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Leicestershire Partnership NHS Trust

Trust Board Public Meeting – 29th July 2025

Declarations of Interest Report

Purpose of the Report

This report details the Trust Board members' current declarations of interests. The Trust uses an online system Declare and does not hold paper copies. Trust Wide declarations for all decision makers are available to view here: https://lpt.mydeclarations.co.uk/home.

Board Member:	Current Declarations:	Declaration Reference:	Date Interest Arose:
Angela Hillery CEO	Hospitality - APNA	3935	14.09.23
	Loyalty Interests – LLR – voting member	4031	25.10.23
	Loyalty Interests – East Midland Alliance	4030	25.10.23
	Loyalty Interests - Sister employed by William Blake charity – homes for people with a Learning Disability	4029	25.10.23
	Outside Employment – NHFT – Joint CEO	4068	14.11.23
	Director of 3Sixty (On behalf of NHFT)	4108	01.04.23
	Member of NHS Employers Workforce Policy Board	4106	01.04.23
	Member of National Mental Health Programme Board	4105	01.04.23
	Midlands region CEO representative for National Mental Health working group	4104	01.04.23
	Loyalty Interests - Dale Hillery (husband) - property surveyor	4273	01.04.23
	Loyalty Interests - Member of NHSE/Providers Group	4272	01.04.23
	Hospitality – NHS Providers	4393	21.02.24
	Gifts – Proud2beOpsConference	4502	07.11.23
	Hospitality - UNAM-UK CIC	5754	13.07.24
	Gifts – REACH Network	6006	31.10.24
	Member of Advisory Group supporting NHSE- led by Sam Allen CEO (Management and leadership)	6046	30.10.24
	Member of RCSLT Senior Leaders Network	6357	01.05.25

Board Member:	Current Declarations:	Declaration Reference:	Date Interest Arose:
Jean Knight Deputy CEO/Managing Director	Loyalty Interests – Northamptonshire Street Pastors	3664	01.04.23
	Loyalty Interests – Age UK Northamptonshire	3663	01.04.23
	Loyalty Interests – BLMK ICB	3662	01.04.23
	Loyalty Interests – Ellis (formerly Berendsen)	3661	01.04.23
Crishni Waring Chair of the Trust	Loyalty Interests - NHS Leicester, Leicestershire and Rutland (LLR)	3968	03.09.23
	Loyalty Interests - NHS Northamptonshire	3967	03.09.23
	Loyalty Interests - NHSE Midlands Regional People Board	3966	03.09.23
	Loyalty Interests - NHS Herefordshire and Worcestershire	3965	03.09.23
	Loyalty Interests - Northamptonshire Healthcare NHS Foundation Trust	3964	03.09.23
	Loyalty Interest – Raising Health	5746	01.04.24
Hetal Parmar NED	Outside Employment – The Mead Educational Trust	3936	04.09.23
	Outside Employment – Washwood Heath Multi Academy Trust	3097	04.09.23
Liz Anderson NED	Outside Employment – University of Leicester Professor	4285	12.09.23
Josie Spencer NED	Outside Employment – Staffordshire & Stoke on Trent ICB	3649	01.05.23
	Loyalty Interests – Leicestershire Police	5584	01.04.24
Manjit Darby NED	Outside Employment – Magistrate – Leicester Court	5589	01.04.24
	Outside Employment – NHS Leadership Academy	5588	01.04.24
	Outside Employment – Nottinghamshire County Council	5587	01.04.24
	Outside Employment – General Osteopathic Council	5586	01.04.24
	Loyalty Interests – Husband works for LPT Bank (Memory Service)	5948	03.06.24
Faisal Hussain NED	Loyalty Interests – Raising Health Charity	3200	01.07.22
	Loyalty Interests – Spinal Injuries Association Enterprise	3146	25.08.22
	Loyalty Interests – APNA NHS Network	909	24.02.22
	Loyalty Interests – Disabled NHS Directors Network	910	24.02.22
	Loyalty Interests – Seacole Group	911	24.02.22
	Loyalty Interests – Spinal Injuries Association	912	24.02.22

