shall support the implementation and delivery of personalised care by complying with legislation and having due regard to guidance on personalised care.	Compliant	• The Trust has internal processes to ensure patient care is as personalised as possible, including the development of personalised care plans. • have not raised any significant concerns in this area.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
			• CQC inspections during 2025/26 have not raised significant concerns in regard to personalised care there have been other findings that are linked to the consistency of personalised care plans and improvement work directly addresses this, for example 'My Care My Recovery' approach. Reports published in 2025/26 include: Community Health Inpatient Services April 2026 Forensic Inpatient / Secure Wards April 2025 (patients not always involved in care planning) Acute Wards for Adults of Working Age & PICU July 2025 (care plans had improved, but mixed access to care plans) Wards for People with Learning Disabilities or Autism November 2025 (Gaps in risk assessments) Long Stay / Rehabilitation Mental Health Wards (Working Age Adults) April 2026 (Patients admitted without appropriate risk assessments) • Where the CQC have identified some gaps in relation to personalised care plans, these are being taken forward as part of the CQC Improvement Plan. • IA of management and implementation of CQC actions provided a substantial assurance opinion.
IC2.2	Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee must ensure people who use their services are offered information, choice and control to manage their own health and well-being to best meet their circumstances, needs and preferences, working in partnership with other services where required.	Compliant	• The Trust has internal processes which ensure people who use the services are offered information, choice and control to manage their own health and wellbeing. • The Trust operates a principle of "no wrong door" to ensure individuals are provided with the right level of information and receive the right choice of care wherever they access services. • The Trust operates a principle of purposeful admission for inpatient services to ensure there is a clear pathway for patients entering inpatient services from admission to discharge.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
			• The Trust works with other providers and system partners to ensure the patient pathway is clear, including the Mid & South Essex Collaborative, where partners providing similar services can work together to ensure personalised, holistic care can be provided between organisations. • The Strategic Objective "The Trust will help our communities to thrive" includes ensuring the wellbeing of the local communities and to ensure people are able to manage their own care and wellbeing. The Social Impact Strategy and Charter are taking this forward. • The Trust developed a Community First Strategy in 2025/26 to improve patient pathways in community mental health services, including with partner organisations.
IC2.3	Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, the person is notified of that choice and told where information about that choice can be found.	Compliant	• All services have eligibility criteria agreed with commissioners in line with relevant guidance and documented in commissioning contracts and service specifications. The criteria are reviewed with commissioners as required. • The EPUT website provides details of service provision by geography and service type. The information includes eligibility criteria and contact details for the service or to find further information. • There are some limitations to choice for some Tier 4 and / or specialised services, where patients may require urgent intervention provided by a particular service provider.
IC2.4	Information and advice about patient choice of provider made available by the Licensee shall not be misleading.	Compliant	• The information on the EPUT website is provided by the individual services and is accurate based upon the service specifications / commissioning contracts. • Commissioners monitor EPUT's compliance with the legal right of choice as part of contract monitoring in

Ref	Condition Summary	EPUT Position	Evidence/Assurance
			line with NHS Standard Contract requirement.
IC2.5	Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that, as far as reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services.	Compliant	• The EPUT service directory on the website sets-out the services available. • The service information and eligibility criteria is clear on the function of the service and the eligible patients, which allows individuals to make an informed choice in accessing services.
IC2.6	In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.	Compliant	• The Standing Orders for the Board of Directors provides a clear procedure for tendering and contracting services, which does not include the providing of gifts and / or benefits in kind for the tendering / contracting of services.
SECTION 2: TRUSTS WORKING IN SYSTEMS			
WS1: COOPERATION			
WS1.1	This condition shall apply if the Licensee is an NHS trust NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.	N/A	N/A - Statement
WS1.2	The Licensee shall carry out its legal duties to co-operate with NHS bodies and with local authorities.	Compliant	• The Trust works with other NHS bodies as part of contractual arrangements and collaborative working. • EPUT has representation on local partnership boards feeding into system wide working and planning. • Section 75 arrangements in place with local authorities and the Trust attends Health Oversight Scrutiny Committees (HOSC) with local authorities.
WS1.3	Without prejudice to the generality of paragraph 2, the Licensee shall: a. consistently co-operate with: • other providers of NHS services; and • other NHS bodies, including any Integrated Care Board of which it is a partner;	Compliant	• As above. • The Operational Plan (including finance and workforce) is developed alongside the Integrated Care Boards and other NHS bodies to ensure it supports system plans and financial plans. The plan is submitted to regional NHS England for approval.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	i. as necessary and appropriate for the purposes of developing and delivering system plan(s). ii. as necessary and appropriate for the purposes of delivering their individual or collective financial responsibilities including but not limited to contributing to the delivery of agreed system financial plans in each financial year iii. as necessary and appropriate for the purposes of delivering agreed people and workforce plans		
	b. consistently co-operate with: • other providers of NHS services; • other NHS bodies, including any Integrated Care Board of which it is a partner; and • any relevant local authority in England i. as necessary and appropriate for the purposes of delivering NHS services. ii. as necessary and appropriate for the purposes of improving NHS services.	Compliant	• As above regarding collaborative working and working with local authorities.
WS1.4	The Licensee shall have regard to such guidance concerning co-operation as may be issued from time to time by either: a. the Secretary of State for Health and Social Care; or b. NHS England.		• The Trust Secretary's Office receives any new guidance from the Secretary of State for Health and Social Care and / or NHS England and implements as required. • The Chairs Report to the Board of Directors includes a review of any new information / guidance to be shared with the Board of Directors. • The Trust Policy review process includes a requirement for policy authors to horizon scan for any new guidance issued which may impact any policies

Ref	Condition Summary	EPUT Position	Evidence/Assurance
			and procedures, including any relating to co-operation with partners.
WS2: THE TRIPLE AIM			
WS2.1	This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.	N/A	• N/A - Statement
WS2.2	When making decisions in the exercise of its functions which relate to the provision of health care for the purposes of the NHS, the Licensee shall comply with its duty relating to the triple aim.	Compliant	• The Trust Operational Plan, overseen through the Finance and Performance Committee, has continued to support delivery of the Triple Aim by optimising the use of resources whilst maintaining quality and patient outcomes. • The efficiency plan aligned and also with system partners, with schemes focused on: Improving productivity within clinical pathways (including reduction in length of stay and improved flow); Reducing unwarranted variation across services; and Maximising workforce efficiency through redesign (TTC) and skill mix. • The Trust Strategic Objectives helping communities to thrive, which includes promoting wellbeing and reducing health inequalities. • The Financial Plan (as part of the Operational Plan) has been developed to take into consideration the financial position of the NHS and local system. The capital programme has been used to support improvements in patient care, safety and experience, in line with the Triple Aim duty. E.g. enhancing quality and safety of the estate, including improvements to inpatient environments; supporting digital transformation, with progress towards a unified EPR enabling more coordinated and efficient care pathways; and investment in equipment. • The Trust has robust processes and systems in place to ensure it has the resources necessary to deliver services and support the wider system.
WS2.3	The Licensee shall have regard to the triple aim and to any guidance published by NHS England under section 13NB of the 2006 Act.	Compliant	
WS2.4	In this condition, "the triple aim" refers to the aim of achieving: a. better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing) b. better quality of health care services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) c. more sustainable and efficient use of resources by NHS bodies, and "duty relating to the triple aim" means, in relation to an NHS trust, its duty under section 26A of the 2006 Act, and in relation to an NHS foundation trust, its duty under section 63A of the 2006 Act.	Compliant	

Ref	Condition Summary	EPUT Position	Evidence/Assurance
WS3: DIGITAL TRANSFORMATION			
WS3.1	This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.	N/A	• N/A - Statement
WS3.2	The Licensee shall comply with information standards published under section 250 of the 2012 Act where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).	Compliant	• The Trust has an Information Governance and Security Policy & Procedure in place, which takes into consideration any legislation as required. • The Trust has an Information Governance Team, responsible for overseeing governance processes within the organisation to ensure it is in line with relevant legislation, including where information is shared as part of cooperation and the triple aim.
WS3.3	The Licensee shall comply with required levels of digital maturity as set out in guidance published by NHS England from time to time where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).	Compliant	• The Trust Digital & Data Strategy 2023 - 2029 sets-out a plan for digital and data maturity to ensure required levels of digital maturity are reached. • As part of the mid-term review of the Digital Strategy, Artificial Intelligence (AI) as a programme of strategic transformation is being developed. This is to ensure the Digital Strategy is up to date with national policy. • In partnership with MSEFT, EPUT is implementing a new unified electronic patient record system (NOVA) to mature its digitally enabled care pathways.
SECTION 3: GENERAL CONDITIONS			
G1: PROVISION OF INFORMATION			
G1.1	The Licensee shall provide NHS England with such information, documents and reports (together 'information') as NHS England may require for any of the purposes set out in section 96(2) of the 2012 Act. This requirement is in addition to specific obligations set out elsewhere in the licence. If requested by NHS England, the Licensee shall prepare or procure information in order to comply with this condition.	Compliant	• The Trust has systems and processes in place to identify and respond to any routine and non-routine information requests. • The Trust submits all documents, reports and declarations in accordance with all relevant statutory and regulatory requirements in force from time to time. • Any submissions required are made by the Finance
G1.2	Information shall be provided in such manner, in such form, and at	Compliant	

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	such place and times as NHS England may require.		Directorate and retained. • Copies of all documents to NHSE are retained
G1.3	The Licensee shall take all reasonable steps to ensure that information is: a. in the case of information or a report, it is accurate, complete and not misleading; b. in the case of a document, it is a true copy of the document requested.	Compliant	• The Trust has check and balance processes in place, to ensure any information supplied to NHS England is accurate, complete, not misleading and is a true copy of any documentation requested.
G1.4	This Condition shall not require the Licensee to provide any information which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.	N/A	• N/A - Statement
G2: PUBLICATION OF INFORMATION			
G2.1	The Licensee shall comply with any instruction by NHS England, issued for any of the purposes set out in section 96(2) of the 2012 Act, to publish information about the health care services it provides for the purposes of the NHS. The Licensee shall publish the information in such manner as NHS England may instruct.	Compliant	• The Trust publishes information / documentation on its public website as required and would publish any additional information instructed by NHS England. • The Trust complies with all reporting guidance for annual documents, including the ARM, Quality Account and Constitution.
G2.2	For the purposes of this Condition, "publish" includes making available to the public at large, to any section of the public or to particular individuals.	N/A	• N/A - Statement
G3: FIT AND PROPER PERSONS AS GOVERNORS AND DIRECTORS (ALSO APPLICABLE TO THOSE PERFORMING THE FUNCTION OF; OR FUNCTIONS EQUIVALENT OR SIMILAR TO THE FUNCTIONS OF, A DIRECTOR			
G3.1	The Licensee must ensure that a person may not become or continue as a Governor of the Licensee if that person is: a. a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; b. a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);	Compliant	• The Trust Constitution sets-out disqualifications for acting or continuing as a Director or Governor at EPUT, which includes the criteria provided by this condition. • The Trust has robust systems in place for completing Fit and Proper Persons Test (FPPT), in line with NHS England guidance published in 2023. This includes the completion of self-attestations by members of the

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	c. a person who has made a composition or arrangement with, or granted a trust deed for, that person's creditors and has not been discharged in respect of it; d. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person.		Board of Directors and a check on public registers to ensure no members of the Board of Directors meets any of the disqualification criteria. An internal audit of the processes for FPPT checks was completed in 2025/26, achieving reasonable assurance. • The Trust Fit and Proper Persons Test Policy & Procedure sets-out the requirements for the Board of Directors. • The Code of Conduct for Members of the Board of Directors references the Trust Constitution for any disqualification criteria. • The Council of Governors Code of Conduct includes disqualification criteria, in line with the Trust Constitution, and Governors are required to sign documentation to confirm they do not meet any of the disqualification criteria.
G3.2	The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper.	Compliant	• The Fit and Proper Persons Test process described above, is completed as part of the pre-appointment checks prior to any appointment. Annual checks are completed to ensure this is maintained.
G3.3	For the purposes of paragraph 2, a person is not fit and proper if that person is: a. an individual who does not satisfy all the requirements as set out in paragraph (3) and referenced in paragraph (4) of regulation 5 (fit and proper persons: directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936); or b. an organisation which is a body corporate, or a body corporate with a parent body corporate: i. where one or more of the Directors of the body corporate or of its parent body corporate is an individual who does not meet the requirements referred to in sub-paragraph (a); ii. in relation to which a voluntary arrangement is proposed, or has effect, under section 1 of the Insolvency Act 1986;	Compliant	• As above, the FPPT checks include a review of relevant public registers, including Companies House.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	iii. which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking; iv. which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act; v. which passes any resolution for winding up; vi. which becomes subject to an order of a Court for winding up; or vii. the estate of which has been sequestrated under Part 1 of the Bankruptcy (Scotland) Act 1985.		
G3.4	In assessing whether a person satisfies the requirements referred to in paragraph 3(a), the Licensee must take into account any guidance published by the Care Quality Commission.	Compliant	• The Trust takes into consideration any guidance published by the CQC in relation to FPPT requirements, for example, DBS Checks.
G4: NHS ENGLAND GUIDANCE			
G4.1	Without prejudice to specific obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by NHS England for any of the purposes set out in section 96(2) of the 2012 Act.	Compliant	• The Trust has systems and processes in place to ensure it responds to / meets guidance issued by NHS England. • A monthly Legal Update report is presented to the Executive Team, which would identify any new guidance. • Full reviews of NHSE guidance are undertaken by relevant teams including Compliance Team, Trust Secretary's Office, Legal Team, Finance Team as part of reviewing internal processes.
G4.2	In any case where the Licensee decides not to follow the guidance referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform NHS England of the reasons for that decision.	Compliant	
G5: SYSTEMS FOR COMPLIANCE WITH LICENCE CONDITIONS AND RELATED OBLIGATIONS			
G5.1	The Licensee shall take all reasonable precautions against the risk of failure to comply with: a. the Conditions of this Licence,	Compliant	• The Trust has a Board Assurance Framework in place and processes, supportive of the identification and management of risk across the organisation.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	b. any requirements imposed on it under the NHS Acts, and c. the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.		• Risks are identified and managed at all levels of the organisation, including Board, Standing Committees and local clinical business units. • The Trust undertakes an annual review of compliance with the terms of the provider licence, with actions to address any areas for improvement. • Compliance declarations made by the Board of Directors within required timeframe (note NHSE no longer require these to be submitted)
G5.2	Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include: a. the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and b. regular review of whether those processes and systems have been implemented and of their effectiveness.	Compliant	
G6: REGISTRATION WITH THE CARE QUALITY COMMISSION			
G6.1	The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able to lawfully provide health care services for the purposes of the NHS.	Compliant	• The Trust is fully registered with the CQC.
G6.2	The Licensee shall notify NHS England promptly of: a. any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or b. the cancellation by the Care Quality Commission for any reason of its registration by that Commission.	Compliant	• The Trust CQC Registration has not been cancelled by the CQC to date. • The Compliance Team manages the CQC Registration and any cancellation by the CQC would be notified to NHS England within the relevant timescales.
G6.3	A notification given by the Licensee for the purposes of paragraph 2 shall: a. be made within 7 days of: i. the making of an application in the case of paragraph (a), or ii. becoming aware of the cancellation in the case of paragraph (b), and b. contain an explanation of the reasons (in so far as they		

