Well-Led assessment report

Essex Partnership University NHS Foundation Trust

Assessment Plan ID : AP18817

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Essex Partnership University NHS Foundation Trust

Overall findings

Our view of the service

Rating Requires improvement

Essex Partnership University NHS Foundation Trust (EPUT) was formed on 1 April 2017 following the merger of North Essex Partnership University NHS Foundation Trust (NEP) and South Essex Partnership University NHS Foundation Trust (SEPT).

EPUT provides community health, mental health and learning disability services to support more than 3.2 million people living across Luton and Bedfordshire, Essex and Suffolk. The trust employs over 5000 permanent staff who work across 200 different sites, including providing care in people's homes.

The trust headquarters are based in Wickford, Essex.

There are 42 integrated care systems (ICSs) in England, EPUT provides services in 4 – Mid and South Essex Health and Care Partnership, Hertfordshire and West Essex, Suffolk and North East Essex and Bedfordshire, Luton and Milton Keynes.

NHS England launched a new interactive dashboard to provide a view on how NHS trusts are performing in key areas. This means people can see how their local trust compares with other across England, each trust is placed into a segment depending on their performance in their services and other areas like financial performance. Segment 1 means an organisation is performing well and has fewer challenges, with Segment 4 being trusts with the most challenging circumstances. As of quarter 2 (July – September 2025) EPUT was placed in Segment 3.

EPUT are 1 of 3 lead providers that host the commissioning contract with NHS England for the East of England Provider Collaborative. The Collaborative had established new ways of working together to create services and support patients.

In 2025/26 the trust had a planned turnover of £649.8m and a savings requirement of £31.3m (5%). In month 12 of the financial year the trust was forecasting full achievement of its financial plan agreed with NHS England.

We undertook a trust level (well-led) assessment which included an onsite visit from 24 to 26 March 2026. We also held 12 staff focus groups on and off site and observed a board meeting in January 2026.We assessed all the quality statements in the well-led key question in this assessment.

The well-led review followed assessments of 3 of the trusts frontline assessment service groups (ASGs):

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long stay or rehabilitation mental health wards for working age adults, child and adolescent mental health wards and community health inpatient services. We also visited 1 acute ward for adults of working age and although this report was unrated some findings are relevant to our well led assessment. These assessments were completed due to the length of time since our last visit and rating. Ardleigh ward (acute ward for adults of working age) was visited due to concerns raised to CQC about the quality and safety of the service.

At the time of our assessment EPUT and the two previous trusts which combined in 2017 were subject to an independent statutory inquiry, The Lampard Inquiry was investigating the deaths of mental health inpatients in Essex between 2000 and 2023. The inquiry was engaged in its 'collecting evidence' stage and the trust were engaging with its requests.

The assessments identified concerns about staffing, risk management, safety and governance and oversight.

At this well led assessment there was a breach of regulation 12 (Safe care and treatment) and 17 (Good governance)

We identified areas for improvement across 6 well-led quality statements. These areas were as follows:

- Further work was needed to improve the culture of the trust with staff reporting differing experiences across teams and care groups and at times a disconnect between senior leaders and front-line services. Some staff said they were worried about speaking up for fear of reprisal. Others said that some managers did not tackle behaviours that failed to represent the values of the organisation.
- Whilst work was underway to improve the leadership development programme and support managers to promote a positive culture, this had not yet been implemented.
- The trust had put arrangements in place to cover for the impending departure of the chief executive. These will need to be kept under review to ensure they are robust and effective.
- There was not a clearly defined strategic approach to equality, diversity and inclusion (EDI) and there hadn’t always been clear leadership in this area. Improvement work is required to improve the experience of people with a disability and people from all ethnic groups equally. The patient and carer race equality framework (PCREF) was at an early stage and the lead role for was yet to be embedded following recruitment.

- Oversight of the care being delivered on the frontline and the assurance received by board needs improving. In two of our assessment service group assessments completed prior to the well led assessment we considered the use of our urgent enforcement powers due to the concerns we found. Restraints were increasing, particularly in children's inpatient services and in inpatient services for people with a learning disability and/or autism.
- Learning in the organisation happened but was isolated and not always shared. Incident reviews were not consistent, backlogs existed that the board were not sighted on. There were missed opportunities for learning as information on delays does not make its way to board. There were repeated themes and trends in incident reviews that need to be addressed to reduce likelihood of reoccurrence.

However, we also recognised some good practice across the organisation and there were also positive findings across all quality statements. These were:

- The board was collegiate, well formed and able to function cohesively with respectful challenge.
- Effort had been made to ensure the trust was a valued system partner.
- There were good financial management arrangements and ambitions for the next financial year.
- There were ambitious and innovative plans in place for the future, particularly around understanding the culture and implementing a first of its kind system wide electronic patient record.

People's experience

Prior to completing the well led assessment we carried out 3 assessment service group (ASG) assessments at long stay or rehabilitation mental health wards for working age adults, child and adolescent mental health wards and community health inpatient services. We also visited one acute ward for adults of working age and although this report was unrated some findings are relevant to our well led assessment.

Across these ASG assessments we spoke with 41 service users. The feedback from these services was

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mixed. Many patients reported feeling unsafe at times, due to staffing levels, lack of staff interaction and staff responsiveness when incidents happened. Some patients also reported feeling bored on the wards. However, young people on 2 out of three wards complimented the way staff treated them and spoke specifically about how cared for they felt. Young people also felt involved in their care and could talk about what was included in their care plans.

Overall, we observed mainly positive and caring interactions between staff and service users. Our main concern related to the acute ward where we raised issues with staff not responding to alarms.

A review of service user complaints highlighted that 41% of 155 complaints were against the trust's response target of 60 days. Twelve complaints were awaiting consent prior to investigation starting, 44 required allocation to a complaint's liaison officer, 64 were under investigation and 35 were waiting for final approval.