Board Member:	Current Declarations:	Declaration Reference:	Date Interest Arose:
Melanie Hall Associate NED	Outside employment - Synlab plc and Mid & South Essex NHS FT - Chair	6362	01.05.25
	Outside employment - Northamptonshire Healthcare NHS FT	6363	01.04.25
Kate Dyer Director of Governance	Nil Declaration	6300	NA
David Williams Director of Strategy and Partnerships	Outside Employment – Northamptonshire Healthcare NHS Foundation Trust	3137	01.04.22
	Loyalty Interests – LPT Charity Raising Health	3934	27.09.23
	Hospitality – Yale University	4138	01.12.23
	Volunteer Run Director – Parkrun	5955	02.11.24
	Hospitality – Commercial Company - £40	6176	18.03.25
	Hospitality – Commercial Company - £50	6423	26.6.25
Sarah Willis Director of HR	Nil Declaration	6252	NA
Paul Williams Interim Director of FYPCLD	Loyalty Interests – Partner & son work for LPT	5863	01.04.24
Sam Leak Director of Community Health Services	Loyalty Interest – NHFT	3730	03.08.23
	Loyalty Interest – Age UK Northamptonshire	3729	01.04.23
Tanya Hibbert Director of Mental Health	Nil Declaration	6197	NA
Sharon Murphy Director of Finance	Loyalty Interest – Raising Health	5570	01.04.24
James Mullins Interim Director of Nursing	Nil Declaration	6359	NA

Board Member:	Current Declarations:	Declaration Reference:	Date Interest Arose:
Bhanu Medical Director	Outside Employment	4046	01.11.23
	Outside Employment – Four Elements Medical Services LTD	4045	01.11.23
	Loyalty Interests - Daughter participating in voluntary work through LPT for medicine calling project	5638	03.07.24
	Loyalty Interests - Apollo hospital and medical college in Chittoor, India.	5637	11.07.24
Paul Sheldon Chief Finance Officer	Outside Employment - Northamptonshire Healthcare FT - Joint role with LPT and NHFT	4116	19.09.23
	Loyalty Interests – Carly Sheldon (wife) – Senior Finance Manager at Black Country ICB	4275	01.04.23

Decision required – Please indicate:

Briefing – no decision required	✓
Discussion – no decision required	
Decision required – detail below	

Governance table

For Board and Board Committees: Paper sponsored by:	Public Trust Board 29th July 2025 Kate Dyer Director of Governance & Risk	
Paper authored by: Date submitted: State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s): If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured: State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Kay Rippin Deputy Trust Secretary 21st July 2025 NA NA Bi-Monthly report at Trust Board	
LPT strategic alignment:	**T** - **T**echnology	
	H – **H**ealthy Communities	
	R - **R**esponsive	
	I – **I**ncluding Everyone	
	V – **V**aluing our People	
	E – **E**fficient & Effective	✓
CRR/BAF considerations *(list risk number and title of risk):* Is the decision required consistent with LPT's risk appetite: False and misleading information (FOMI) considerations:	NA Y Considered	
Positive confirmation that the content does not risk the safety of patients or the public	Y	
Equality considerations:	Considered	

B
Unconfirmed

Leicestershire Partnership NHS Trust

Minutes of the Public Meeting of the Trust Board
27th May 2025, 9.30am-1.00pm
Meeting held virtually via MS Teams

Present:
Crishni Waring, Chair
Faisal Hussain, Non-Executive Director/Deputy Chair
Josie Spencer, Non-Executive Director
Alexander Carpenter, Non-Executive Director
Hetal Parmar, Non-Executive Director
Liz Anderson, Non-Executive Director
Manjit Darby, Non-Executive Director
Angela Hillery, Chief Executive
Jean Knight, Managing Director/Deputy Chief Executive
Sharon Murphy, Director of Finance
James Mullins, Interim Director of Nursing, Allied Health Professionals and Quality