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	are known to the Licensee) for: i. the making of an application in the case of paragraph (a), or ii. the cancellation in the case of paragraph (b).		
G7. PATIENT ELIGIBILITY AND SELECTION CRITERIA			
G7.1	The Licensee shall: a. set transparent eligibility and selection criteria, b. apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and c. publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them.	Compliant	• Patients' eligibility criteria agreed with commissioners in line with relevant guidance and documented in commissioned contracts within individual service specifications: available on request. • Commissioned contracts are subject to regular reviews. • EPUT website includes its service provision by geography and service type and contact details and there is limited eligibility criteria included.
G7.2	"Eligibility and selection criteria" means criteria for determining: a. whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and b. if the person is selected, the manner in which the services are provided to the person.	N/A	• N/A - Statement
G8: APPLICATION OF SECTION 6 (CONTINUITY OF SERVICE) - N/A - Section required for Commissioner Requested Services – EPUT does not currently provide any Commissioner Requested Services.			
SECTION 4: TRUST CONDITIONS			
NHS1: INFORMATION TO UPDATE THE REGISTER			
NHS1.1	The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.	N/A	• N/A – Statement
NHS1.2	The Licensee shall make available to NHS England written and electronic copies of the following documents: a. the current version of Licensee's constitution;	Compliant	• Trust Constitution submitted to NHS England on an annual basis and following any in-year review. • Annual Report & Accounts sent to NHS England upon approval by the Board of Directors.

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	b. the Licensee's most recently published annual accounts and any report of the auditor on them, and c. the Licensee's most recently published annual report, and for that purpose shall provide to NHS England written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published.		
NHS1.3	Subject to paragraph 4, the Licensee shall provide to NHS England written and electronic copies of any document that is required by NHS England for the purpose of NHS foundation trust register within 28 days of the receipt of the original document by the Licensee.	Compliant	• Copies documents listed above submitted to NHS England following approval at Board of Directors.
NHS1.4	The obligation in paragraph 3 shall not apply to: a. any document provided pursuant to paragraph 2; b. any document originating from NHS England; or c. any document required by law to be provided to NHS England by another person.	N/A	• N/A - Statement
NHS1.5	The Licensee shall comply with any instruction issued by NHS England concerning the format in which electronic copies of documents are to be made available or provided.	Compliant	• Documents submitted to NHS England via email and would be submitted in any format instructed by NHS England.
NHS1.6	When submitting a document to NHS England for the purposes of this Condition, the Licensee shall provide to NHS England a short written statement describing the document and specifying its electronic format and advising NHS England that the document is being sent for the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act.	Compliant	• The documentation is submitted via email with key information in the body of the email advising of the content of the documentation and reason for submitting.
NHS 2: GOVERNANCE ARRANGEMENTS			
NHS2.1	This Condition shall apply if the Licensee is an NHS trust or NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.	N/A	• N/A – Statement

Ref	Condition Summary	EPUT Position	Evidence/Assurance
NHS2.2	The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.	Compliant	• EPUT has sound corporate governance systems and processes in place, based upon NHS England guidance and other legislation. • The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of EPUT, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. • Board effectiveness reviews are undertaken – there we no reported gaps reported in 2025/26 to the Board. Outcomes of effectiveness reviews are acted on.
NHS2.3	Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall: a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and d. comply with the following paragraphs of this Condition.	Compliant	• The EPUT Green Plan 2026-29 sets-out the Trust ambition for sustainability and the reduction of the Carbon Footprint. • The Trust has corporate governance systems in place which are matured through the delivery of the Digital and Data Strategy 2023 – 2029. • The Finance & Performance Committee provides oversight and assurance of the delivery of the Digital and Data Strategy. • The Digital Strategy Group has undertaken a mid-term review of the strategy, in line with changes in national policy and proposed strategic changes, such as shift to AI.
NHS2.4	The Licensee shall establish and implement: a. effective board and committee structures; b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and	Compliant	• The Trust has an effective Board and committee structure with appropriate terms of reference. • The Terms of Reference provide clear areas of responsibility, reporting lines and accountabilities for each Standing Committee. • Effectiveness reviews of Board and its committees

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	c. clear reporting lines and accountabilities throughout its organisation.		are completed annually. • Scheme of Reservation and Delegation sets out the powers reserved to the Board and those that the Board has delegated, i.e. the schedule of matters reserved to the Board. This is reviewed annually and reflects delegation derived from the constitution, accounting officer memorandum, standing orders, SFIs, NHSE *Code of Governance* and Board *Code of Conduct* • Reviews of the corporate governance systems included in internal audit annual work programme. • The Trust operates an Accountability Framework, which provides clear accountability for Clinical Business Units.
NHS2.5	The Licensee shall establish and effectively implement systems and/or processes: a. to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations; c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions; d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	Compliant	• The minutes of Board of Director meetings and Standing Committees provide details of the effectiveness and scrutiny of all operations. • Regular reports to the Board of Directors cover quality, performance, finance, corporate and clinical governance. • The Board Assurance Framework provides details of any key risks to achieving objectives and is reported to Board on a regular basis. This is supported by a series of local corporate risk registers. • An annual review of the *Code of Governance for NHS Providers* is completed to ensure compliance with all governance requirements. The review completed in 2025/26 indicated the Trust was compliant with all provisions. • An annual review of the provider licence is completed and scrutinised by the Finance & Performance Committee, Executive Team and Board of Directors. • Regular monitoring of progress with objectives set out in the operational plan and enabling strategies, via a regular Strategic Impact Report. The Trust also

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h. to ensure compliance with all applicable legal requirements.		completed a review of its strategy in October 2025 to ensure it remained fit for purpose and proposed three key shifts to ensure it capitalised on the changing environment. • Resources allocated to provision of internal legal services team and to secure appropriate legal advice when necessary. • HOIA opinion for 2025/26 is indicated to be stated as reasonable and effective risk management, control and governance processes in place, which is consistent with prior years.
NHS2.6	The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c. the collection of accurate, comprehensive, timely and up to date information on quality of care; d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the	Compliant	• The Board complete an annual appraisal process, including review of skills and meeting of objectives. • The Quality Committee as a standing committee of the Board oversees quality of care considerations for any planning and decision-making processes and reports to the Board of Directors. • The Quality of Care Strategy sets-out the Trust approach to quality and safety over the next few years. • Accurate, timely and up to date information on the quality of care provided by the Quality and Performance Scorecards and other reports to the Board of Directors. The Quality Committee receives a Quality of Care dashboard which provides information relating to the Quality of Care Strategy. • Governors and members of the public attend Board meetings and can query any information provided to the Board of Directors, including any relating to the quality of care.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	Board where appropriate.		
NHS2.7	The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.		• Safe staffing reports to Finance and Performance Committee, Quality Committee and Board included in performance, quality and finance reports. The Trust also completes a bi-annual establishment review for its inpatient wards. • Staffing remains a risk highlighted on the Board Assurance Framework, with the risk recently reviewed and split into three focused areas (Staff Retention, Workforce Sustainability and Organisational Development). • Robust HR recruitment processes and selection criteria and information provided to the Board via the Quality and Performance scorecard. • Time to Care programme concluded in 2025/26, which ensured the right personnel are completing the right tasks, to ensure better overall staffing, including the introduction of additional roles such as Peer Support Workers. • Fit and Proper Persons Requirements incorporated in employment contracts, contracts and appointing letters to ensure individuals are employed meet the fit and proper requirements. An internal audit completed in 2025/26 provided reasonable assurance for these processes. • Regular appraisals in place to ensure individuals are appropriately qualified. • Board skills and experience review undertaken when any changes to the Board are being made. The Trust is in the process of implementing the Board-level competency framework published by NHS England. • 2025/26 has seen an improvement in vacancy rate
SECTION 5: NHS CONTROLLED PROVIDERS CONDITIONS – N/A – Does not apply to Foundation Trusts			
CP1: GOVERNANCE ARRANGEMENTS FOR NHS-CONTROLLED PROVIDERS			

Ref	Condition Summary	EPUT Position	Evidence/Assurance
SECTION 6: CONTINUITY OF SERVICES			
CoS1: CONTINUING PROVISION OF COMMISSIONER REQUESTED SERVICES – N/A – EPUT does not currently provide any Commissioner Requested Services.			
CoS2: RESTRICTION OF THE DISPOSAL OF ASSETS			
CoS2.1	The Licensee shall establish, maintain and keep up to date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register")	Compliant	• The Finance Directorate maintain an asset register of all capitalised and right of use assets in line with accounting and NHSE guidance. This is subject to external audit and would include both relevant and non-relevant assets that are owned (or have had tenant improvements where leasehold) • Estates retain an asset register for leasehold assets in line with the Asset Register and Disposal of Assets Guidance for Providers of Commissioner Requested Services guidance. • Development work is ongoing to integrate the asset register, in line with recent external audit discussions
CoS2.2	The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.	N/A	• EPUT does not currently provide any Commissioner Requested Services
CoS2.3	The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional.	Compliant	• The register is maintained and updated by the Finance Directorate and is subject to external audit.
CoS2.4	The obligations in paragraphs 5 to 8 shall apply to the Licensee if NHS England has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.	Compliant	• EPUT is only required to seek NHSE's consent for disposal of assets if NHSE had a concern about its ability to continue as a going concern (currently does not apply). EPUT has a procedure on asset disposals which includes NHSE's requirement for relevant and non-relevant assets.
CoS2.5	The Licensee shall not dispose of, or relinquish control over, any relevant asset except: a. with the consent in writing of NHS England, and b. in accordance with the paragraphs 6 to 8 of this Condition.	Compliant	
CoS2.6	The Licensee shall provide NHS England with such information as NHS England may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.	Compliant	
CoS2.7	Where consent by NHS England for the purpose of paragraph 5(a) is	Compliant	

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	subject to conditions, the Licensee shall comply with those conditions.		
CoS2.10	The Licensee shall have regard to such guidance as may be issued from time to time by NHS England regarding: a. the manner in which asset registers should be established, maintained and updated, and b. property, including buildings, interests in land, intellectual property rights and equipment, without which a licensee's ability to provide Commissioner Requested Services should be regarded as materially prejudiced.	Compliant	• The Finance Directorate would take into consideration any guidance issued by NHS England in the maintaining of the asset register. • N/A for Commissioner Requested Services
CoS3: STANDARDS OF CORPORATE GOVERNANCE, FINANCIAL MANAGEMENT AND QUALITY GOVERNANCE			
CoS3.1	The Licensee shall at all times adopt and apply systems and standards of corporate governance, quality governance and of financial management which reasonably would be regarded as: a. suitable for a provider of the Commissioner Requested Services, provided by the Licensee, or a Hard to Replace Provider, b. providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern, and c. providing reasonable safeguards against the licensee being unable to deliver services due to quality stress.	Compliant	• EPUT has comprehensive corporate and financial governance arrangements, systems and processes in place; these are updated according to changes in guidance/requirements. • Compliance with the *Code of Governance* reviewed annually. • Annual review of EPUT's constitution, SFIs, SoRD and DSoD against regulation and NHSE guidance • Annual review of Board standing committees' terms of reference against regulation, NHSE guidance and good practice. • Monthly monitoring of performance, quality and finance by Finance and Performance Committee with quarterly review of governance arrangements (Board Governance Framework) and considered at each Board meeting. Information is also provided into Accountability Framework meetings. • Risk management programme in place monitored through Finance and Performance Committee and considered at each Board meeting. • Flow and Capacity meetings take place at clinical unit level to ensure services are delivered during periods of high demand or acuity.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
			• N/A – re. Commissioner Requested Service
CoS3.2	In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to: a. such guidance as NHS England may issue from time to time concerning systems and standards of corporate governance, financial management and quality governance; b. the Licensee's ratings using the risk rating methodologies published by NHS England from time to time, and c. the desirability of that rating being not less than the level regarded by NHS England as acceptable under the provisions of that methodology	Compliant	• As above re. consideration of any guidance published by NHS England.
CoS4: UNDERTAKING FROM THE ULTIMATE CONTROLLER			
CoS4.1	The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by NHS England, that the ultimate controller ("the Covenantor"): a. will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the NHS Acts or this Licence, and b. will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS England.	N/A	• Not applicable – the Trust does not have an ultimate controller