Complaint responses were mainly of good quality. When lessons were identified action plans ensured follow up and the sharing of learning.

People who had previously made complaints to the trust co-produced the complaint process in 2022. Staff described a patient led process where within 3 days a complaint was acknowledged. Following allocation a Complaints Liaison Officer (CLO) would call or write to people ensuring the points are correct and they wished for it to be formally investigated. Staff described the role of CLO as more independent than in previous processes and that support could be sought from clinical advisors who provided clinical information and advice, supported learning and ensured clinical accuracy.

In 2025 EPUT received 5212 responses through iWantGreatCare (a health reviews website to collect patient feedback). Of those responses 94% of people said they had a positive experience.

Feedback from the local Healthwatch, an organisation that champions the voice and feedback of service users, was entirely negative. It related to a lack of person centred care and staff lacking empathy. Feedback was critical of communication and diversity, equity of access and inclusion. Whilst it was reported staff behaved professionally in meetings this was deemed to be due to preparation of a corporate script rather than being a meaningful engagement. Information also criticised the trusts lack of engagement with partners outside of their own geography. Most concerning was a fear of speaking up which has been reflected in various other parts of the well led assessment.

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Shared direction and culture

Score: 2. Evidence shows some shortfalls in the standard of care

The trust had a vision and strategy in place. The strategy was being kept under review and had been updated as needed. Whilst the NHS staff survey showed improvements in staff engagement, the trust acknowledged that further work needed to improve the culture in parts of the organisation.

The trust established a vision in 2021 'to be the leading health and wellbeing service in the provision of mental health and community care'. Alongside their vision the trust stated its purpose to be 'we care for people every day. What we do together, matters'. Staff across the organisation had been involved in developing the trust values which were: 'we care, we learn, we empower'.

To achieve their vision the trust launched a strategy in 2023 setting out the work needed to meet those goals. The strategic plan for 2023 – 2028 set out the following priorities: to deliver safe, high quality integrated care services, to enable each other to be the best that we can, to work together with our partners to make our services better, to help our communities to thrive. The strategy described the trusts commitment to driving change, learning, listening and innovating with the aim of delivering the highest quality and safest care possible. It included appropriate references to national policies for mental health and community health, examples including the NHS Mental Health Implementation plan and the NHS Long Term Plan.

The strategy was developed through extensive engagement with service users, families and carers and staff and partners. For each strategic objective the trust identified outcomes, sub-outcomes and measures that helped them determine progress.

A mid term review of the strategic plan took place to assess if the objectives remained fit for purpose when there had been significant changes in the mental health landscape such as demand pressures and developments in technology. The trust assessed their strategic direction as remaining valid, underpinned by their four objectives, but recognised that capacity, performance and financial pressures continued to challenge the delivery of their strategy.

Leaders identified 3 shifts to support delivering their strategy. These included transforming work through AI (artificial Intelligence), becoming a trauma informed organisation and taking on accountable care delivery – meaning improving neighbourhood working and equity of access through

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integrated leadership and population based care.

The board had oversight of progress via twice yearly annual strategic impact reports and enabling executives had oversight of enabling strategies via board oversight committees.

It was acknowledged by the board that there were some challenges with culture in parts of the organisation and there was still progress to be made in connecting the board to front line delivery. The trust also recognised the need to prioritise work with equality, diversity and inclusion.

A total of 43 cases categorised as “Feedback from staff” were extracted and reviewed from CQC’s central systems. These cases covered dates from 3 January 2024 to 24 December 2025. We also spoke with approximately 110 staff across 13 focus groups.

Staff reported various challenges at the trust, including safe staffing levels, experiences indicative of a closed culture, concerns around leadership and financial management, and risk management and safeguarding (including alleged breaches of trust policies related to observations). These concerns were considered to have notable impact on both patient safety, and staff safety, well-being and morale.

The trust had processes in place to address staff behaviours that did not align with the values of the organisation or the NHS, including the Trust's Behaviour Framework, which set clear expectations for professional conduct. At the time of our assessment there were 47 open disciplinary processes for substantive staff. The longest had been open since 14 January 2025 (436 days). There were 144 cases open for bank staff; the trust did not provide data for us to analyse the length of time cases had been open. Twenty three percent of all cases recorded the issue being staff sleeping on duty which has been a previous feature of safety concerns in well led reports and assessment service group reports.

The trust had recently (January 2026) had sight of their staff survey and had undertaken an initial review of the results. There was a 10% improvement on the response rate from the previous year at 52%. The trust recognised more work would be required to address bank staff morale and staff motivation, but saw improvements in people promise scores, staff recommending the trust as a place to work and staff engagement. The staff survey national comparison data, as well as free text comments was not available for the most recent survey at the time of this assessment. The trust intended to analyse the results, create local improvement plans where required and then present to the people committee and then to board.

Governors and Non Executive Directors (NEDs) spoke of an open and transparent organisation who

were willing to learn from mistakes and share learning. Both groups felt the board were open to challenge and recognised the importance of NED and governor contributions.

System partners spoke of the trust highly with their willingness to lead forums and committees that served their local communities. They spoke of openness and transparency and said the trust were open to challenge when things went wrong.

Medicines optimisation (MO) was a priority for the trust. They developed a pharmacy strategy in 2024 and involved staff and people with lived experience. The strategy aligned with trust strategy and key performance indicators and performance measures underpinned this. The pharmacy team received four nominations at the quality and excellence awards.

The Patient and Carer Race Equality Framework (PCREF) is a new mandatory race equity and accountability framework for mental health trusts in England. The purpose of PCREF is to support trusts to improve racial inequalities in access, experience and outcomes of mental health care. All mental health providers were expected to implement the framework by March 2025.

The trust completed a self-assessment checklist to understand their position against six national organisational competencies included in the PCREF.