In Attendance:
Melanie Hall, Associate Non-Executive Director
Sam Leak, Director of Community Health Services
Tanya Hibbert, Director of Mental Health
Paul Williams, Acting Director of Families, Young People, Children, Learning Disability and Autism Services
Sarah Willis, Director of Human Resources and Organisational Development
Alison Gilmour, Director of Strategy and Partnerships (on behalf of David Williams)
Richard Brown, Associate Director Estates and Facilities (for item TB/25-6/002)
Kate Dyer, Director of Corporate Governance
Kamy Basra, Associate Director of Communications and Culture
Sonja Whelan, Corporate Governance Coordinator (Minutes)

TB/25-6/001	**Apologies for absence** Apologies were received from David Williams, Paul Sheldon and Bhanu Chadalavada. Alison Gilmour (deputising for David Williams) and Melanie Hall (Associate Non-Executive Director) were both welcomed to the meeting.
TB/25-6/002	**Enabling (Cleanliness Standards at LPT)** Richard Brown introduced the service presentation for Estates and Facilities which focussed in particular on cleanliness standards at LPT. Representatives from the Estates and Facilities Team were in attendance and were introduced as Helen Walton (Head of Facilities), Rob Jones (Head of Capital Projects and Property), Rob Wyles (Interim Head of Estates Manager), Nick Adams (Senior Facilities Manager), Colista Gaskin (Senior People Partner) and Luke Kilgannen (Senior Business Administrator). The presentation described the service model for Estates and Facilities and included WTE staff numbers, budget and number of buildings serviced.

	Since bringing the Estates and Facilities services in-house, Richard Brown advised there had been rapid transformation and continuous improvement in all aspects of estates and facilities work in order to meet the clinical and corporate needs across the trust. Overall, the service worked across the whole of Leicestershire which totalled in excess of 830 square miles. Helen Walton then explained the new national Standards for Healthcare Cleanliness introduced in 2021 by NHS England. Unlike previous standards, a functional risk category was allocated to all areas based on the risk of the activity being carried out and the environmental conditions. Using Loughborough Community Hospital as an example; the operating theatre is classified as functional risk category one, the wards a functional risk category two, the urgent care centre a category three and the office administration accommodation a functional risk category six. The functional risk category designates which of the fifty elements relevant to the trust are required for cleaning although the standards were revised earlier this year where an additional ten elements were added, specifically relating to ambulance and patient transport providers. Rather than take no action as the ten additional elements were for different organisations, the opportunity to demonstrate good practice was taken and arrangements were reviewed within LPT. An exercise was undertaken to check spaces were aligned to the correct functional risk category ensuring all responsibilities were aligned to the correct teams. However, trusts can derogate from the functional risk category recommendations, and this was executed in LPT with mental health wards being allocated a functional risk category two (NHSE recommendations are that mental health wards are a functional risk category three). The risk category also determines the frequency of auditing ranging from weekly for functional risk category one, to monthly for functional risk category two. The audit outcomes are in a value which is then translated into a star rating, with star ratings being displayed at the entrance to all departments, wards and premises and, in terms of governance, are reported at the trust Infection, Prevention and Control Assurance Group for oversight, scrutiny and support. Additionally, the Patient Led Assessment of the Care Environment programme (PLACE), which is a voluntary programme and powerful tool, is where the patient voice validates internal audit outcomes - offering further assurance. An example of the Cleanliness Charter and Star Rating poster displayed at entrances to wards, departments and premises was then described. Rob Jones added that cleanliness was not undertaken in isolation but with support from the whole estates and facilities service. Capital investment is approximately £10m to £15m per annum and this incorporates current cleaning and infection and prevention control (IPC) thinking for materials; wall, floor, ceiling coverings, wipeable surfaces, kitchens and domestic surfaces and spaces. As such, staff from both facilities and IPC are part of project design teams and ultimately sign off designs prior to final costings and contracts being issued. Rob Wyles shared that the wealth of experience, knowledge and expertise within the estates team ranged from apprentices to chartered engineers. The majority of estates managers had been promoted within the NHS who, alongside their day-to-day roles, undertake ‘authorised person duties’ for