Ref	Condition Summary	EPUT Position	Evidence/Assurance
CoS4.2	The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee.	N/A	• Not applicable – as identified above
CoS4.3	The Licensee shall: a. deliver to NHS England a copy of each such undertaking within seven days of obtaining it; b. inform NHS England immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and c. comply with any request which may be made by NHS England to enforce any such undertaking.	N/A	• Not applicable – as identified above
CoS4.4	For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if: a. directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and b. that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others.	N/A	• Not applicable – as identified above
CoS4.5	A person is not an ultimate controller if they are: a. a health service body, within the meaning of section 9 of the 2006 Act; b. a Governor or Director of the Licensee and the Licensee is an NHS foundation trust; c. any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the	N/A	• Not applicable – as identified above

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	ownership of the Licensee and the Licensee is a body corporate; or d. a trustee of the Licensee and the Licensee is a charity.		
CoS5: RISK POOL LEVY			
CoS5.1	The Licensee shall pay to NHS England any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid.	Compliant	• No payment requests received from NHSE; any payment required would be made in accordance with licence conditions
CoS5.2	In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by NHS England.	Compliant	
CoS6: COOPERATION IN THE EVENT OF FINANCIAL OR QUALITY STRESS			
CoS6.1	The obligations in paragraph 2 shall apply if NHS England has given notice in writing to the Licensee that it is concerned about: a. the ability of the Licensee to continue to provide commissioner requested services due to quality stress b. the ability of a Hard to Replace Provider being able to continue to provide its NHS commissioned services due to quality stress, or c. the ability of the Licensee to carry on as a going concern.	N/A	• N/A – NHS England has not given notice that it is concerned carry on as a going concern.
CoS6.2	When this paragraph applies the Licensee shall: a. provide such information as NHS England may direct to Commissioners and to such other persons as NHS England may direct; b. allow such persons as NHS England may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and c. co-operate with such persons as NHS England	N/A	

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	may appoint to assist in the management of the Licensee's affairs, business and property.		
CoS7: AVAILABILITY OF RESOURCES			
CoS7.1	The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.	Compliant	• Operational Plan and Financial Plan developed, setting out details of resource requirements and efficiencies. • EPUT has robust processes and systems in place to ensure it has the resources necessary to deliver its services.
CoS7.2	The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.	Compliant	• The Financial Plan developed setting out any plans for entering into agreements and undertaking any activity, with consideration for any material risk to the availability of resources. • The governance documents (SoRD, SFI's, DSoD) provide delegated spend limits for Executive Directors, after which approval would be required by the Board of Directors. Any request for approval by the Board of Directors to undertake a transaction would include consideration of any material risk to the availability of resources. • The Trust Constitution provides for the Council of Governors approval of any transaction defined as "significant" and a procedure is in place for the identification / approval should this occur.
CoS7.3	The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS England a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms: a. "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account	Compliant	• EPUT submits certificates/statements as required by NHSE.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate." b. "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources". c. "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".		
CoS7.4	The Licensee shall submit to NHS England with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.	Compliant	
CoS7.5	The statement submitted to NHS England in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.	Compliant	
CoS7.6	The Licensee shall inform NHS England immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3	Compliant	• This has not occurred, but the Trust would inform NHS England immediately if any circumstances were to occur.
CoS7.7	The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.	Compliant	• The certificates are included in the Annual Report & Accounts, published on the Trust public website.
SECTION 7: COSTING CONDITIONS			
C1: SUBMISSION OF COSTING INFORMATION			
C1.1	Whereby NHS England, and only in relation to periods from the date	Compliant	• EPUT maintains a costing system that utilises

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	of that requirement, the Licensee shall: a. obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information, b. establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information, as are necessary to enable it to comply with the following paragraphs of this Condition.		information from the general ledger to calculate planned and fully absorbed costs of providing services. These costs are published on an annual basis. • Information can be provided to NHSE as required. • Although no material gaps have been identified, there is a risk concerning the Trust's ability to produce timely and accurate data to support quarterly service line reporting. This risk has already been picked up by the Performance and Reporting Team, and efforts are underway to enhance the completeness and quality of data to strengthen future submissions
C1.2	Licensee should record the cost and other relevant information required in this condition consistent with the guidance in NHS England's Approved Costing Guidance. The form of data collected, costed and submitted should be consistent with the technical guidance included in the Approved Costing Guidance (subject to any variations agreed and approved with NHS England) and submitted in line with the nationally set deadlines.	Compliant	
C1.3	If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by NHS England the Licensee shall procure that each of those sub-contractors: a. obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and b. provides that information to NHS England in a timely manner.	N/A	• The Trust does not sub-contract any services that has been required by NHS England.
C1.4	Records required to be maintained by this Condition shall be kept for not less than six years.	Compliant	• The Storage, Retention & Destruction of Records Procedure (Appendix 1) provides for any information relating to the ledger (as described above) to be retained for a period of six-years.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
C2: PROVISION OF COSTING AND COSTING RELATED INFORMATION			
C2.1	Subject to paragraph 3, and without prejudice to the generality of Condition G1, the Licensee shall submit the mandated information required per Costing Condition 1 consistent with the approved costing guidance in the form, manner and the timetable as prescribed.	Compliant	• EPUT submits to NHSE all documents, reports and declarations in accordance with all relevant statutory and regulatory requirements in force from time to time in respect of pricing. • Copies of all documents are submitted to NHSE and retained by the Finance Directorate.
C2.2	In furnishing information documents and reports pursuant to paragraph 1 the Licensee shall take all reasonable steps to ensure that: a. in the case of information (data) or a report, it is accurate, complete and not misleading; b. in the case of a document, it is a true copy of the document requested;	Compliant	• Information provided is approved through the relevant and appropriate authorisation processes to ensure information is accurate, complete and not misleading; and is a true copy of the document requested.
C2.3	This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.	N/A	• N/A – Statement
C3: ASSURING THE ACCURACY OF PRICING AND COSTING INFORMATION			
C3.1	Providers are required to have processes in place to ensure itself of the accuracy and completeness of costing and other relevant information collected and submitted to NHS England is as per the Approved Costing Guidance.	Compliant	• The Trust operates an internal process for maintaining accurate and complete records in relation to costing. • Internal audit could review the costing and pricing processes within EPUT as part of the internal audit programme, and this assurance could be provided to NHSE as required. • Data Quality checks are undertaken by the Information team.
C3.2	This may include but is not limited to a. Regular assessments by the providers internal and/or external auditor b. specific work by NHS England or NHS England nominated representative on costing related issues and c. use of tools or other information or assessments of costing information produced by NHS England on costing and other	Compliant	

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	relevant information. d. Evidence of the assurance process (including work by the internal or external auditor of the provider) should be maintained and submitted as and when requested by NHS England and may be subject to follow up by NHS England. NHS England reserves the right to undertake specific work at a provider where issues are identified which may be undertaken by a nominated representative.		
SECTION 8: PRICING CONDITIONS			
P1: COMPLIANCE WITH THE NHS PAYMENT SCHEME			
P1.1	Except as approved in writing by NHS England, the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the NHS Payment Scheme published by NHS England in accordance with section 116 of the 2012 Act, wherever applicable.	Compliant	• All NHS Foundation Trusts continued to operate under the financial regime during 2025/26. The Trust has been paid on the basis of block contract payments for 1st April 2025 to 31st March 2026.

Summary

Based on the assurance provided through this end of year review, the Board of Directors is satisfied that the has complied with the provisions of the NHS England Foundation Trust Provider Licence.

As Chair and CEO of the Board of Directors, we confirm that this End of Year Review has been considered and approved by the Board. On behalf of the Board, we are satisfied that the Trust has complied with the provisions of the Foundation Trust Provider Licence during the year ended 31 March 2026.

Loy Lobo, Acting Chair [Place Hold] [Date]

Paul Scott, Chief Executive Officer [Place Hold] [Date]

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CODE OF GOVERNANCE FOR NHS PROVIDERS END OF YEAR REVIEW

2025/26

Board assurance statement

The Board of Directors has reviewed its compliance with the Code of Governance for NHS Provider Trusts for the year ended 31 March 2026. Based on the evidence presented in this review, the Board is satisfied that the Trust has applied the principles of the Code and complied with its provisions throughout the year.

The Board recognises that some areas of governance – particularly culture, system working and provider collaboration – are evolving and has identified further work to strengthen assurance during 2026/27.

Code	Provision	Comply	Narrative 2025-26
Section A: BOARD LEADERSHIP & PURPOSE			
A.2. Provisions			
A.2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaborates. The trust should describe in its annual report how opportunities and risks to future	✓	• The Board of Directors has undertaken a review of its effectiveness to ensure efficiency and economy. A review is undertaken annually as part of the Board sign-off of operational plans. These plans include both revenue and prioritised capital budgets with Operational Plans approved by NHS approval. • The Trust External Auditors performed and Annual Audit Review which includes Value for Money (VFM) assessment. The assessment reviews that the proper arrangements are in place to secure economy, efficiency and effective Use of Resources. The 2024/25 annual assessment concluded there were no matters to report by exception on VFM. The External Auditors Report was presented to the Council of Governors in October 2025. • The outcome of the well-led review undertaken by NHS England in 2024 was developed into a plan and is being implemented, with an independent cultural review

Code	Provision	Comply	Narrative 2025-26
	sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.		undertaken in 2025/26 and reporting to the Board of Directors in 2026/27. The CQC commenced a well-led inspection of the Trust in March 2026 and is ongoing. • The Trust has performance, quality and finance management systems in place to measure and monitor the Trust effectiveness, efficiency, economy and quality of services on a day-to-day basis. The internal processes are monitored via an integrated performance dashboard and a series of audit processes, including External Audit, Internal Audit and Clinical Audit programmes. • The Target Operating Model provides for individual care units to make decisions on the delivery of services by clinical managers which provides for the quality and safety of services for patients. The Accountability Framework provides clarity on the level of responsibility and accountability for the decisions made within the clinical care units. • The Board uses a Quality & Performance Scorecard which provides detailed data to measure the effectiveness, efficiency, economy and quality of services on a regular basis. The scorecard is scrutinised by the Board standing committees, with both assurance and escalations provided to the Board through their respective committee key control reports. The Power BI report allows for a more detailed review of all data, including any hotspots and mitigating actions. • The Board uses the Board Assurance Framework (BAF) at each Board meeting and relevant standing committees, reviewing any key strategic risks and providing updates on any mitigating actions or hotspots for escalation. • The Trust is inspected by the Care Quality Commission (CQC) and the outcomes of any inspection are acted on by the Board of Directors to provide assurance on services provided or addressing any issues highlighted by the CQC. • The Trust has a CQC Improvement Plan, which incorporates all areas for improvement identified. The Plan was refreshed in 2025 which confirmed actions from inspections up until since 2022 had been completed following an evidence assurance process. Three actions were transferred to a new plan.. The new plan incorporates actions from inspections undertaken from 2022 and the Quality Committee provides assurance on progress to the Board of Directors. Following reporting of action completion, an evidence assurance process is undertaken to ensure the actions have been fully implemented and embedded. The Board is satisfied that the process for the development of CQC improvement actions, their implementation and assurance of completion is in place and working effectively (noting IA review of the process in 2025/26 provided a substantial assurance opinion).

Code	Provision	Comply	Narrative 2025-26
			• The Compliance Team complete an internal review programme which provides from areas tested, assurance in relation to the quality of services and respond to any information requests / inquiries from the CQC. • The Trust works closely with system partners and is involved in collaborative working across the system. Examples include: The Mid & South Essex Community Collaborative partners (EPUT, NELFT & Provide); Mental Health Specialist Commissioning Collaborative; and joint working with MSEFT for the joint procurement of new Electronic Patient Record. • The Annual Report for 2025/26 provides a section on Key Issues, Opportunities and Risk which includes information on opportunities and risks to future sustainability, aligned to the strategic objectives for the organisation. • Where risks arising from system pressures or collaborative working were identified, these were incorporated into the Board Assurance Framework and monitored through the Board's governance processes. (e.g. SR4 Demand and Capacity and SR8 Use of Resources). • During the year, the Board considered the outcomes of NHS England's Provider Capability Assessment and the Trust's segmentation under the NHS Oversight Framework. The Board used this information as part of its broader assessment of organisational capability, system delivery and governance effectiveness, and is satisfied that it provides additional independent assurance over the Trust's leadership, oversight and performance.
A.2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaborates. This should be a formally agreed statement of the organisation's purpose and intended outcomes, and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning,	✓	• The vision and values of the organisation are underpinned by partnership working. The Vision and Values for the organisation were developed in September 2021 and re-confirmed as part of the development of the Strategy Objectives refresh in 2025, which included consideration of the development of the Essex ICB from April 2026/27 and the focus on place-based delivery of services. These were developed in consultation with a range of key system partners. The Board has reviewed and is satisfied that these remain appropriate. • The Vision and Values are underpinned by an overall purpose, which articulates working together with patients, families and system partners as part of the ICB working to ensure there are joined-up services.

Code	Provision	Comply	Narrative 2025-26
	collaboration with system partners and other decisions.		• The Vision and Values led to the development of Strategic Objectives, which includes a focus on transformation to develop the culture within the organisation to deliver the vision and values. • The Board uses the Strategic Impact report to monitor key transformation work and progress towards developing and driving the culture and behaviours within the organisation to achieve the vision and values of the organisation. • The Board has considered the Trust's contribution to system working, including provider collaboratives, integrated care partnerships and place-based arrangements. The Board is satisfied that appropriate governance arrangements are in place to manage risks and opportunities arising from system collaboration and will continue to develop system-focused assurance during 2026/27.
A.2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	✓	• The Quality & Performance Scorecard includes a Workforce & Culture section. The Board used this information on a range of KPI's for monitoring culture, including staff turnover and sickness absence. • The Staff Survey results are used by the Board of Directors to assess the culture of the organisation. Where the results raise cultural issues, these are developed into action plans to identify and address the concerns. • The Trust commissioned a cultural review with BRAP and the King's Fund which is due to report in early 2026/27. • The Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) are used as a measure of internal culture. The results from previous years as well as national comparisons used to identify potential issues and actions identified to address the concerns. • The Board uses the Board Assurance Framework (BAF) detailing three focused workforce risks at each Board meeting and its People Committee. These provide assurance that actions being taken by management are progressing for staff retention, workforce planning and organisational development – all shaping the culture of the organisation as a place to work, train and be cared for.