In the 'draft' 2025/26 annual PCREF action plan the trust identified 15 items for attention. As of March 2026, 5 items remained red with no action yet taken and 8 remained amber with actions 'in progress' although no timescales for completion were listed. The trust had completed 2 items which required them to 'establish a PCREF task and finish group and appoint a chair' and 'identify key stakeholders and assign roles'.

Whilst the trust established a task and finish group to address the PCREF plan this meeting was not recorded so we were unable to comment on progress.

Capable, compassionate and inclusive leaders

Score: 2. Evidence shows some shortfalls in the standard of care

Feedback from staff was mixed about the quality of leadership in the trust, particularly at team and middle management levels. The trust leadership development programme was being redeveloped

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with a greater focus on staff culture but had not yet been fully implemented.

The trust's board was made up of 8 executive directors including the Chief Executive Officer (CEO); however, the CEO announced their resignation to us immediately before our well led assessment. The decision was taken that the 2 deputy CEOs would share the role of interim CEO whilst the trust recruited to the permanent role. We expressed our concerns about the appropriateness of this and how the trust would ensure nothing of importance would fall between 2 people. The trust reported that they believed this was the right decision for their organisation and initial feedback on this approach was positive. There would be one accountable officer which was yet to be decided. The trust had 8 non-executive directors including the chair. The board members had a variety of skills and backgrounds from finance and audit to medical and nursing. There were clear boundaries about the responsibilities of the CEO and the chair to provide balance. Executives had clear portfolios covering all necessary areas of the trust. These included areas such as patient safety, risk management, quality, performance, finance and organisation development.

There was a board development programme in place for 2026/27. The plan aimed to support the delivery of the strategic objectives and was divided into key topic areas such as flow and capacity, governance culture and accountability and quality and safety. Each month had allocated topics and a structured session focus.

The trust had a fit and proper person policy, and we found most records to be in line with requirements, although there were some inconsistencies with medical staffing records at board level.

There was recognition of the need to improve the quality of leadership development and succession planning. The current programme focused on how to implement policies and lacked in the development of leaders. The trust had commissioned a review into the leadership programme and had requested that there was a focus on diversity to include cultural issues that could then be fed into the development of a new leadership programme. The trust reported the content of the leadership programme to be at 70% completion with a plan to finish the content and launch to 120 staff in September 2026. Participants were due to be selected via nomination to ensure fair spread of roles and diversity. A middle managers programme was being developed with Anglia Ruskin University, with 50 middle managers expected to complete by early 2027.

Staff raised concerns over ineffective leadership at the trust and the impact this had on well-being, particularly from senior leaders. There were concerns around the financial management of the trust, with the suggestion that finances were prioritised over staff and patient safety. Leaders were also

considered to be disengaged and disconnected, displayed ineffective communication and decision making, and there were allegations of discrimination and bullying.

Staff felt that senior leader's decisions were focused on finances and managing the 'overspend', rather than on patient outcomes. Several described how the booking system was increasingly restricted to who could allocate additional staffing, limiting autonomy for staff. Some voiced frustration at seeing spending on refurbishments prioritised over other areas, such as staffing or materials for people who use the service (e.g. cups).

Staff experience of leadership was mixed. Some staff described not being supported by more senior leaders. There was a feeling of disconnect between leadership and staff, with one example describing a "vacuum of leadership within the team". Others noted that when leaders were present, they would be disengaged, such as staying in the office. One case, raised through the freedom to speak up service, described several issues about the leadership at a service. These included concerns about lack of visibility, communicating in a dismissive way and decision-making around risks. However, other staff groups spoke of visible leadership, regular visits and open communication through multiple levels of leadership.

Staff spoke highly of the chief pharmacist and local pharmacy leaders. They described open door policies and clear lines of accountability and ways for staff to raise concerns. Staff felt supported by regular one to one sessions which gave time for reflection and professional development. Staff gave examples of the trust supporting pharmacy support workers being supported to achieve pharmacy technician qualifications.

Partners and stakeholders commented on the quality of leaders in the organisation. They reflected their open and engaging approach and their candour when things went wrong.

Freedom to speak up

Score: 2. Evidence shows some shortfalls in the standard of care

The trust had arrangements in place to support staff speaking up. Whilst staff had raised concerns, nearly half were done anonymously which reflected feedback that staff did not feel safe to undertake this process. Some staff did not feel their concerns were addressed.

The trust had a freedom to speak up (FTSU) policy which was due for review in November 2028, having been recently reviewed in February 2026.

From 1 April 2025 to 31 March 2026 there were 289 cases raised to via freedom to speak up. These figures demonstrate that some staff felt comfortable reporting their concerns. However, between April and June of 2025 it was recorded that 48% concerns received were anonymous rather than openly/ confidentially as previously reported. Anonymous reporting not only raises concerns about culture but also prevents the trust from identifying and analysing opportunities to make improvements or to provide feedback to individuals regarding action they have taken or learning they have identified. For example, anonymous reporting means it does not identify what professional group the concerns are being raised from. For April to June 2026 the main themes and issues related to concerns around worker safety and wellbeing.

By the end of September 2025 there were 291 open cases. There was minimal progression in closing cases from April 2025 to March 2026. The longest open cases dated back to July and September 2023.

In August 2025 the trust moved FTSU training to 3 yearly.

There were multiple concerns raised which potentially indicate a closed culture within the trust. Some staff cases described concerns about speaking up and raising concerns, often resulting in inaction or concerns dismissed or covered up.

Several staff described repercussions after speaking up including confrontation, disciplinary action and being made to feel ‘to be the problem’. Multiple staff requested for the feedback they were sharing to remain anonymous, which raised concerns about the culture and potential fear of reprisal.