	the trust. An authorised person has key operational responsibility for specialist services – roles included high voltage, low voltage, medical gases, ventilation and water. Working closely with facilities, key areas are identified for improvement whilst undertaking pre-planned and reactive maintenance tasks. Estates monitor water systems monthly in catering, patient and domestic areas. Service contracts for catering and cleaning appliances are also managed by the estates team. Next, Nick Adams referred to PLACE and explained how it was the system for assessing the quality of the clinical environment and was introduced in 2013 to allow patients to have a strong voice, to identify what is important, and to focus on improvement with trusts being required to report publicly. The PLACE assessment team includes non-clinical staff and service user/carer representatives which supports the provision of clinical care, assessing such things as environment, quality of food, condition of buildings and external areas. With regard to cleanliness, PLACE assessors look closely at the condition, appearance and maintenance of fixtures and fittings as well as provision of care with regard to privacy, dignity and well-being. Food assessments also take place within environments that support the care of people with dementia. A slide was shown on PLACE results/comparison which evidenced a continued improvement year on year for the LPT outcomes and the trust achieving a higher than national average outcome across all domains. LPT achieved the highest score available when the results of the 2024 PLACE assessments were published earlier this year. A video was then shown of David Batchelor who shared his experience of being a PLACE assessor with LPT. He was asked 2 years ago by the patient experience and involvement team to become an assessor. He felt it was important that family, friends and carers feel their loved ones are cared for in a safe and clean environment, so undertook the training. On the day of a PLACE assessment, he initially considers how welcoming foyer areas are before moving to ward areas where he looks at floors, ceilings, lighting, décor and clean laundry - checking for accumulated dust or dirt. Once a PLACE assessment is complete and the report made, it was important to display the report on notice boards so that the information is available to all. Colista Gaskin then outlined the challenges when the estates and facilities contracts transferred to LPT in November 2022. The first challenge was around the helpdesk team (responsible for all the facilities and maintenance of space calls) who did not transfer over to LPT. Therefore, new job descriptions were created, a brand new helpdesk team were recruited and supported with training, all whilst existing managers covered the helpdesk calls. Due to the inaccurate workforce data provided by the previous provider, a recruitment strategy was devised to fill vacancy gaps of over 300 hours. This gap impacted on the ability to deliver the required standards of cleanliness, maintenance and catering etc but as a solution, a careers event and Job Centre career days were attended, and linking in with local colleges took place where LPT was promoted as an organisation to work.

	Alongside the onboarding to substantive posts, negotiations with agencies about rates of pay, onboarding agency staff to an estates and facilities bank and existing vacancies took place which reduced the agency spend to zero. In addition to using agency, the existing workforce was relied upon with the use of overtime and additional hours which presented not only a financial pressure but also impacted on staff health and wellbeing. Given the known fact that the workforce is not only of a diverse demographic but also an ageing one there were further challenges of staff retiring which created more vacancies. On transfer of staff, the amount of inadequate equipment staff had was another barrier, but LPT has invested heavily in procuring new equipment so that cleanliness standards could be met. Technology had also posed challenges as staff had been using paper-based systems so, prior to transfer, training was arranged to prepare staff for the transition to electronic systems. Another challenge included the legal and statutory requirement to ensure staff had up to date DBS or Right to Work documents and mandatory training compliance. It was noted the majority of staff had been through enormous change while still being employed in the same role, having been transferred approximately four times to different organisations over the last ten years. Throughout this time, the culture had manifested itself whereby the term 'forgotten service' had been articulated as staff felt devalued, forgotten about and underappreciated. Following the transfer to LPT, it became apparent that staff had been left to their own devices, so implementing LPT policies, processes and ways of working had presented some obstacles. Some of the staff transferred over were illiterate, disabled, neurodiverse or English was not their first language. To address this, welcome events had been arranged where staff were met and greeted by senior managers and advised to speak up about any issues or concerns. Out of these welcome events one concern raised was that communication was a barrier and visibility of management was lacking. In response, a monthly estates and facilities newsletter has been created, suggestion boxes have been implemented, an estates and facilities WhatsApp group has been created, an employee of the month has been implemented and drop-in sessions to raise visibility of management. In addition, working with staff networks including REACH (Race, Ethnicity and Cultural Heritage) to target key hotspot areas has taken place as well as signposting and working with colleagues to promote their English and Maths with courses as well as carrying out risk assessments to identify any reasonable adjustments within the workplace. Loughborough Hospital staff had been asked what it was like to work for LPT, and the overwhelming response was that they enjoyed work, felt more included and listened to and worked well as a team supporting each other locally as well as feeling the support of the wider management team. Richard Brown concluded that the transformation had only been possible because of the team in LPT, and the aim was to continue on the significant progress already made. Finally, he reminded all of the National Healthcare Estates and Facilities Day taking place on 18 June 2025 and added how proud he was of the whole estates and facilities team and the work achieved on a daily basis to deliver a great service for patients, visitors and staff.