Code	Provision	Comply	Narrative 2025-26
			• The Annual Report 2024/25 (Page 119) includes information on staff wellbeing, involvement and recognition, and staff support. • Where indicators identified potential cultural risks, the Board sought assurance that management had developed and implemented appropriate improvement actions and monitored progress through agreed reporting mechanisms. The Board will review the findings of the independent cultural review during 2026/27 and use this to further strengthen organisational culture and leadership behaviours.
A.2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners (This may also include working to deliver the financial duties and objectives the trust is collectively responsible for with ICB partners, and improving quality and outcomes and reducing unwarranted variation and inequalities across the system), and that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaborative.	✓	• The Quality & Performance Scorecard provides a range of operational and financial KPI's to regularly monitor the effectiveness, efficiency, economy and the quality of health services provided by the Trust. This is supported by narrative provided in the CEO Report, providing information on key success and hotspots in relation to operational and financial performance. • The KPI's are developed to take into consideration regulatory / contractual requirements and operational / strategic plans which take into consideration partnership and collaborative working. • The Finance & Performance Committee scrutinises the Scorecard and provides any challenge prior to presenting to the Board of Directors. The Quality Committee oversees a new developed Quality of Care Scorecard, which informs the overall Quality & Performance Scorecard. During 2025/26, the Trust continued to strengthen its quality reporting arrangements to support effective Board oversight. Further development of the Quality Dashboard has been undertaken to improve clarity, consistency and triangulation of quality, safety and patient experience information, enabling the Quality Committees to better identify emerging risks, trends and areas requiring improvement. • The Operational and Financial Plan for 2026/27 was discussed at the Board of Directors in April 2026 prior to formal submission to NHS England. The plan takes into consideration the requirements of the Trust and the wider system as part of the planning process. • The Board uses the above information to hold executives to account for delivery against agreed plans and regulatory requirements. Where performance has fallen

Code	Provision	Comply	Narrative 2025-26
			outside of tolerance, the Board has required recovery actions and monitored their implementation through committee and Board reporting. • The Board also considered the Trust's position under the NHS Oversight Framework during the year. The Board is satisfied that oversight arrangements, performance monitoring and escalation processes are aligned with NHS England expectations and support timely identification and management of risks across quality, finance and operational delivery. The Board will continue to use the Oversight Framework, alongside internal assurance mechanisms, to inform its focus and priorities during 2026/27.
A.2.5	In line with principle 1.3 above, the board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, e.g. from the internal audit function, to provide an adequate and reliable level of assurance.	✓	• The Board uses the Quality & Performance Scorecard at each meeting and at relevant Committee level (Finance & Performance, People and Quality). The Power BI scorecard allows data to be reviewed in detail and broken down by relevant demographics. • Internal Audit function in place, with programme of work. Audit Committee progress and outcomes of the programme to provide assurance to the Board of Directors via the Committee Chairs Key Issues Report. • The Board is satisfied that the range of metrics and disaggregated data provided enables it to understand performance and emergent risks. Where areas of increased risk or complexity have been identified, the Board has sought additional assurance through the internal audit programme and other reviews.
A.2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.	✓	• The EPUT Strategic Plan 2023-2028 contains plans for each of the clinical care units, which provides information on the local approach to clinical governance. The plan was reviewed during 2025/26 to ensure it remained fit for purpose and identified three areas to shift focus to ensure the Trust remains fit for future developments. • The Quality of Care Strategy sets-out the Trust approach to clinical governance. The Quality Senate established by the strategy has continued to meet, attended by multi-professionals, to discuss clinical governance. The Quality Senate reports to the newly formed Quality of Care Group, which oversees all aspects of quality governance, reporting to the Executive Team and Quality Committee.

Code	Provision	Comply	Narrative 2025-26
			• The Trust has in place a clinical governance structure, which includes subject matter experts, forums and procedural documents. • The Quality Committee focuses on the Trust approach to quality and outcomes. It oversees the establishment of appropriate systems for ensuring effective clinical governance and quality management arrangements are in place throughout the Trust. • The Trust employees key subject matters experts who lead of specific areas of clinical governance e.g. Director of Patient Experience and Participation; Director of Patient Safety; Director of Infection Prevention and Control; etc.
A.2.7	The chair and board should regularly engage with stakeholders, including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of all stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.	✓	• The Trust is satisfied it has a positive relationship with stakeholders and staff through the delivery of strategic plans and delivering performance against contracts. Any risks to public stakeholders are managed through formal review processes with NHS England and the ICBs through joint actions on specific issues. • Risks are reviewed via scrutiny meetings with Local Authorities Health and Overview Scrutiny Committees (HOSC). • Members of the Board of Directors engage regularly with the ICB's, including membership of the individual Boards (ICB and ICP). Noting this will change to one Essex ICB from April 2026. • The Working In Partnership with People and Communities Strategy sets-out the movement towards co-production and co-design, which includes having service user representatives on various groups, quality improvement initiatives and service led programmes. Including holding an annual Co-Production Conference. • The Board is satisfied that the Membership Strategy, will enhance the engagement with its members. • The papers for the Board of Directors public meetings are published and members of the public can review performance data using the Power BI system. Members of the public are invited to attend the meeting and submit any questions on any information contained within the Board reports. • The Council of Governors Engagement with the Board of Directors Policy and Procedures sets-out the processes in which the Board of Directors will engage with the

Code	Provision	Comply	Narrative 2025-26
			Council of Governors, including information to be provided to allow Governors to represent the views of the members at all levels of the organisation. • The Board of Directors (Executive and Non-Executive) regularly attend the Council of Governors meetings. • Executive and Non-Executive Directors attend the Your Voice Meetings, where members of the public are invited to share their views on a particular subject and there is an open session for members of the public to share their views on any subject. • The Trust Annual Members Meeting was last held on the 26 November 2025. • Executive Directors, Non-Executive Directors and Governors undertake service visits to engage with staff, patients, service users and family members to understand the level and quality of services being provided and represent any views during relevant Board-level discussions. • The Board considers that these engagement mechanisms provide it with meaningful insight into stakeholder perspectives and uses this intelligence to inform decision-making and priority-setting.
A.2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective.	✓	• Annual Report 2024/25 (Page 159) includes an Involvement of Stakeholders section. • The Annual Report 2024/25 (Page 31) includes details of the Mental Health Provider Collaborates in which the Trust is involved.
A.2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising	✓	• The Trust has a Freedom to Speak-Up Principal Guardian (Bernadette Rochford) to complement existing systems for raising any concerns including line management, Employee Relations, Safeguarding and Student Facilitators.

Code	Provision	Comply	Narrative 2025-26
	from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.		• The Trust has a Freedom to Speak-Up / Whistleblowing Policy, which supports existing arrangements. • The Principal Guardian presents update reports to the Board of Directors and has attended meetings to provide the update. • The Principal Guardian attended a Council of Governors meeting, providing details of the current process and plans for future improvements. • The Trust has mandatory training modules for all staff to complete, focusing on the three key elements of Freedom to Speak-Up (Speak-Up, Listen-Up, Follow-Up) • The Freedom to Speak-Up Principal Guarding has an open invitation to address the Board of Directors if there are any significant concerns identified.
A.2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement (directors are required to declare any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with bodies contracting for NHS services. The trust must enter these into a register available to the public in line with Managing conflicts of interest in the NHS: Guidance for staff and organisations. In addition, NHS foundation trust directors have a statutory duty to manage conflicts of interest. In the case of NHS trusts, certain individuals are disqualified from being directors on the basis of conflicting interests).	✓	• The Board of Directors has in place a Conflict of Interest Policy and Procedure which clearly sets-out the process to be followed should a conflict of interest arise. • The Board of Directors has an item at each meeting for Board members to declare any conflict of interest for items on the agenda and action is taken by the Chair should a conflict arise. • The Conflict of Interest register is available via the Public Website.
A.2.11	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these	✓	• Board of Director meetings are comprehensively and accurately record in the minutes and include any concerns raised by Directors.

Code	Provision	Comply	Narrative 2025-26
	should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.		• Evidence contained in the minutes that Directors seek assurance relating to concerns they may have and request assurance or action where it is not immediately available. • There have been no instances where a Non-Executive Director has resigned due to having concerns. However, concerns would be circulated to the Board of Directors if this situation were to arise.
Section B: Division of Responsibilities			
B.2. Provisions			
B.2.1	The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	✓	• The Board of Directors schedule of business provides items for all future meetings and is used to develop each agenda. The agenda is discussed with the Chair to ensure they are satisfied with the focus of the business and there is adequate time for discussion on all items. • The Chair is provided with an annotated agenda prior to any meeting, which provides information on each item to help ensure the right amount of time is dedicated to each item. • The Council of Governors schedule of business provides the items for all future meetings and is used to develop each agenda. The Lead / Deputy Lead Governor meets with the Chair prior to the Council of Governors to review and agree the agenda. • The Standing Orders for the Board of Directors and Standing Orders for the Council of Governors includes provisions for setting the agenda, including any additional items being added with written permission from the Chair.
B.2.2	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the	✓	• Papers and information for Board meetings are shared with Directors via a Board Portal, which allows papers to be uploaded as they are made available. • The papers are circulated to the Council of Governors prior to the Board meetings and for public board meetings posted on our externally facing website. • The Standing Orders for the Board of Directors provides the minimum time for papers to be circulated to Directors prior to any Board of Director meeting.

Code	Provision	Comply	Narrative 2025-26
	necessary skills and knowledge to undertake their role.		• Governors receive a weekly Governor Update, which includes any additional information to enable them to perform their duties effectively. Additional information is circulated to Governors outside of this if the information is time sensitive or urgent. • The Learning and Development Plan for Governors provides topics to ensure Governors have the necessary skills and knowledge to undertake their role. The plan is developed and monitored by the Council of Governors Training & Development Committee. • The Governors receive a Governor Induction booklet upon election and annually, which provides detailed information on the Trust and the role of a Governor.
B.2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular and ensuring a constructive relationship between executive and non-executive directors.	✓	• The Trust operates an open and honest culture, which is underpinned by the Code of Conduct for the Board of Directors, which is based on the Nolan Principles. • The Chair promotes a culture of honesty, openness, trust and debate at each Board of Directors meeting, ensuring that Executive Directors / Non-Executive Directors are provided with the opportunity to constructively challenge each other in an open environment. • The Standing Committees of the Board are chaired by Non-Executive Directors, allowing a detailed scrutiny of items prior to the Board of Director meetings. • The Chief Executive Officer regularly meets with the Non-Executive Directors to share details of the operating of the Trust and any topical / emergent issues. • There is a programme of Board Seminar / Development sessions where Executive and Non-Executive Directors meet to discuss certain topics or upcoming strategies / services.
B.2.4	A foundation trust chair is responsible for ensuring that the board and council work together effectively.	✓	• The Council of Governors Relationship with the Board of Directors Policy & Procedure sets-out how the Board and Council will work together effectively, including in the event of any dispute. • The Board and Council hold joint seminar sessions twice per-year to discuss key topics of shared interest.

Code	Provision	Comply	Narrative 2025-26
			• Executive and Non-Executive Directors regularly attend (by invitation) Council of Governor meetings.
B.2.5	The chair should be independent on appointment when assessed against the criteria set out in provision 2.6 below. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.	✓	• The independence of the Chair is set-out in the recruitment criteria for any appointment. • The Trust operates an electronic declaration of interest system where individuals, including the Chair, are required to make annual declarations. • The role of Chair (Hattie Llewelyn-Davies) and CEO (Paul Scott) are held by separate individual s. The current Chair has not been a CEO of the Trust. • The Trust has a Vice Chair (Loy Lobo). The role and appointment of the Vice Chair is set-out in the Managing the Absence of the Chair Procedure. • The Trust has a Senior Independent Director (Dr Mateen Jiwani) • The Chair is not a member of the Audit Committee. The Chair of the Audit Committee is Elena Lokteva.
B.2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances that are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, material shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's	✓	• The Annual Report 2024/25 (Pg133) provides a statement confirming the independence of the Non-Executive Directors following review of the Code of Governance. • The electronic declaration of interest system requires Non-Executive Directors to make an annual declaration. The Board of Directors agenda includes an item for Board members to declare any interest that may impact their independence for any items on the agenda. • The Board has considered these factors and is satisfied that all non-executive directors were independent in character and judgement during 2025/26.

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	fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment (but note 4.3 in Section C below, where chairs and NEDs can serve beyond six years subject to rigorous review and NHS England approval). • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.		
B.2.7	At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.	✓	• The Board of Directors in 2025/26 had seven Non-Executive Directors (excluding the Chair) and seven Executive Directors in a voting capacity.

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B.2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	✓	• There are no Directors who are also Governors of the Trust.
B.2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.	✓	• The Trust reviews the roles of Non-Executive Directors, including membership / chairing of Standing Committees. This is reviewed and refreshed on appointment of new Non-Executive Directors. • The Council of Governors Nominations Committee reviews a skills matrix to ensure any gaps in skill sets, backgrounds and lived experience are considered as part of any appointment process. This includes ensuring at least one Non-Executive Director has a clinical background. This has not taken place in 2025/26 as no appointment process has been required.
B.2.10	Only the committee chair and committee members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	✓	• The Audit and Remuneration & Nominations Committee have clear Terms of Reference in place, setting-out the Chair and Membership. • Other individuals attend the Committees to present papers and discuss items within their portfolio or area of expertise. For the Remuneration & Nominations Committee this is usually only the CEO and Chief People Officer.
B.2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to	✓	• Dr Mateen Jiwani is the current Senior Independent Director. The appointment was undertaken as an expression of interest, approved by the Board of Directors and endorsed by the Council of Governors at respective meetings. • The Senior Independent Director appraises the Chair on an annual basis. The process includes receiving and considering views from the Board of Directors, Council of Governors and a range of external stakeholders / partners.