When staff did speak up, there was a perception of inaction including covering up, dismissing concerns or little to no response. Alleged examples included staff being told not to report low staffing levels on the incident reporting system, or when it was reported, staff felt “nothing changed”. Multiple staff alleged that efforts including having additional staff on shift, cleaning, and checks were made to ‘cover-up’ issues ahead of inspections. Another case raised concerns about reporting culture and alleged staff did not report events accurately and that issues were not escalated appropriately. However, the trust did proactively contact CQC about a serious incident during seclusion.

In the weeks following our assessment we continued to receive whistleblowing concerns relating to a fear of speaking up and leaders listening to staff concerns.

The trust did not have freedom to speak up ambassadors. Ambassadors should act as a confidential listening network supporting the Principal Freedom to Speak Up Guardian.

In July 2025 a national quarterly pulse survey included the question 'We each have a voice that counts (speak up)'. Twenty one percent of people reported having something happen in the organisation in the last 12 months that they wanted to speak up about and 15% preferred not to say. Of those who responded 'yes', 76% reported that they did speak up about the issue. However, of those people 30% recorded there being a negative impact of speaking up. Of those who did not speak up some reasons included: 'did not feel anything would be done and worry about the consequences' and 'fear of retribution, it has been quoted that the executive team do not like to hear bad news'.

For those who spoke about their concerns the top 5 themes were: organisation and workplace culture, leader/manager behaviour, staff wellbeing, bullying and harassment from staff and colleagues and patient safety.

The board requested a FTSU report twice yearly from the FTSU guardian. We were concerned with the overall picture of the culture that this may not be frequent enough and the board may be missing opportunities to improve the culture of the organisation.

From our conversations with staff, it was a mixed picture about their confidence in speaking up. Some felt that they could take concerns to their local managers but would be worried about it being raised higher. Staff were most confident in raising concerns about safe practice and patient safety, but less confident about issues relating to culture, wellbeing and bullying.

Workforce equality, diversity and inclusion

Score: 2. Evidence shows some shortfalls in the standard of care

Whilst some arrangements were in place to support equality, diversity and inclusion for patients and staff, the trust recognised there was more to do. The Patients and Carer Race Equality Framework to improve racial inequalities for people using mental health services was at an early stage of implementation and significantly more work was needed. The experience of ethnic minority staff groups was still worse than white staff and there were plans in place to make improvements. The trust was making positive progress in supporting staff with a disability.

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The Workforce Race Equality Standard (WRES) was created to support trusts performance against the NHS race equality agenda. It considers 10 indicators along with NHS staff survey results to understand how employees from black and minority ethnic (BME)experience access to opportunities and fair treatment.

In the 2025 (1 April 2024 – 31 March 2025) WRES the trust reported 32.1% of staff being from a BME background, a 2.9% increase from the year before. There was an improvement in 2 indicators, with the remaining 8 being close to national average. However, there remained disparities across all indicators in comparison to the experience of white colleagues. Indicators included the likelihood of entering disciplinary proceedings and access to career progression.

In 2025 308 BME staff joined the organisation with the biggest increase being at bands 3,6,7 and 8a. BME staff were less likely to be appointed to roles from shortlisting compared to white colleagues. This had increased from 1.27 to 1.44. BME staff had a 17.2% success rate of being appointed to roles, whereas white colleagues had a 24.8% success rate. Whilst the trust reported a decrease in the likelihood of BME staff entering disciplinary proceedings (3.47 to 3.32), BME staff were still significantly more likely to enter this process than white colleagues. The annual reporting showed an increase overall for formal conduct proceedings, mainly relevant to mental health inpatient services and urgent care services, where the trust had significantly higher levels of BME staff.

BME staff were less likely to access training and continual professional development opportunities than their white colleagues. Seventeen point four percent of BME staff engaged with training and continuous professional development (CPD) in comparison to 24.5% of white staff. This is despite the fact the trust offers a specific BME leadership programme.

On 17 July 2025 the trust held a session as part of the ethnic minority and race equality network to discuss the results of WRES and the steps required to make improvements. Leaders used the information and feedback from this meeting to develop the WRES action plan, specifically looking to address indicators 3, 4, 5, 6,7 and 8: BME staff entering disciplinary action, accessing training, having a belief that EPUT provides equal opportunities for progression and promotion and experiencing bullying and harassment from staff, patients or families.

The Workforce Disability Equality Standard (WDES) was created to support trusts performance in ensuring staff with disabilities are supported. It considers 10 metrics along with NHS staff survey results to understand how employees with disabilities experience access to opportunities and fair treatment.

In the 2025 (1 April 2024 – 31 March 2025) WRES the trust reported 8.84% of staff declaring a disability, a 1.28% increase on the year before. There was an improvement in 3 metrics, with the remaining 7 being close to national average. However, the remained disparities across metrics for discrimination and bullying from colleagues, difficulty accessing accessibility improvements and beliefs regarding career progression and promotion.

One hundred and nineteen more staff declared a disability in 2025, compared to the previous year (1.28% increase). Whilst there was an increase in people with disabilities at the trust, this was not reflected in the more senior organisational roles. There was a near equal (0.91%) chance of staff with a disability and non-disabled staff being appointed to roles from shortlisting. Staff with disabilities did not disproportionately enter disciplinary proceedings compared to non-disabled colleagues.

The trust provided a variety of ways for the voices of disabled people to be heard. This included executive sponsors attending staff networks, access to freedom to speak up staff and processes, online meetings providing subtitles and transcribing features and access to equality advisors.

On 7 July 2025 the trust held a session as part of the disability and mental health network to discuss the results of WDES and the steps required to make improvements. Leaders used the information and feedback from this meeting to develop the WDES action plan, specifically looking to address issues across 4 metrics: Disabled staff experiencing bullying, harassment or abuse from colleagues, feeling pressure to come to work when unwell and feeling that appropriate reasonable adjustments had been made to the support their work.