The Chair thanked the team for such a fantastic presentation which had highlighted the importance of a decision taken to bring a service in-house and all the improvements being made.

James Mullins added his thanks and in particular the PLACE recognition of being seen as the cleanest mental health trust in the country being testament to the team and what they had achieved.

Angela Hillery also echoed her thanks and was proud of the journey and transformation and sense of continual improvement. In terms of career progression, she believed this was something that could be shared with others in LPT as well as the Care Quality Commission.

Faisal Hussain echoed the comments made and reflected on the difficult decision-making involved in bringing the service in-house, stating how clear the vindication was from that journey and also offered thanks for the work around integration of staff and associated challenges. He then asked whether staff felt a sense of belonging and benefit from some of the support change programmes offered. Helen Walton responded that locally the teams absolutely felt like they were part of the LPT family, felt more informed, appreciated and were enjoying their work.

Sharon Murphy commented on the breadth of services provided and asked how the team worked together so quickly to deliver such high standards. Helen Walton advised that investment in equipment made a big difference to staff as they feel valued and feel like they are being invested in both personally and as a service but that having the right equipment in the right place at the right time enabled staff to do their jobs efficiently and to have pride in their work.

Liz Anderson was particularly impressed by the use of patients as PLACE assessors and thanked the team for their commitment to that and asked how diverse members of the team were being supported. Tanya Hibbert thanked the whole team for their presentation but felt Helen Walton who always goes ‘above and beyond’ and leads by example warranted a special mention and Hetal Parmar asked how the good work would be captured for the wider benefit of LPT. In summary, how staff were encouraged to speak up particularly those who have different challenges, how people get involved in PLACE assessments and how learning was captured.

Helen Walton provided an update on efforts to promote inclusivity and embed the values of LPT. She highlighted the extensive training in place including the development of bespoke sessions tailored specifically for staff. Helen noted a cultural shift, explaining that while the team had historically tended to “put up, shut up, and make do” there has been a significant increase in staff speaking up. This improvement is attributed in part to growing confidence amongst staff, who now feel heard and acknowledged.

Nick Adams reported on collaborative work with the patient experience team to involve patients, carers and service users in PLACE assessments. He emphasised ongoing communication with assessors from previous years, providing updates on identified issues, actions taken and associated