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	appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the Chair appraisal framework.		
B.2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.	✓	• The Board of Directors Remuneration & Nominations Committee leads on any Executive Director recruitment, including final approval of candidates. The Trust appointed a new Executive Chief Medical Officer in 2025/26. • The Executive Directors have an established set of objectives developed in line with the Trust strategic objectives. • The Interview Panels and Stakeholder Groups included Non-Executive Directors. • The Chair meets with Non-Executive Directors on a weekly basis, without the presence of Executive Directors.
B.2.13	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available. The annual report should give the number of times the board and its committees met, and individual director attendance.	✓	• The Standing Orders for the Board of Directors sets-out the role of the Chair and Chief Executive. The appointment of the Senior Independent Director is included and the role outlined as part of descriptions of specific processes led by the SID. • The Scheme of Reservation & Delegation (SoRD) provides the responsibilities reserved for the Board of Directors and the delegated authority provided to the Standing Committees. • The Standing Committees of the Board of Directors each have a Terms of Reference setting-out the responsibilities of each Committee. • The Annual Report 2024/25 provides records of Board and Standing Committee attendance for individual Directors.
B.2.14	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time	✓	• The job descriptions (Executive Directors) and Terms & Conditions (Non-Executive Directors) sets-out the time commitment for the specific roles. • Directors are required to disclose any significant commitments prior to their appointment.

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	involved. They should not take on material additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chair ship of such an organisation.		• The Declaration of Interest system requires Directors to make annual declarations and identify any new commitments. Any significant commitments would require approval by the Board of Directors Remuneration & Nomination Committee. • No current Executive Directors holds a non-executive directorship of another trust or organisation of comparable size and complexity to EPUT.
B.2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.	✓	• The Executive Director of Corporate Governance (Denver Greenhalgh) acts as the Trust Secretary and is accessible for all directors. • The Executive Director of Corporate Governors is a member of the Board and provides any relevant governance advice as required.
B.2.16	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, request further information if necessary, and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	✓	• Non-Executive Directors have the opportunity at Board meetings and standing committee meetings to challenge as well as at Board Development Sessions. • The Board of Directors receives a Quality & Performance Scorecard using Power BI, which allows directors to undertake deep dive reviews of financial and clinical quality data which allows for the scrutiny of performance and assessment of the integrity of internal controls. • The Board Assurance Framework provides relevant information on the risks and internal control mechanisms. • All Board Standing Committees have Non-Executive Director representation and are chaired by a Non-Executive Director. • Any such challenges are recorded in the minutes

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B.2.17	The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions. For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions that are delegated to the executive management of the board of directors.	✓	• The Board of Directors meets a minimum of six-times per year and holds extra-ordinary meetings to consider relevant items outside of this schedule of business. The Board of Directors met nine times in 2025/26. • The Scheme of Reservation & Delegation (SoRD) clearly provides the matters reserved specifically for its decisions. The Board of Directors Schedule of Business provides a list of items for consideration and / or decision for the financial year. • The Standing Orders for the Council of Governors provides the roles and responsibilities of the Council of Governors. The Standing Orders also includes a section setting-out the process for resolving any disagreement between the Board and Council. • The Council of Governors Relationship with the Board of Directors Policy & Procedure provides for the action to be taken should there be a disagreement. The Council of Governors also has a number of procedures in place detailing processes to be undertaken for any statutory function, including a section on the action to be taken should there be a disagreement. • The Annual Report 2024/25 provides details of the governance arrangements for the Trust, including the Board of Directors, Standing Committees and the Council of Governors. The report provides information on any key decisions made, including appointment / re-appointment of Directors.
SECTION C: COMPOSITION, SUCCESSION AND EVALUATION			
C.2: Provisions for Foundation Trusts Board Appointments			
C.2.1	The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities	✓	• The Trust has two committees responsible for Executive Director appointments and Non-Executive Directors appointments / reappointments as set out in their terms of reference: - Board of Directors Remuneration and Nominations Committee reviews the structure, size and composition of the Board of Directors, considers succession planning and makes recommendations for changes as appropriate; it is responsible for the Executive Director appointment process.

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	facing the trust, and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB, and the foundation trust should engage with NHS England to agree the approach.		- Council of Governors Nominations Committee implements the procedure for the identification and nomination of suitable candidates for Chair and Non-Executive Director appointments / reappointments (for recommendation to the full Council) that fit the succession planning criteria recommended by the Board of Director Remuneration and Nominations Committee. • The Trust completed a recruitment process in 2025/26 for the recruitment of an Executive Chief Medical Offcer, overseen by the Board of Directors Remuneration Committee.
C.2.2	There may be one or two nominations committees. If there are two, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.	✓	• See C.2.1 • Composition of the Board of Directors considered as part of appointment process for Board members. • A regular review of skills and experience is undertaken to ensure that the Board has the right skill mix to discharge its duties, including when appointing new Non-Executive Directors.
C.2.3	The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.	✓	• The Chair (Hattie Llewelyn-Davies) chairs both the Board of Directors Remuneration & Nominations Committee and the Council of Governors Nominations Committee. The Lead Governor or the Vice Chair acts as Chair of the Council of Governors Nominations Committee where items are related to the Chair.

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C.2.4	The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.	✓	• The Council of Governors Nominations Committee leads on the appointment of the Chair and Non-Executive Directors. • The Council of Governors Appointment of the Chair and Non-Executive Directors Procedure provides the process.
C.2.5	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team is available for use by nominations committees to support the council of governors in the appointment of the chair and non-executive directors. If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	✓	• The Trust engages Executive Search organisations for the recruitment of Directors. • For the appointment of the Executive Chief Medical Officer, the Trust engaged Hunter Healthcare to provide independent assurance.
C.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.	✓	• The Council of Governors Nominations Committee membership has Governors in the majority, which is outlined in the Terms of Reference for the Committee. • The Interview Panel for the appointment of the Chair and Non-Executive Directors includes Governors as the majority in a voting capacity, as outlined in the Appointment of the Chair / Non-Executive Directors Procedure. • An independent external chair joins the interview panel to provide an objective view of suitability for post for Non-Executive Directors.
C.2.7	When considering the appointment of non-executive directors, the council of governors	✓	• Arrangements in place between the Board of Directors Remuneration and Nominations Committee and Council of Governors Nominations Committee to ensure there is a

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	should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.		dialogue between the two Committees (as detailed in terms of reference, for continuity Chair of the Trust is Chair of both committees • Members of the Board of Directors participate in Stakeholder Panels for the appointment of Non-Executive Directors. The views of the Stakeholder Panel are provided to the Interview Panel for consideration.
C.2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	✓	• The Annual Report 2024/25 provides details of appointment / re-appointment process undertaken during the financial year. • The Terms of Reference for the Council of Governors Nominations Committee is available on request.
C.2.9	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.	✓	• The Trust Constitution process for Governors to hold terms of office of up-to three years before re-election. • The election process completed in 2024/25 were undertaken using Mi Voice, which provided the names and biographical information for candidates. The Trust would include any performance related information as necessary.
C.2.10	A requirement of the National Health Service Act 2006 as amended (the 2006 Act) is that the chair, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies	✓	• The Board of Directors Remuneration & Nominations Committee leads on the appointment of Executive Directors, as outlined in the Terms of Reference.

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	as they arise and make recommendations to the chair, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.		
C.2.11	It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.	✓	• The Board of Directors Remuneration & Nominations Committee leads on the appointment of Executive Directors, as outlined in the Terms of Reference. • The Trust Constitution provides for the Chief Executive Officer to be appointed and removed by Non-Executive Directors, with the appointment being approved by the majority of members of Council of Governors present and voting at a general meeting. • The Appointment of the Chief Executive Officer Procedure in place sets-out the process for Governor involvement in the process and process for the Council to approve the appointment. The procedure sets-out the minimum requirement and the actual process may change in agreement with the Council.
C.2.12	The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chair and other non-executive directors.	✓	• Procedure for the recruitment of Chair / Non-Executive Directors in place. • Council of Governors Nominations Committee has a clear terms of reference • Recommendations made to Council of Governors by Council of Governors Nominations Committee for appointment of Non-Executive Directors and are recorded in the minutes. • The Council of Governors approved the re-appointment of two Non-Executive Directors during 2025/26.
C.2.13	Non-executive directors, including the chair, should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.	✓	• The Council of Governors appoint Non-Executive Directors for a specific term of office that does not exceed three-years. This is outlined in any reports to the Council and subsequent minutes. • The Trust Constitution provides clear criteria, in line with the 2006 Act, for the removal of a Director and this would be undertaken if required.

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C.2.14	The terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to do what is expected of them. Their other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved, and the council of governors should be informed of subsequent changes.	✓	• The Terms and Conditions for Non-Executive Directors are available to the Council of Governors on request. • The letters of appointment for Non-Executive Directors sets-out the expected time commitment. This is established as part of the recruitment process with Non-Executive Directors agreeing to the time commitment. • Any additional significant commitments are provided to the Council of Governors Nominations Committee as part of the recruitment process. • The publicaly available declaration of interest system provides for any new commitments, and a process is undertaken to approve any NED who is appointed as a NED of another NHS Body. • The time commitment of Non-Executive Directors is informally monitored as part of regular NED team meetings. Any issues with time commitment would be reported to the Council of Governors as required. Governors can also raise concerns regarding the time commitment of NEDs if required.
C.3: Provisions for NHS Trust Board Appointments (N/A)			
C.4: Board Appointments: Provisions Applicable to both NHS Foundation Trusts and NHS Trusts			
C.4.1	Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain	✓	• The Fit and Proper Persons Policy & Procedure sets-out the process for assessing if a person is fit and proper. • The Trust implemented the Fit & Proper Persons Test requirements issued by NHS England. The Trust Secretary's Office complete all relevant checks of Directors and identifies any concerns to the Chair / CEO for consideration in annual appraisals. • Following annual appraisals, the Chair is required to sign the Fit and Proper Persons Test form to confirm an individual Director is Fit and Proper. Action would be taken if there are any concerns raised as part of this process. • The Trust Constitution sets-out the criteria for disqualification as a Director and Governor, in line with the FPPT requirements.

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	recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.		• Directors complete an annual Self-Attestation confirming they do not meet any of the disqualification criteria, as part of the overall FPPT test. • Governors complete a Self-Attestation on appointment, confirming they do not meet any of the disqualification criteria and sign-up to the Council of Governors Code of Conduct.
C.4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience. Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	✓	• The Annual Report 2024/25 provides biographies of the Board of Directors, including skills, expertise and experience. • The Annual Report 2024/25 provides a statement of the balance, completeness and appropriateness of the membership of the Board of Directors. • The Annual Report is available on the Public Website.
C.4.3	Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a chair was an existing non-executive director. The need for all extensions should be clearly explained and should have been agreed with NHS England. A NED becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as chair.	✓	• No current Non-Executive Director has exceeded nine-years in post.
C.4.4	Elected foundation trust governors must be subject to re-election by the members of their	✓	• See section C.2.9

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	constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.		• The Trust Constitution provides for Governors to serve a maximum of three terms of office of up to three-years, before having a break of a year before seeking any further term of office.
C.4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.	✓	• The Annual Report 2024/25 provides details of the regular review of the performance of the Board / Organisation, including internal and external audit. • The Council of Governors complete an annual effectiveness review, including its own performance and that of its sub-committees. • The Board and standing committees undertake an annual effectiveness review. • The Chair and Chief Executive Officer complete annual appraisals of Non-Executive Directors and Executive Directors respectively, which includes a review of performance against objectives. • The appraisal of the Chair is undertaken by the Senior Independent Director. • The Council of Governors Remuneration Committee reviews Non-Executive Director appraisals and meets with each individual to discuss the content. The Committee considers the quality and accuracy of the appraisals and reports back to the Council of Governors. • The Board has considered the findings from its effectiveness reviews and appraisals and is satisfied that the evaluation process has informed Board development activity, areas of focus and succession planning during the year. Progress against agreed actions is monitored during the year.

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C.4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.	✓	• Any action plans from annual reviews are presented to the Board of Directors and monitored by the relevant Standing Committee. • The Chair / Senior Independent Director acts on the outcome of appraisals of Non-Executive Directors, recognising strengths and addressing any weaknesses. • The Chief Executive Officer shares the outcome of the Executive Director appraisals with the Chair to identify strengths and discusses addressing areas of weakness.
C.4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors or governors.	✓	• NHS England completed an externally facilitated development review of leadership in 2024/25. • The CQC completed a Well-Led inspection of the Trust in March 2026 and the feedback is awaited. • The Board has considered the findings from previous external reviews and overseen implementation of agreed actions. The Board will formally consider the outcome of the March 2026 Well-Led inspection once published and incorporate any required actions into its governance and improvement plans.
C.4.8	Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on: • holding the non-executive directors individually and collectively to account for the performance of the board of directors • communicating with their member constituencies and the public and transmitting their views to the board of directors	✓	• The Council of Governors completes an annual review of its own performance and its sub-committees. The last full review was completed in 2024/25 with the results presented to the Council of Governors for discussion and the identification of any actions to be taken forward. • The Council of Governors completed an effectiveness review of its sub-committees in 2025/26 with results presented to relevant sub-committees where sufficient responses had been received.