The trust achieved certified Disability Confident Leader status. This meant they had taken a development opportunity to establish themselves as an employer who prioritised disability inclusion.

The trust adhered to accessible information standards. They expected staff to ask people about their communication needs and how to meet them, record these needs in a clear way, make it clear when people had specific communication needs, share those needs when appropriate with other agencies and ensure people had access to information in a way that they could understand. Staff met these expectations across the services we visited before the well led assessment.

The trust had 5 staff equality networks: ethnic minority and race equality, LGBTQ+, disability and mental health, faith and spirituality and carers. The networks aimed to help the trust understand the different needs of their communities and to support the trust in making improvements. Some networks identified ongoing challenges about structures and consistent chairs which reduced the

influence they felt they had on policy and experience. Staff also commented on time being challenging in that there was no protected time for them to focus on their network responsibilities. Networks also commented on a lack of funding to support activities such as pride events and promotion of networks. Executives sponsored the staff networks, although some sponsorships were new so staff felt they needed more time to decide how productive their sponsor would be in supporting their networks.

The trust employed a chaplaincy team to provide spiritual, religious and pastoral care to patients, families and staff. The team consisted of multi faith chaplains and volunteers to provide a variety of faith based support.

The trust actively encouraged staff and people using their service to share their pronouns to support their expression of gender identity.

The organisation recognised and celebrated staff achievements. Across 2024/25 staff and teams received a variety of recognition for their work. This included: the personality disorder and complex needs service use network won a mental health award for positive practice, staff took home awards for diversity and inclusion work at the nursing times workforce awards and the Queens nurse title recognised the care in the community delivered by a member of staff in the Brentwood memory service.

The trust had recently recruited to a new position whose portfolio included equality diversity and inclusion. The new role required embedding prior to assessing its ability to strengthen the trusts position.

The trust monitored gender pay gaps (GPG) and the board received and annual report. The GPG hourly rate pay gap for EPUT was 12.41%, with males receiving an average of £21.64ph and females receiving £18.02ph. This is higher than the median gender pay gap for the NHS which was recorded as 8.83%. On comparison to EPUT's gender pay gap for the year 2017, there was a reduction of 4.49% over the seven years to 2024. The trust had developed an action plan to better understand the reasons for this gap and to put in place measures, including training and support, to address issues identified.

Governance, management and sustainability

Score: 2. Evidence shows some shortfalls in the standard of care

The trust had strengthened its governance arrangements, especially with the use of an accountability framework for its care units (directorates). However, the inspection of individual services highlighted that further work is needed to ensure areas for improvement are identified and addressed to deliver consistently safe and effective care and treatment.

There were 5 sub committees of the board. These were quality, renumeration and nominations, audit, finance and performance and people. Each subcommittee reported to the board with key risks, updates and performance. Non-executive directors (NEDs) were allocated to specific committees and had responsibility for chairing the meetings. The structure for the quality committee changed in April 2024 following a board review to improve assurance processes. Feedback from NEDs stated this had been successful. Meetings focused on relevant risks and provided space for challenge. Agendas provided adequate time for discussion and reflection. Following recommendations in an NHS England well led review in October 2024, minutes from meetings improved to clarify actions taken by people in committees and to reduce duplication or similarity of recommendations.

The board assurance framework from January 2026 contained 11 strategic risks and 1 corporate risk. No changes to the risk scores were made in January. The strategic risk of 'capital and cash' had been extended to consider increased risk to cash balances, and this was documented in finance and performance committee discussions. Suicide prevention featured as the single corporate risk, and it was recorded that there was an ongoing risk of maintenance backlogs as EPUT estate aged and the challenges with estates and facilities recruitment. These risks were to be elevated to the corporate risk register.

The top 4 risks for the trust and rated as red were recorded as 'capital and cash', 'use of resources', 'reputation' and 'staff morale skills gap workforce sustainability'. Executives and senior leaders described the top risks for the trust and the actions being taken to mitigate.

Lines of accountability and oversight processes had matured since the previous assessment of well led when we commented on the embryonic nature of many strategies, policies and procedures. The trust used a care unit leadership model supported by its accountability framework. The board identified 6 clinical care units: community Mid and South Essex, community North East Essex, community West Essex, psychological services, specialist services and urgent care and inpatient services. The accountability framework aimed to hold service and corporate directors to account and to support the trust to achieve its strategic objectives and key performance targets. The framework set out how oversight took place in a consistent way and supported leaders to make decisions as locally as possible. There were 5 domains to the framework: quality and safety, operational performance,

workforce and culture, finance and external relations.

EPUT operated a care unit leadership model and had recently strengthened the clinical leadership in these units with the appointment of a deputy medical director and deputy directors of quality and safety. Underpinning care units was the accountability framework. The accountability framework launched in 2021 and was designed for the executive team to hold service directorates to account for their performance and quality and safety. The framework supported devolved leadership and supported care units in being empowered. All leaders we spoke with reflected the importance of the accountability framework and how it had positively impacted their services.

Care group leadership spoke highly of governance structures and gave multiple examples where they discussed risk. They met regularly to increase oversight, identify and share learning and to review any action plans. Local meetings fed into care group meetings, which then fed into the quality and safety committee with any relevant issues being fed to board.

The trust used electronic dashboards to see different levels of performance from ward to care unit overall data. Every person in the trust had access to this. Dashboards ranged from quality and safety information to flow and capacity information and provided live information. The trust produced integrated quality and performance reports to monitor data topics such as waiting times, out of area placements, complaints and patient safety incidents.

In 2024/25 52 quality assurance visits took place across the trust. Executives, non executive directors, governors and ICB colleagues completed the visits.

The trust secured a new electronic patient record system that would be available to staff from ‘late’ 2027. This replaced 7 different electronic systems at EPUT that staff had been working with previously. The new system would allow staff to see patient records across all EPUT services but will also include Mid and South Essex NHS Foundation Trust records. This will be a first of its kind system. CQC raised this an issue in the trusts report published in July 2023 and identified this as a breach of regulation: “The trust must ensure that they have a robust and timely plan for the implementation of a consistent patient record in line with their current strategic aim. (Regulation 17(1)).” Whilst the trust has now committed to a new system and it will be in place soon, the timeliness of addressing this breach remains a concern.

The trust had a guardian of safe working hours and reports were delivered to the board quarterly. Currently at the trust working practices for trainees continued to be safe. The trust had arrangements

in place to complete medical appraisals and revalidation.

As of December 2025, data showed turnover as 7.4%; vacancies at 9%; and sickness as 7%. Although the trust had ongoing initiatives in place to support the recruitment and retention of staff in March 2026 turnover had increased to 8.6% albeit the vacancy rate reduced to 9%. Over 1200 staff joined the trust in 2025 including 334 registered nurses. The trust remained focused on reducing the use of temporary staff.

Mandatory training compliance was 90% across the organisation. Compliance rates for supervision and appraisal were under the trust KPI of 90% at 74% and 84% respectively. Corporate care groups reported the lowest performance, and the trust was taking targeted action to address this.

The trust monitored the skill mix of staff on wards to ensure the teams met the needs of the patients. This was undertaken daily via situational report meetings and monitored at board via annual workforce reviews.

Medicines optimisation (MO) worked closely with the new medical director and established joint committees for pharmacy and medical staff that took place quarterly. There was a clear governance structure and line of accountability from operation staff MO to senior leaders to chief pharmacist then to executive board. There were mechanisms for sharing learning and alerts via newsletter and bulletins. MO staff produced an annual report on pharmacy services which highlighted pharmacy performance over the year

There were arrangements in place to ensure that the trust discharged its specific powers and duties according to the provisions of the Mental Health Act 1983 (MHA). Mental Health Act and Mental Capacity Act audits took place regularly across relevant services and teams developed and monitored action plans where improvements were required. There was a dedicated MHA team who provided administrative and case specific support to staff in the trust. Section 75 approved mental health professional responsibilities and arrangements sat with the local authority. The trust met regularly with the local authority to discuss and address any challenges.

The trust monitored the use of restraint, seclusion and long term segregation. In January 2026 adult and older adult inpatient services achieved a 9% reduction in restraint. However there remained challenges in children and adolescent inpatient services and inpatient services for people with a learning disability and/or autism which saw a 59% increase in restraints. Standing restraint was the most common intervention used.

From October 2025 – December 2025 there were 30 episodes of seclusion recorded. The highest figures being attributed to inpatient services for people with a learning disability and/or autism (10 episodes). The trust identified high level of restraints linked to episodes of deliberate self harm, particularly in patients with complex trauma backgrounds and people with an autism spectrum disorder diagnosis.

The Safewards model continued to be rolled out across wards, with monthly learning events and co-produced training sessions. Peer support workers and Lived Experience Ambassadors were actively involved. The Safewards model is an evidence-based, nurse-led intervention designed to reduce conflict and coercive containment (such as restraint or seclusion) on mental health wards. Reducing restrictive practice leads reported to the executive nurse via the quality of care committee on a quarterly basis. Reducing restrictive practice groups gave staff the opportunity to ask questions, discuss case specific examples and increase their confidence in reducing restrictive interventions.

Prior to completing the well led assessment we carried out 3 assessment service group (ASG) assessments at long stay or rehabilitation mental health wards for working age adults, child and adolescent mental health wards and community health inpatient services. We also visited 1 acute ward for adults of working age and although this report was unrated some findings are relevant to our well led assessment.

For long stay or rehabilitation mental health wards for working age and one acute ward for adults of working age we issued a letter of intent using our powers under the health and social care act. A letter of intent means we are considering urgent enforcement action under section 31 because we found serious concerns that posed a current or ongoing risk to people's safety.

For acute wards this related to issues with responding to incidents, staff not completing enhanced observations properly, concerns about the environment, staff handovers and the recording of incidents. The trust provided immediate assurances for the issues raised and implemented intensive support to the ward to drive improvements in quality and safety. Following increased engagement and monitoring we were assured changes had taken place to decrease the risk to people using the service, however, there remain breaches that the trust needs to address to be fully compliant with regulations.

For long stay or rehabilitation mental health wards this related to admitting patients without robust assessments, not involving patients with risk assessments, concerns over incidents with a sexual safety element and responding to incidents. The trust provided immediate assurances about changes and improvements and implemented intensive support to the wards. However, based on the evidence we made the decision to issue a warning notice under our enforcement powers. This meant the trust is

required to make improvements by a certain date and we will revisit the ward to check.

Across both assessments where we issued a letter of intent there were similar themes relating to patient safety and we were concerned that this was not identified by the trust through their own governance and oversight structures. Whilst Ardleigh ward had been highlighted as a concern we were not assured by the action taken prior to our assessment which left people exposed to the risk of harm.

There were processes to manage the financial resources and sustainability of the trust. The trust Board has strong financial skills and experience within the group of Non-Executive Directors. The Audit Chair and the Chair of the Finance, Investment & Performance Committee are qualified accountants with a broad range of financial sector and commercial experience and acumen.

In 2025/26 the trust had a planned turnover of £649.8m and a savings requirement of £31.3m (5%). At the time of the inspection with one reporting period left (Month 12) the trust was forecasting full achievement of its financial plan agreed with NHSE.

The trust had strong financial track record, having delivered their financial plan in recent years. The Executive Chief Finance Officer had the right skills and experience for the role. The Executive Chief Finance Officer will be the Interim Chief Executive, alongside the Chief Operating Officer. The backfill arrangements within the Finance Directorate were under discussion at the time of the visit, however the trust were confident that the current deputies would provide robust cover in the short term.