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	• contributing to the development of the foundation trust's forward plans. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.		
C.4.9	The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest that prevents the proper exercise of their duties. This should be shared with governors.	✓	• The Trust Constitution sets-out the criteria for the disqualification of a Governor, including failing to attend Council meetings and conflicts of interest. The Constitution also provides for the process to be followed for the removal of a Governor if the need arises, which is supported by the Council of Governors Code of Conduct. • The Monitoring of Council of Governors Attendance Procedure provides further context to the terms "consistently and unjustifiably fails to attend" and the process to be followed. The procedure was developed and approved by the Council of Governors.
C.4.10	In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider	✓	• The Trust Constitution includes criteria for the disqualification of a Governor and removal from office where their values and behaviours are not compatible with the Trust. • As above re. process for removal of a Governor. • The Council of Governors Code of Conduct is based on the Nolan Principles and is based on the Trust values. Governors are required to agree to the Code of Conduct on appointment and includes the process to be followed should a Governor breach the Code.

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	the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances: where it has imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.		
C.4.11	The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.	✓	• See Section C.2.1
C.4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	✓	• To date no Executive Directors have left the Trust outside of the terms of their employment contract.
C.4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to	✓	• The Annual Report 2024/25 provides details of the Board of Directors Remuneration & Nominations Committee and the Council of Governors Nominations Committee.

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	succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors, governors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion, including in relation to disability, its objectives and linkage to trust strategy, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.		• The Annual Report 2024/25 provides details of the Equality Monitoring policies in place. Page 33 provides information relating to the race equality of the workforce, linked with the WRES. • The Annual Report 2024/25 provides a workforce profile, which provides gender and ethnic balance for senior management and their direct reports.
C.5: Development, Information and Support			
C.5.1	All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or	✓	**Director induction** • NED induction is included in NED's objectives and is monitored and reviewed by Chair

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	the council of governors, and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.		• NED and ED induction programme and information pack reviewed and updated in line with good practice; induction programme is tailored to the Director's requirements based on skills and experience • All Directors new to the NED role completed the NED induction programme • NEDs are encouraged to attend relevant briefings and conferences organised by NHS Providers and other national NHS-related organisations, and provide feedback at the NEDs Discussion Group meeting • Executive Directors undertake corporate induction training programme; additional induction and ongoing training requirements will be identified relevant to role. The Executive Director induction is managed through the Trust's Supervision and Appraisal Policy and Procedure. **Governor induction** • Governor induction programme reviewed and included as part of the Governor Learning & Development Schedule and regularly updated taking account of good practice and relevance to the Trust • Governor Induction Handbook based on documents developed by NHS Providers provided to any new Governors. • Individual induction sessions held with new Governors joining the Trust throughout the year due to Governor resignations and Appointed Governors.
C.5.2	The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. Directors should also be familiar with the integrated care system(s) that commission material levels of services from the trust. The trust should provide the necessary resources for its directors and, for foundation trusts, governors	✓	• Directors' individual appraisal and performance evaluations undertaken annually. • Directors have individual personal objectives and professional/personal development plans. • Directors have access to training courses/materials as identified in their individual personal development plan • Non-Executive Directors personal development objectives received by Council of Governors Remuneration Committee as part of review/assurance of Non-Executive Directors performance.

Code	Provision	Comply	Narrative 2025-26
	to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training, including on equality, diversity and inclusion, and unconscious bias.		• The Council of Governors have a Learning & Development Plan, monitored by the Council of Governors Training & Development Committee which identifies a wide range of topics for learning and development. The Plan is regularly reviewed and updated with any new learning requirements. • The Council of Governors Nominations Committee receives training in recruitment prior to any NED appointment process as required.
C.5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.	✓	• The induction programme includes details about the Trust, including operations and key issues, for both Board and Council members. • The Quality & Performance Scorecard presented to the Board of Directors incudes Key Performance Indicators developed to monitor the operational practices of the Trust. The Chairs Report and CEO Report to the Board of Directors / Council Governors provides regular updates on operational matters. • Directors and Governors complete service visits to understand the operations of the Trust. • The summary reports for the Board of Directors and Council of Governors contain boxes providing the Trust Values and indicating if the report impacts any of the values of the Trust. The Board of Directors and Council of Governors were involved in the development of the values when first implemented. • Directors have access to the intranet which includes policies and procedures developed by the Trust. Governors can access policies and procedures through the publication scheme and procedures relevant to the Council are monitored via the Council of Governors Governance Committee and approved by the Council of Governors.
C.5.4	The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system	✓	• See Section C.5.1 • Directors and Governors are invited to attend a wider range of stakeholder meetings and events to engage with stakeholders, this includes constituency meetings, patient forums, Your Voice meetings, ICB meetings, service visits etc. • Directors are able to claim expenses through the internal EASY expense system, with NEDs accessing this via the Chairs Office. Governors are able to submit expenses to

Code	Provision	Comply	Narrative 2025-26
	partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.		the Trust Secretary's Office for any expense incurred whilst undertaking their role of a Governor.
C.5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	✓	• The appraisal process reviews and agrees training and development needs for each Director. This is undertaken by the Chair (NEDs) and CEO (Executive Directors).
C.5.6	A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	✓	• See Section C.5.2 regarding the Learning & Development Plan.
C.5.7	The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.	✓	• Comprehensive reports and executive summaries (including detailed appendices) circulated prior to each Board of Directors and Council of Governors meetings, as well as Committee meetings. Standardised approach for all meetings. Information available on website/intranet. • Annual meeting business schedule in place for Board of Directors and Council of Governors. • All Board of Director standing committees and Council of Governors sub-committees have developed a work plan and progress against the plan is regularly monitored • Circulation of papers / uploading of papers to the Board Portal requirements detailed in Board of Director and Council of Governors standing orders • Directors and Governors able to request information as necessary. • Informal confidential briefings prior to each Council of Governors meeting by the Chief Executive Officer • Governor Updates distributed regularly to all Governors

Code	Provision	Comply	Narrative 2025-26
			• Information on ICS plans, decisions and delivery that directly affect the organisation and its patients are included within reports as relevant to the subject matter.
C.5.8	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.	✓	• See section C.5.7
C.5.9	The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.	✓	• This is covered by Sections above relating to the sharing of information, the induction programmes, the relationship between Executive Directors and Non-Executive Directors and communication between the Board of Directors and Council of Governors.
C.5.10	The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems	✓	• See Section C.5.7 • The Board of Directors Schedule of Business is developed in conjunction with Executive Directors. Standing Committees of the Board of Directors have clear Terms of Reference and clear work plans are currently being developed. • The Council of Governors Schedule of Business is discussed with the Chair and the Lead / Deputy Lead Governor when planning the agenda for each Council of Governors meeting. The Lead / Deputy Lead Governor can request any additional items to be added to the agenda following consultation with fellow Governors. • Board papers are developed and approved by relevant Board directors to ensure these are concise, accurate and timely. These are reviewed by the Trust Secretary's Office prior to uploading to the Board Portal.

Code	Provision	Comply	Narrative 2025-26
	necessary to discharge its duties, as well as access to senior management and other employees.		
C.5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.	✓	• Non-Executive Directors have the opportunity at Board meetings and standing committee meetings to challenge as well as at Board Development Sessions • All Board standing committees have Non-Executive Director representation and are chaired by a Non-Executive Director. • Advice will be sought from relevant adviser if required as detailed in terms of reference • Any such challenges are recorded in the minutes
C.5.12	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	✓	• Independent professional advice is made available at the Trust's expense to directors in respect of critical or significant activities, e.g. audit, Mental Health Act Managers, legal advisors, other specialist advisors • Appointment of advisers in relation to significant transactions is approved by the Board and the process scrutinised by the Audit Committee. • Board of Director Committees are provided with support as identified in their terms of reference • Board of Director Remuneration and Nominations Committee may, at the Trust's expense, appoint independent consultants or commission independent professional advice if considered necessary (included in terms of reference)
C.5.13	Committees should be provided with sufficient resources to undertake their duties. The	✓	• Board of Director Committees are provided with support as identified in their terms of reference.

Code	Provision	Comply	Narrative 2025-26
	board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.		• All Council meetings and committee meetings are supported directly by the Trust Secretary's Office • Trust Secretary's Office also provides day to day support to Governors including regular communications and updates, advice, managing queries, etc.
C.5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.	✓	• Non-Executive Directors have the opportunity at Board meetings and standing committee meetings to challenge and/or to request 1:1 meeting with EDs to seek further clarification/assurance • Regular briefing with the CEO with NEDs. • All Board standing committees have Non-Executive Director representation and are chaired by a Non-Executive Director. • Any such challenges are recorded in the minutes • Non-Executive Director skills balance considered in succession planning
C.5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	✓	• Public and members meetings (Your Voice) held virtually and face-to-face. The last Your Voice meeting was held in March 2026. • Governors invited to participate in discussions for the new EPUT Strategy. • The Trust has developed a Membership Strategy which sets-out the priorities to ensure Governors are able to canvass the opinion of Trust members and represent these to the Board of Directors. • Annual Report 2024/25 outlines how Governors have 'canvassed' members/public
C.5.16	Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's	✓	• Governors have been involved in the forward plans of the organisation, included being included in the development of key enabling strategies in the Trust. This has been undertaken as part of stakeholder engagement and Joint Board / Council Seminar Sessions.

Code	Provision	Comply	Narrative 2025-26
	plans, and explain the reasons for any not being included.		
	The board of directors must have regard to the council of governors' views on the NHS foundation trust's forward plan.	✓	
C.1.17	NHS Resolution's Liabilities to Third Parties Scheme includes liability cover for trusts' directors and officers. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.	✓	• The Trust Constitution (Section 50) includes information on liabilities for the Board of Directors and Council of Governors in-line with this provision.
SECTION D: AUDIT, RISK & INTERNAL CONTROL			
D.2. PROVISIONS			
D.2.1	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant	✓	• The Trust has an established Audit Committee with the membership including three Non-Executive Directors / Associate Non-Executive Directors. • The Chair of the Board of Directors is not a member of the Committee. • The Chair of the Audit Committee (Elena Lokteva) is not the Vice Chair or the Senior Independent Director. • The Terms of Reference provides for at least one member of the Committee to have recent and relevant financial experience. This is currently with the Chair of the Committee (Elena Lokteva).

Code	Provision	Comply	Narrative 2025-26
	financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.		• The Terms of Reference provides for a regular attendance of key individuals to support the Committee to ensure competence relevant to the sector in which it operates, including the Executive Chief Finance Officer.
D.2.2	The main roles and responsibilities of the audit committee should include: • monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them • providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy • reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself • monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors	✓	• The Audit Committee Terms of Reference outlines the role and responsibilities of the Committee and covers each of the points included in this provision. Evidence of discussion is included in the minutes of the meeting. • The Audit Committee reports to the Board of Directors at each meeting via the Committee Chairs Report, summarising the work of the Committee in the preceding months.

Code	Provision	Comply	Narrative 2025-26
	• reviewing and monitoring the external auditor's independence and objectivity • reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements • reporting to the board of directors on how it has discharged its responsibilities.		
D.2.3	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this. These timeframes are not affected by an NHS trust becoming a foundation trust.	✓	• The Trust completed a market testing exercise of the External Auditors in 2025/26 and appointed Grant Thornton. The contract is for three-years, with a review every year to confirm re-appointment by the Council of Governors and an option to extend for a further two-years subject to performance review.
D.2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm,	✓	• The Annual Report 2024/25 includes a section on the work of the Audit Committee, which includes significant issues relating to financial statements. • The Annual Report 2024/25 confirms the External Auditors did not complete any non-audit work. The section identifies Ernst & Young as the External Auditors. The section also includes confirmation of re-appointment by the Council of Governors and details of the length and value of the contract. • The Audit Committee completes an annual review of Audit Services and oversaw a market-testing exercise. • The Audit Committee completes an annual review of Audit Services in November 2025 and oversaw a market-testing exercise in January 2026 for the appointment of new External Auditors.

Code	Provision	Comply	Narrative 2025-26
	when a tender was last conducted and advance notice of any retendering plans • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.		
D.2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services. The council of governors is responsible for appointing external governors.	✓	• The Standing Financial Instructions (SFI's) include a section on the responsibilities of the External Auditors, which does not provide for any non-audit services to be undertaken. The External Auditors do not currently undertake any non-audit work for the Trust and this is not permitted. • The Standing Orders for the Council of Governors provide for the Council of Governors to appoint and remove the External Auditors. The Council of Governors Appointment of the External Auditors procedure sets-out the process to be followed. The Council of Governors appointed new External Auditors at a meeting in January 2026.
D.2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	✓	• The Annual Report 2024/25 provides a section outlining the director's responsibility for preparing the annual report and accounts. • The section includes a statement that the Directors consider the annual report taken as a whole as fair, balance and understandable and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy.
D.2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	✓	• The Board Assurance Framework has been developed to identify and assess emerging and principle risks to the Trust achieving its strategic objectives. The framework is regularly discussed by the Executive Team and presented to the Board of Directors, including any mitigation to emerging risks. • The Annual Report 2024/25 provides details of the assessments completed to identify and manage risk within the organisation. This includes the identification of significant risks to the achievement of its strategic objectives as at 31 March 2025.

Code	Provision	Comply	Narrative 2025-26
			• The Board has reviewed the operation and effectiveness of risk management and internal control arrangements during the year and is satisfied that they were adequate and effective in managing the Trust's principal and emerging risks. (Noting that Internal Audit provide a substantial assurance opinion on the Risk Management Framework in 2025).
D.2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	✓	• As above regarding the Board Assurance Framework and annual report information, which also includes reviewing internal controls relating to quality governance. • The Annual Report (Page 153) provides the Annual Governance Statement and includes all material controls, including financial, operational and compliance controls. • Having reviewed the effectiveness of the Trust's risk management and internal control systems, the Board is satisfied that appropriate arrangements were in place during 2025/26 to identify, assess and manage principal and emerging risks. (Noting that Internal Audit provide a substantial assurance opinion on the Risk Management Framework in 2025). • External assessments, including the NHS Oversight Framework and Provider Capability Assessment, are considered alongside internal assurance to inform the Board's assessment of principal and emerging risks.
D.2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual, which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over a going concern are expected to be rare.	✓	• The Annual Report 2024/25 (Page 21 provides a statement concluding the adoption of the going concern basis of accounting when preparing the annual accounts. The statement identifies any material uncertainties considered when making the statement.

Code	Provision	Comply	Narrative 2025-26
SECTION E: REMUNERATION			
E.2. PROVISIONS			
E.2.1	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions. • Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients. • Pay-outs or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria that reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. • Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed, and	✓	• There were no performance-related elements of Executive Director remuneration for 2025/26. • The Board of Directors Remuneration and Nominations Committee agreed to consolidate the contractual due payment in place for the CEO into their overall salary. The last contractual due payment was agreed for Quarter 4 2024/25. • The Terms and Conditions for the Non-Executive Directors are set by the Council of Governors Remuneration Committee and Council of Governors. The Terms and Conditions are standard and any changes are approved by the Remuneration Committee, in line with any adjustment to remuneration.

Code	Provision	Comply	Narrative 2025-26
	must be limited to the lower of £17,500 or 10% of basic salary. • For NHS foundation trusts, non-executive terms and conditions are set by the trust's council of governors. • The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.		
E.2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	-	• The Council of Governors agreed to adopt the principles of the Chair and Non-Executive Director Remuneration Structure Framework when setting remuneration levels, whilst not being bound to any previous decision of the Council in the setting of future remuneration. • The Council of Governors Remuneration Committee considers the framework when agreeing any adjustment to Chair / NED Remuneration. However, it should be noted the framework has not been updated since 2019 and does not consider any recommended annual uplift from NHS England. • The remuneration of the Chair is set using the table included in the Framework considering the annual turnover of the Trust. The Council of Governors utilised this table and other relevant information to determine the remuneration of the Chair for the recent recruitment process. • The remuneration of the Non-Executive Directors was originally set in line with the framework, with an adjustment to the uplift recommended to ensure it reflected the additional time commitment of the Vice Chair and Chair of the Audit Committee. • There have been no changes to NED remuneration for 2025/26.
E.2.3	Where a trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration disclosures in	✓	• Executive Directors are required to make annual declarations of interest which would identify any positions held such as a non-executive director role.

Code	Provision	Comply	Narrative 2025-26
	the annual report should include a statement as to whether or not the director will retain such earnings.		• If an Executive Director is released to serve as a Non-Executive Director of another organisation, a statement would be included in the Annual Report as required.
E.2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered where a director returns to the NHS within the period of any putative notice.	✓	• The responsibility for the approval of termination of employment arrangements and / or making of any extra contractual payments to Executive Directors is within the remit of the Board of Directors Remuneration & Nominations Committee and referenced in the Terms of Reference. • During the year, no extra contractual payments have been made to Executive Directors following termination of employment.
E.2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity (severance payment includes any payment whether included in a settlement agreement or not, redundancy payment, a secondment arrangement, pay in lieu of notice, garden leave and pension enhancements).	✓	• The MARS arrangements as highlighted above were discussed with NHS England prior to implementation.
E.2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The	✓	• The Trust has an established Remuneration & Nominations Committee that includes all Non-Executive Directors as members. The Terms of Reference for the Committee sets-out the roles and responsibilities for the Committee. • The Executive Chief People Officer attends the meeting from time-to-time as required to provide HR advice and is outlined in the Terms of Reference.

Code	Provision	Comply	Narrative 2025-26
	board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.		• The Trust has not used remuneration consultants.
E.2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.	✓	• The Remuneration & Nomination Committee Terms of Reference provides the remit of the Committee, including setting remuneration for Executive Directors, including pension rights and any compensation payments. • The Terms of Reference includes for the remit of the Committee the level and structure of remuneration for very senior managers (VSM's).
E.2.8	The council of governors is responsible for setting the remuneration of a foundation trust's non-executive directors and the chair.	✓	• The Council of Governors Remuneration Committee is responsible for agreeing the remuneration for the Chair and Non-Executive Directors. Recommendations are made to the Council of Governors for approval.

Summary

Based on the assurance provided through this end of year review, the Board of Directors is satisfied that the Trust's governance arrangements have been effective in supporting the delivery of high-quality care, sound financial stewardship and accountability during 2025/26

As Chair of the Board of Directors, I confirm that this End of Year Review has been considered and approved by the Board. On behalf of the Board, I am satisfied that the Trust has applied the principles of the Code of Governance for NHS Provider Trusts and complied with its provisions during the year ended 31 March 2026. The Board remains committed to strengthening governance arrangements further during 2026/27, particularly in support of system working, organisational culture and effective stewardship of public resources.

Signed on behalf of the Board of Directors:

Loy Lobo, Acting Chair	[Place Hold]	[Date]

On behalf of the Council of Governors, I acknowledge that the Council has considered this End of Year Review and noted the Board of Directors' assurance regarding compliance with the Code of Governance for NHS Provider Trusts for the year ended 31 March 2026.

Stuart Scrivener, Lead Governor	[Place Hold]	[Date]

10.2 STATUTORY DUTY OF CANDOUR ANNUAL REPORT 2025-2026

Decision Item AS

REFERENCES

Only PDFs are attached

Duty of Candour Report 03.06.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	03 June 2026

Report Title:	**Statutory Duty of Candour Annual Report 2025-2026**					
Executive/ Non-Executive Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Bethan Simpson, Clinical Lead for Patient Safety and Family Liaison Officers & Patient Safety Specialist and Lucy Beach, Director of Safety & Patient Safety Specialist					
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	If the Trust does not effectively engage with people who have experienced a degree of harm during the use of our service and offer an apology, then the Trust will be at risk of not fulfilling the requirement of Statutory Duty of Candour.		
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure		
	SR5 Statutory Public Inquiry		✓
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		✓
	SR9 Digital and Data		
	SR10 Workforce Sustainability		
	SR11 Staff Retention		
	SR12 Organisational Development		
	SR13 Quality Governance		✓
Does this report mitigate the Strategic risk(s)?	Yes		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors with details of how the organisation has fulfilled its' responsibilities in complying with Statutory Duty of Candour requirements for incidents which occurred between 1 April 2025 and 31 March 2026.	**Approval**	✓
	Discussion	✓
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

Introduction:
Duty of Candour actively encourages transparency and openness; the Trust has a legal obligation to ensure compliance with the standards. Within EPUT, the Trust's incident reporting system (Datix) is used to capture a broad range of events beyond patient safety incidents, including all deaths in line with Learning from Deaths processes, safeguarding concerns, and other non-patient safety events. Consequently, in some instances the grading recorded within Datix reflects the outcome of the event (for example, death or safeguarding status) rather than harm arising directly from a patient safety incident.

All reported events therefore require further review to determine whether they meet the criteria for a notifiable safety incident and trigger the Statutory Duty of Candour (DoC).

Position during 2025/26:
During 2025/26, notifiable safety incidents were not consistently identified or recorded as such within Datix. This meant that reporting of Statutory DoC compliance was not sufficiently robust.

In addition, organisational learning identified that:

- The classification of harm and identification of notifiable safety incidents can be complex in practice
- The breadth of events recorded in Datix can make differentiation between patient safety incidents and other event types less clear

Actions Taken:
A focused Trust-wide programme has been undertaken during 2025/26 and into 2026/2027 to strengthen understanding, consistency and assurance in relation to harm grading and Statutory Duty of Candour. This has included:

- **Staff engagement and training**
  - Delivery of Harm Level and DoC training and targeted engagement sessions
  - Strengthening understanding of patient safety harm levels and their relationship to notifiable incidents
- **Strengthened governance and oversight**
  - Structured discussion of incidents through the weekly Emerging Incident Review Group and Care Unit Incident Review groups
- **System and process improvements**
  - Introduction of functionality within Datix to:
    - Formally categorise incidents as notifiable
    - Record Statutory DoC activity
  - Implementation of a standardised Statutory DoC letter, with an expectation of issue within 10 working days once an incident is confirmed as notifiable
  - Commencement of a data quality and cleansing exercise to improve accuracy and enable reliable reporting

Revised Governance Arrangements:
In response to identified variation, a more consistent and robust decision-making model has been implemented.

Responsibility for:

- confirming harm grading, and
- determining whether an incident meets the threshold for Statutory DoC has been centralised within the Patient Safety Lead role, supported by the central Patient Safety Team and Care Unit Deputy Directors of Quality and Safety.

This approach:

- Strengthens organisational oversight
- Promotes consistency in the application of national guidance
- Supports care units in making defensible, high-quality decisions
- Reduces unwarranted variation in practice

Current Position and Assurance:
The revised governance framework was implemented in April 2026.

This is expected to:

- Improve the accuracy of incident classification
- Ensure consistent identification of notifiable safety incidents
- Strengthen compliance with Statutory DoC requirements, including timeliness of communication
- Enable reliable reporting to Board and external stakeholders once data quality work is complete

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

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

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

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

Acronyms/Terms Used in the Report			
PSIRF	Patient Safety Incident Response Framework	PSIM	Patient Safety Incident Management
FLO	Family Liaison Officer	CQC	Care Quality Commission
PSP	Patient Safety Partners	PSIRP	Patient Safety Incident Response Plan
PSI	Patient Safety Incident		

Supporting Reports and/or Appendices

Please see attached report:

- CP3 Adverse Incident Policy CP3
- CP36 Being Open and Duty of Candour Policy
- Patient Safety Incident Response Framework Policy
- Patient Safety Incident Response Plan

Executive Lead:

Ann Sheridan,
Executive Nurse

STATUTORY DUTY OF CANDOUR ANNUAL REPORT 01 APRIL 2025 TO 31 MARCH 2026

1.0 INTRODUCTION

All Health and Social Care Services in England have a legal requirement to carry out Statutory Duty of Candour (DoC), (Regulation 20 of the Health and Social Care Act 2008) which mandates that organisations must be open and transparent with patients/families when unintended or unexpected events happen that result in death or harm. The people affected must be given the information to understand what has happened, receive an apology, and detail of how that organisation intends to learn and improve in the future.

As part of this duty, the Trust must provide an annual report detailing how this Statutory DoC was implemented in our services. Therefore, this report describes how Essex Partnership University NHS Foundation Trust (EPUT) has operated Statutory DoC during the period between 01 April 2025 and 31 March 2026.

EPUT serves a population of around 3.2 million and services are delivered by more than 5,500 staff. The Trust provides a full range of clinical services covering the county of Essex and parts of Suffolk, Luton and Bedfordshire. The Trust operates over four acute hospital sites; Basildon Hospital, Broomfield Hospital, Colchester Hospital and Southend hospital, as well as over 200 community based healthcare settings including GP practices.

The Trust is committed to delivering high quality services with honesty, openness, transparency, accountability, and integrity. All staff are actively encouraged to contribute to an open and honest culture to support DoC, improvements in patient safety and the patient and service user experience. The Trust considers 'being open' as fundamental to relationships between patients, the public, staff, and other healthcare organisations.

There are two parts to DoC: Professional (Part 1) and Statutory (Part 2). Both the Professional DoC and Statutory DoC have similar aims; to make sure that those providing care are open and transparent with the people using their services, whether or not something has gone wrong.

Professional DoC (is outlined by the professional bodies the General Medical Council and the Nursing and Midwifery Council). It is a duty on individual registrants to be open and honest with patients (and, where appropriate, those close to them) without delay when something goes wrong that causes, or has the potential to cause, harm or distress. This includes telling the patient what happened, apologising, offering appropriate remedy or support, explaining potential short and long-term effects, reporting the incident, cooperating with reviews/investigations, and supporting a learning culture.

The Statutory DoC applies to all notifiable safety incidents. Notifiable safety incidents are patient incidents that meet the following criteria:

- It must have been unintended or unexpected
- It must have occurred during the provision of a Care Quality Commission (CQC) regulated activity
- In the reasonable opinion of a healthcare professional, already has, or might result in death, or severe or moderate harm to the person receiving care.

2.0 DUTY OF CANDOUR PERFORMANCE

The Trust's incident reporting system (Datix) is used to capture a broad range of events, extending beyond patient safety incidents. Table 1 below data reflects the totality of reports on the system. This includes all

deaths in line with Learning from Deaths processes, as well as safeguarding concerns and other non–patient safety events. In some instances, the grading applied reflects the nature of the event recorded (for example, death or safeguarding status) rather than harm arising directly from the event.

Each reported event requires further review to determine whether harm has occurred from the care delivered and if the level of harm meets the criteria for a notifiable safety incident triggering the requirements of the Statutory DoC. The focus taken on DoC in 2025/2026 has found inconsistency in the recording of such events within Datix, meaning that assurance taken from the system relating to the Statutory DoC may not have been reliable. This has led to a programme of improving work including practice, process and data that was discussed with the Care Quality Commission Inspector during the Well Led Review in March 2026. A programme of data quality assurance is underway to fully validate the data in Table 1 below for 2025/2026 with completion expected in September 2026.

Table 1

	2025/2026
Total number of reports on the system associated with patient episode of care	22798
Number of incidents currently reported as Moderate and above	3258

This table above shows the number of events documented on the system for 2025/2026 and those documented are moderate or above to be validated. It is important to note that the data validation will look at the consistency of documentation and applying the correct nationally agreed definition of harm level.

It is important to emphasise that, as part of discharging responsibilities under the Statutory DoC, staff in many cases will have spoken with families and patients wherever appropriate. At present, it is considered that the main issue relates to documentation rather than actual practice.