For the 2026/27 financial year, the trust planned to breakeven, and to do so needed to achieve £47.1 million of savings, which was 6.8% of the trust turnover. This would be the largest efficiency program the trust had attempted. The trust articulated the scope of the savings plans, and the revisions being considered to the governance of efficiency delivery. However, no firm timescales were provided for this.

The trust experienced issues with the external audit of their 2024/25 annual accounts in respect of the treatment of provisions for the Lampard Inquiry. Whilst a new external audit firm had been appointed for the 2025/26 financial year, at the time of our assessment the finance team had not received confirmation of the proposed audit view on this provision going forwards. This presented a risk to the 2025/26 audit opinion and the final breakeven position. This risk was mitigated by the trust materiality levels.

Whilst the trust could articulate an overarching financial strategy, they did not have a financial strategy document. The shift to financial planning by NHS England over a three-year time horizon represents an

opportunity for the trust to ensure that there are clearer links between financial plans and other supporting strategies of the trusts 2023 to 2029 Strategy. Further, the trust must address their reliance on non-recurrent funding to deliver financial targets, and the financial strategy must address this over the medium term.

There was effective oversight of cybersecurity and information governance at the trust. Information governance was overseen by the information governance group. There had been no cybersecurity incidents recorded.

The trust had a digital strategy. One significant programme focussed on introducing a first of its kind system wide Electronic Patient Record (EPR) system. The current systems was an area of concern raised by staff during our assessment of frontline services and a previous breach identified on inspections.

Partnerships and communities

Score: 3. Evidence shows a good standard of care

The trust understood their duty to collaborate and work in partnership, so services work seamlessly for people. Staff share information and learning with partners and collaborate for improvement.

The trust understood their duty to collaborate and work in partnership with other services, so they worked seamlessly for people. They actively shared information with people and system partners and collaborated widely to drive improvements. Several executives sat on local integrated care boards and partnership boards.

EPUT spanned 4 Integrated Care Systems (ICS): Hertfordshire and West Essex, Mid and South Essex, Suffolk and North East Essex and Bedfordshire, Luton and Milton Keynes. More locally they were actively involved in 6 place-based alliances, whose aim was to bring together local services and stakeholders to address local needs and improve outcomes for people. The trust worked with other health partners such as GP's, acute hospital trusts and independent providers.

The trust had specific collaborative arrangements across its geographical area. In Mid and South Essex, the Community Collaboratives purpose was to attempt to bring together providers delivering community health services. The trust hosted this collaborative. The same purpose was reflected in the

North East Essex Community Collaborative, EPUT held membership but did not host. A Community Collaborative existed in Hertfordshire and West Essex and brought community health services together under informal arrangements to support delivery of high quality services. In the East of England EPUT led the Specialist Mental Health and Commissioning Collaborative, bringing teams together providing specialist care such as children and young people inpatient treatment. In Southend, Essex and Thurrock EPUT partnered with three local authorities, three Integrated Care Partnerships, North East London Foundation Trust and Essex Police. This collaboration focussed on prevention and early intervention for mental health, acute and crisis services and supporting people to recover.

Over 2024/25 the trust implemented the first set of priorities laid out in their 'Working in partnership with people and communities' strategy. The strategy was co-produced with people using their services. The trust had over 300 people working with them who had direct experience, or family experience, of using their services. Leaders involved them in strategy development through to supporting patients and families in services.

The trust governors were provided with training to fulfil their roles. The governor group comprised some longstanding members alongside some who had joined much more recently. Governors acted as key representatives for patients, staff, and the local community, ensuring the trust remained accountable to the public. Governors spoke to us about their focus on improving learning in the trust and access to services. There were some concerns expressed about the information flow between frontline services and the board and the culture in parts of the trust.

Medicines Optimisation staff (MO) had forged strong working relationships with the local integrated care boards (ICB) and the medication safety officer (MSO) had made strong links with other MSOs in the area. There were ongoing pharmaceutical committees to improve transitions of care through the discharge medication service.

The trust had positive working relationships with Anglia Ruskin University and offered training to student nurses. Alongside this the trust offered training placements to junior doctors.

Learning, improvement and innovation

Score: 2. Evidence shows some shortfalls in the standard of care

Whilst the trust was reporting and investigating incidents, this was not always happening in a timely

manner and the learning was not being shared quickly enough across the organisation. This meant that there were missed opportunities to improve the safe care and treatment of people using the trusts services.

The trust participated in the early adoption of the Patient Safety Incident Response Framework (PSIRF). This sets out the NHS approach to developing and maintaining effective systems and processes for responding to patient safety incidents. The purpose is to develop a culture of learning to improve patient safety. PSIRF does not make a distinction between patient safety incidents and serious incidents, instead it promotes a proportionate approach where a response to incidents should have resources allocated to learning.

The trust had a committee structure in place to oversee mortality reviews within EPUT. The board was collectively responsible for ensuring the quality and safety of healthcare at the trust and received it's assurance from the quality committee. The care units were responsible for overseeing mortality in their own areas and were expected to provide assurances to the learning from deaths oversight group (LDOG). The LDOG ensured learning from stage 1 and stage 2 deaths was captured and shared appropriately. Mortality surveillance was completed monthly. The aim of the LDOG was to provide assurance to the learning oversight sub committee (LSOC) that all deaths had been investigated appropriately and that emerging learning was identified and shared. The LSOC provided assurance to the quality committee.