Documentation practice has been updated and put in place, with all events reported since April 2026, whereby Statutory DoC letter is issued within 10 working days of an event being identified as meeting the criteria of moderate harm or above from the delivery of healthcare. The Datix system has been updated to reflect the requirements of DoC, supporting consistent and reliable documentation going forward. Discharge of DoC is reviewed weekly by the Chief Nurse with each care unit at the Emerging Incident Review Meeting. The Trust's Director of Patient Safety is liaising with both regional and national colleagues to support wider conversations on agreeing a better understanding on how to apply standardisation on definitions of levels of harm across the NHS.

Last year's report acknowledged learning and improvement with key priorities for 2025/2026. The following provides an update on progress:

- Approval of the revised DoC Policy:
  - Achieved in August 2025

- Timeframes for completing the DoC recording will be set on Datix and will facilitate enhanced monitoring. To be monitored at a care unit level via the dashboard in Datix and reported into the monthly care unit Quality and Safety meetings, and up to the Board of Directors:
  - In progress due to exploring feasibility of the incident reporting system and amendments made on incident records to capture relevant information.

- Use of data to monitor Trust responses and instigate further quality improvement as required, linking in with the Patient Safety Partners and Patient Experience team:

  - Quality Improvement (QI) project taking learning from experience of reviews involving patients, carers, families and staff has commenced.

- Improving communication that will keep the patients / families central to the reviews and investigations, working closely with system partners:
  - In progress as part of the QI project

- Deliver Family Engagement Awareness sessions to the wider workforce and encourage increased number of people registering as a Family Liaison Officer (FLO) in the Trust:
  - In progress, development of FLO training programme. Patient Safety Incident Response Framework (PSIRF) training provided by MedLed to be scheduled from July 2026.

- DoC learning event to be planned for Trust-wide information sharing in addition to policy and mandatory training:
  - In progress for 2026/2027.

In the last year, there has been a full review of processes with engagement from services to improve the capture of information to monitor DoC application. Listed below are other areas of development:

1. Revision of Policy and Process

1.1. A further review of the policy has been undertaken; the policy is currently being amended to reflect changes to the process. Next step: proceed with approval of revised policy.

2. Patient Safety Triage including DoC

2.1. All incidents, Moderate Harm and above, are triaged centrally Monday to Friday (implemented in December 2025). This enables oversight of incidents that meet the criteria for a notifiable safety incident and triggers DoC requirements. Notifiable incident question added to Datix on 01 May. Next step: Monitoring through CIRG and Emerging Incident Review Group for completion

2.2. Personal Statutory DoC letter developed and shared in December 2025 for care units to use to ensure that earlier engagement with patient and family irrespective of any further review that is to be conducted. Next step: Monitoring through Care Unit Incident Review Group (CIRG) and Emerging Incident Review Group (EIRG) for completion as embedding requires further work.

2.3. Weekly review of all incidents by Patient Safety Leads to ensure notifiable incidents are recorded correctly. Update provided to the CIRG.

2.4. Statutory DoC cases to be reported into the Quality of Care Group on a quarterly basis starting Q1 2026/27.

3. Improvements to Datix Incident Reporting Form

3.1. In July 2025, change to incident reporting form for the degree of harm to be captured at the time of reporting. In addition, revised DoC fields to be completed at point of reporting and at the stage of reviewing the incident as per revised process. Next step: Ensure notifiable incidents are recorded on Datix, development of dashboards on Datix and Power BI for CIRG and EIRG.

4. Duty of Candour Awareness and Implementation

4.1. In July and September 2025, DoC Awareness sessions were held Trust-wide to raise awareness of notifiable incidents and reporting arrangements.

4.2. In December 2025, Degree of Harm Awareness sessions were held Trust-wide to build on understanding harm grading for incident reporting.

4.3. In December 2025, revised online training module was released for staff to update on knowledge. Training module to be completed by operational staff Band 8b and below. Next steps: Training figures to be included in quarterly report.

3.0 TO WHAT EXTENT DID EPUT FOLLOW DUTY OF CANDOUR PROCEDURES

EPUT has improved its process for the identification and management of adverse events with the DoC integrated within those processes.

When applying DoC, all necessary action is in accordance with the Duty of Candour Procedure. The key stages of the procedure include the following requirements:

- Notify the person affected (or family/relative where appropriate)
- Provide a verbal apology with follow-up in writing
- Carry out a review into the circumstances leading to the patient safety incident
- Offer and arrange a meeting with the person affected and/or their family, where appropriate
- Provide the person affected with detail of the review findings
- Provide information about improvement actions
- Make available or provide information about support to persons affected by the adverse event

The Patient Safety Incident Management (PSIM) team are working closely with the Care Unit Operational Leadership team to oversee and monitor adherence to the DoC requirements and engagement with patients and families.

4.0 ENGAGEMENT AND SUPPORT

Compassionate engagement and involvement of those affected by patient safety incidents is one of the key aims of the PSIRF. In view of this, the Trust continues to develop and strengthen its processes on engagement, working closely with the Patient Safety Partners who champion and amplify the voice of the patients and service users.

To understand and evaluate the FLO engagement throughout a patient safety incident review, the PSIM team has implemented an engagement feedback survey. The measurable feedback is slow, due to the nature of the process being used.

Engagement Survey Findings
Response rate: 20%
Although this is lower than the average response rate to a questionnaire, frequently quoted as approximately 33%, this is distributed at a difficult time for families/carers and therefore completing a questionnaire may not be a priority. However, this engagement survey provides insight into the experience of patients/families engaging with the Trust's Learning Response Review processes under PSIRF.

Overall, feedback indicates moderate to good alignment with PSIRF expectations, particularly in communication planning and support, with clear opportunities for improvement in involvement and transparency.

Key Strengths

- **Early communication and support:**
  - 71% of respondents reported receiving information about the Learning Response Review process.
  - 71% confirmed they were informed about support available, including access to FLO.
- **Planned, compassionate engagement:**
  - 86% agreed that the frequency and method of contact were agreed with them, reflecting PSIRF's emphasis on personalised, trauma-informed communication.
- **Ongoing support:**
  - 71% felt supported throughout the process by the FLO.
- **Openness at conclusion:**
  - 71% reported receiving the final report.
  - 71% were offered the opportunity for a face-to-face discussion with a senior staff member, supporting PSIRF's focus on learning-focused dialogue rather than procedural closure.

Areas for Improvement

- **Meaningful involvement in learning:**
  - Only 57% felt they were given adequate opportunity to be involved in the review process, indicating that co-production and shared learning are not yet consistent.
- **Transparency during the review:**
  - Just 43% confirmed that a draft report was shared, which is a key requirement under PSIRF to enable challenge, clarification, and trust.
- **Overall experience:**
  - The Trust received an average experience rating of 3.57 out of 5, suggesting acceptable but not consistently positive experiences.

PSIRF Assurance Summary

- The findings demonstrate partial alignment with PSIRF principles, particularly in planned communication, support, and senior engagement.
- However, inconsistent family involvement and limited draft report sharing present a risk to full PSIRF compliance and may undermine perceived openness and trust.
- The response rate (20%) also highlights the need to strengthen feedback mechanisms to ensure learning reflects a broader range of voices.

Recommended Next Steps

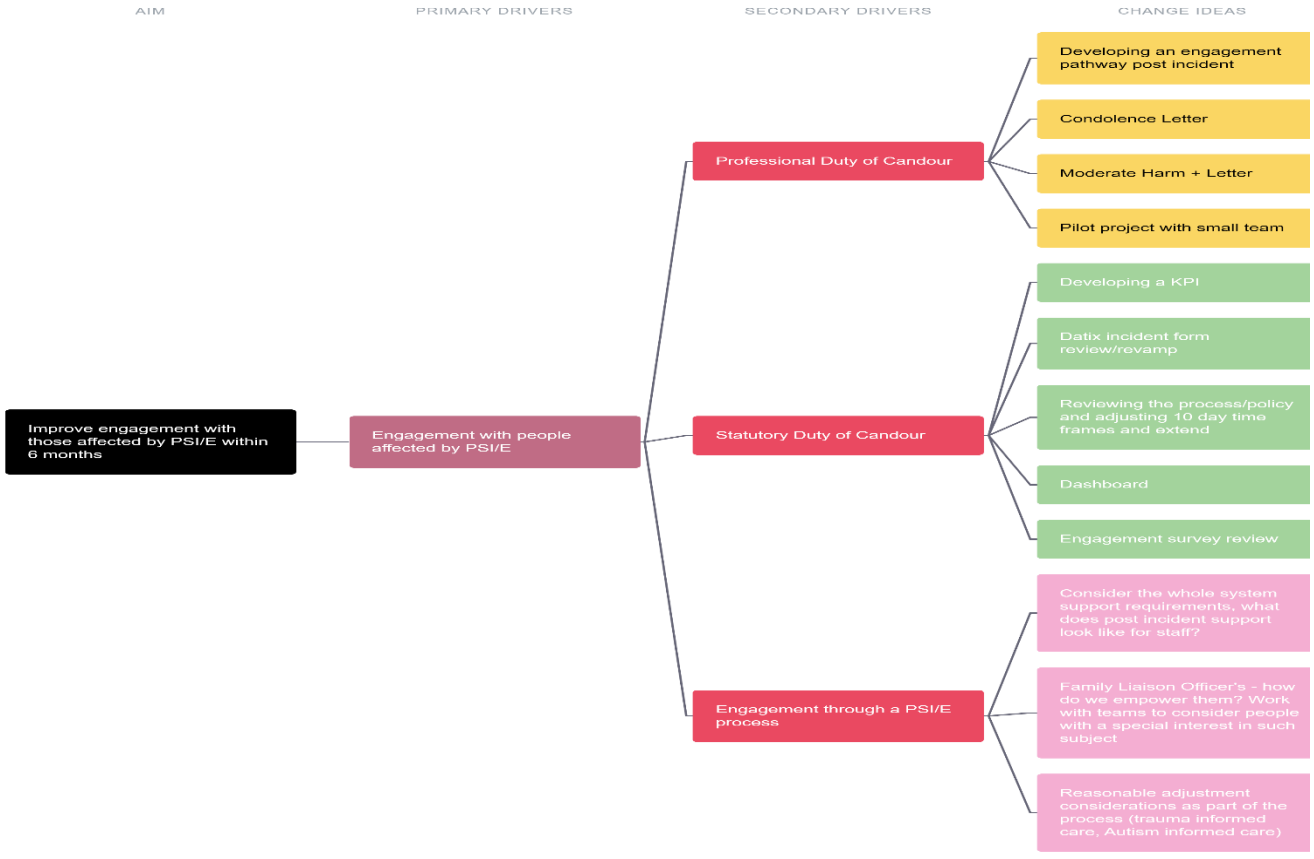
- Strengthen early and ongoing involvement, including clearer expectations around how families can contribute to the learning response.
- Standardise draft report sharing as routine practice unless clearly documented reasons for exception exist.
- Introduction of Trust-Wide family liaison training.

There is a register of FLOs in the Trust, and they regularly undertake training and attend FLO forums for support. 26 forums have been delivered to date with 54 attendees across those forums. The Trust delivered training to 21 FLOs in the last financial year. The individual FLO debrief sessions saw attendance of 85 FLOs.

The PSIM team is responsible for providing training and support for all FLOs in the Trust. One supportive mechanism in place is the FLO forum, held fortnightly and led by the FLO Lead. The forum provides a space for all active and inactive FLOs to share experiences, coach, and network with others. It is a non-mandatory session but essential to the role, with a high number of attendees recorded over the last year.

A quarterly newsletter serves to provide updates to all FLOs in the Trust. This consists of any changes to local process/changes, and nationally driven information that may be relevant. This has received positive feedback and continues to be rolled out consistently.

In addition, a Quality Improvement project has been developed and currently in its early stages to development. The below driver diagram outlines the provisional plans of what we intend to achieve.



6.0 WHAT WE HAVE LEARNT

Further to the review of events that triggered the DoC, various learning points were identified as follows:

- It takes time to ensure all staff are competent and competent in the delivery of Professional and Statutory DoC
- Improve early and ongoing involvement, with clearer guidance on how patients and families can take part in the learning response
- Enhance engagement with staff trained as FLOs to support more compassionate, effective, and meaningful involvement of patients and families
- Build on the organisation's awareness of the crucial role patients and families play in understanding incidents and shaping meaningful improvements
- Work in partnership to enhance the quality and effectiveness of communication with staff, patients, and families following incidents
- Enhance staff understanding and practice by implementing clear, structured processes to support the DoC

Key Priorities for 2026/2027:

1. Approval of the revised DoC Policy
2. Introduction of the Standard Operating Procedure
3. DoC Dashboard
4. Improve understanding and embedding of DoC into everyday work
5. Quality Improvement project to develop a co-produced condolence letter
6. Improving communication that will keep the patients and families central to the reviews and investigations, working closely with system partners
7. DoC learning event to be planned for Trust-wide information sharing in addition to policy and mandatory training

7.0 CONCLUSION

The organisation continues to learn and refine processes to ensure adherence to the DoC process. The embedding of the PSIRF process with the right infrastructure and systems at a care unit level with reporting and oversight from ward to Board, will ensure greater compliance with the DoC, especially the changes to the Datix system. The PSIM team and other key corporate teams have been working closely with the care unit Leadership teams to progress action points in a timely manner.

This report will be published on our public website as per DoC legislation.

The Board of Directors is asked to:

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

QUESTIONS TAKEN FROM THE GENERAL PUBLIC

11. OTHER

11.1 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING.

Information Item LL

• Letter from Sir James Mackey, CEO for NHS England regarding the junior doctors industrial action.

VERBAL

12. ANY OTHER BUSINESS

Information Item ALL

12.1 REFLECTION ON RISKS, ISSUES OR CONCERNS INCLUDING

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

13. QUESTION THE DIRECTORS SESSION

14. DATE AND TIME OF NEXT MEETING

5 August 2026 at 10:00, The Lodge Training room 1