The trust had a learning from deaths policy and a patient safety incident response plan (PSIRP) which detailed how they responded to incidents. They used a variety of tools and approaches to investigate adverse incidents, depending on their severity. These included swarm huddles, after action reviews, multi disciplinary reviews and patient safety incident investigations (PSII). There was specific criteria for a PSII to be undertaken. This included never events (serious, largely preventable patient safety incidents that should not occur), patient safety incidents that met the criteria in the learning from deaths policy, deaths of detained patients and where there may be a link to a failure in care and any other incident where there were opportunities for new learning and that posed a significant safety risk. The trust had a specific PSII team to monitor and allocate PSII's.

EPUT recruited five Patient Safety Partners (PSP) to be the voice of patients, their carers and families across the trust.

In January 2025 EPUT reported 600 incidents to the board involving 22 fatalities. There were 467 overdue incidents awaiting closure following review, this was noted to be an improving situation.

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There were 42 reports under PSIRF, 21 care unit reports and 33 decision monitoring tools in progress. Decision monitoring tools form part of the PSIRF framework. There were 146 open action plans from PSIRF and care unit reviews.

As of 27 March 2026, overdue incidents were 901. Ninety one assessed as severe or fatal. As of 1 April 2026, overdue incidents were reported as 626 with 50 classified as severe or fatal. Three being severe harm and 47 being deaths. The trust had work to do on ensuring staff reviewed and closed incidents in a timely way to support organisational learning. Leaders did not report overdue incidents and PSII's to the board as part of patient safety reporting.. Ninety one incidents classified as severe or fatal were overdue for review. "We were told some reviews had taken 'some time' with reference to being in the process for 'over 2 years'. We remain concerned that there were not robust oversight and action being taken to address overdue backlogs which will impact the trust identifying and implementing learning.

We reviewed 8 examples of specific incidents (unintended events that could cause or have caused harm) to assess quality and timeliness. This reinforced issues with the trust reviewing, investigating and identifying learning in a timely way. There were also gaps in documentation and records.

When they completed investigations and identified learning the trust shared this via safety alerts, learning events, local governance meetings and via their staff intranet.

Medicines optimisation (MO) teams had recently received funding from the National Institute for Health and Care research (NIHR) to have an 18 month position for a clinical trial pharmacist.

The trust had commissioned a joint research project with Anglian Ruskin University to investigate the provision, accessibility and navigability of self harm and suicide prevention services in coastal communities in North East Essex. It commenced in 2025. The trust also fostered clinical academic partnerships with University College London (UCL) and the University of Cambridge. In collaboration with UCL, EPUT were taking part in a trial looking to improve diagnosis of Alzheimer's disease via blood tests.

EPUT worked with patients, families, carers, staff and other organisations to develop services and support innovative practice. The West Essex Hospital at Home team provided community monitoring of patients, via home visits, calls and remote monitoring equipment, to reduce the likelihood of need for hospital admission. The remote monitoring equipment allowed staff to respond urgently to any deterioration and had been shortlisted for the 2025 Health Service Journal Digital Awards for improving out of hospital care through digital.

The Lakes electroconvulsive therapy (ECT) clinic received accreditation from the Royal College of Psychiatrists for the first time, meaning all 3 ECT clinics provided by EPUT were accredited. The Lakes received special commendation for its safe environment, good patient experience and thorough documentation.

In Great Oakley the trust worked with a community interest company, delivering fishing programmes to support people with mental health conditions like depression and post traumatic stress disorder. The programme gave people access to safe spaces and qualified coaches to talk to about their mental health. Op COURAGE, a specialist mental health service for armed forces veterans was one of the largest referrers to the service. Op COURAGE supplemented existing community mental health services by providing specialist advice and guidance to veterans.

Environmental sustainability - sustainable development

Score: 3. Evidence shows a good standard of care

The service had a good understanding of any negative impact of its activities on the environment and made a positive contribution in reducing it and supporting people to do the same.

The trust had a green plan that covered the period from 2026 – 2029 with an aspiration to achieve a net zero carbon future for the trust. It presented an overview of the changes needed for the trust to become more sustainable. The plan would be reviewed and progress reported on annually, alongside a mid-term review in 2028/29.

The trust had four main priorities for their green plan from 2025 – 2040. This included increasing their electrical charging infrastructure. From 2027 the trust aimed to only lease or purchase electric vehicles, along with only allowing electric vehicles to be obtained via salary sacrifice. The second priority was to identify opportunities for renewable energy generation. The third to address heat decarbonisation and the fourth related to climate change mitigation and adaption.

Over the last 5 years the trust had invested approximately £3.5 million to reduce carbon omissions, including the installation of air source heat pumps, EV charging stations and LED lighting.

The trust identified sustainability leads who drove the green plan forward via action plans. The team were skilled and knowledgeable in their area and identified challenges to the trust achieving net zero.

These included issues around funding, time and physical resources. Heat had been a prolonged and difficult challenge due to the balance required when considering patient safety and comfort.

The trust introduced green champions across many different roles, including pharmacy and recognised that the sustainability profile was improving across the organisation. There was a need to continue to work on the sustainability profile and aspirations to increase staff awareness through training.

In 2025 NHS England awarded the trust a bronze award for best reuse initiative of the year for excellence in waste management.

Regulation 12: Safe care and treatment

Regulated activities

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury

How the regulation was not being met

The trust must ensure that systems and processes are in place to effectively assess, monitor and learn from incidents in a timely way (Regulation 12(1)).

Regulation 17: Good governance

Regulated activities

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury

How the regulation was not being met

The trust must ensure they have a robust process for implementing and monitoring improvement processes. Such as breaches identified in assessment service group reports in a timely and effective way. (Regulation 17(1)).

The trust must ensure they have a robust process in place for improving the culture of the organisation and improving the experience of staff. This includes supporting people to speak up about concerns and improving the experience of people with a disability and people from all ethnic groups. (Regulation 17(1)).

The trust must ensure that the governance systems are effective and reviewed to enable the identification of issues affecting the quality of care being delivered. (Regulation 17(1)).