	timescales. Also described was an interactive training session that was developed for potential assessors, after which participants may choose whether to take part in future assessments. Colista Gaskin outlined the next steps, which will focus on implementing reasonable adjustments and exploring various avenues of support. She shared the positive outcomes of a recent team time out session conducted face to face, which was described as fun and interactive. The Chair expressed sincere thanks to all present and extended appreciation to the wider team on behalf of the Board. She commended the team for providing a comprehensive overview of a significant change programme, which included structural changes and the integration of new colleagues into the organisation and acknowledged efforts made to ensure new staff feel a sense of belonging, particularly those who had previously felt like a 'forgotten service'. Colleagues were encouraged to share today's messages with their teams reinforcing they are a vital and integral part of the organisation and asked, if possible, that a portion of the meeting recording be made available for dissemination to the wider team.
TB/25-6/003	**Questions from the Public (verbal)** There were no public questions.
TB/25-6/004	**Declarations of Interest (Paper A)** There were no declarations of interest in respect of items on the agenda. **Resolved:** The Board received this report and noted the declarations of interest contained within.
TB/25-6/005	**Minutes of Previous Public Meeting held 25 March 2025 (Paper B)** The minutes were approved as an accurate record of proceedings. **Resolved:** The Board approved the minutes.
TB/25-6/006	**Matters Arising (Paper C)** TB/24-5/216 action to be closed with the exception of the last bullet point, pending an update from the scheduled meeting on 17 June 2025 with the People's Council. TB/24-5/219: agreed to close action. **Resolved:** The Board received this report for information and assurance.
TB/25-6/007	**Trust Board Workplan 2025/26 (Paper D)** Kate Dyer presented the workplan which identified proposed revisions around plans for the new Group board agenda and would be subject to ongoing revisions. No questions or queries were received. **Resolved:** The Board received this report and supported the revisions identified.
TB/25-6/008	**Chair's Report (Paper E)** The Chair presented this report which summarised Chair and Non-Executive Director (NED) activities and key events relating to the well-led

	framework for the period April-May 2025. The following key points were highlighted:- • Work was ongoing for the Fit and Proper Persons Test (FPPT) which had a submission deadline of 27 June 2025. • Hetal Parmar had been re-appointed for a 3-year term. • This was Alexander Carpenter's last board meeting and thanks were offered for his contribution over the last 3 years - Alexander was sad to leave and thanked all for their support over the years. • From 1 June 2025 Melanie Hall would be a formal voting member of the board and was welcomed again. • A Together Against Racism (TAR) event had recently taken place which was a great opportunity to work with NHFT partners and share programmes of work. • Manjit Darby shared her appreciation for the recent Eid event describing it as one of the most outstanding events she has attended at LPT and praised the enthusiasm and organisation of the event and wished to formally and publicly extend her thanks to all involved. **Resolved:** The Board received this report for information.
TB/25-6/009	**Chief Executive's Report (Paper F)** Angela Hillery introduced this report which provided an update on current local issues and national policy developments since the last meeting. Key points highlighted were:- • Thanks were offered to all staff and volunteers during what has been a very busy period. • National developments were ongoing with changes to Integrated Care Boards (ICBs) and the work underway regarding performance assessment frameworks which would be applicable to LPT. • A change regarding the University Hospital Association's position, with NHS Providers assuming that particular responsibility, represented a significant development and the transition would be monitored closely. • All were encouraged to talk about the Group Strategy and its new vision when undertaking service visits. • Solar panels had been installed in some of LPT's community facilities which was important not least because of the sustainability factors but the value-based approach in providing efficiencies. • The TAR event with Group partners, Northamptonshire Healthcare Foundation Trust (NHFT), was an important face to face event to not only celebrate progress but also to challenge ourselves to improve. TAR continues to be a key priority across the Group and organisation. Josie Spencer commented on how she was pleased to see the development at Beaumont Leys of the audiology service and the Chair wondered how the development of the technical support service for the Central Access Point (CAP) launched in April 2025 was progressing. Tanya Hibbert responded the service was picking up momentum with a lot more people texting directly for support, especially those not comfortable using the telephone as a method of communication. This was a national initiative and LPT was amongst the first trust to go live.

	Resolved: The Board received this report for information.
TB/25-6/010	**Environmental Analysis (Verbal)** Angela Hillery provided an update on the ongoing Care Quality Commission (CQC) transformation programme highlighting that Chief Inspectors had now been appointed and the shift back towards specialist areas is becoming more evident as part of that transformational journey. As part of the East Midlands Alliance, collaboration with key partners continued including holding learning events with another one currently being planned around October 2025. One of the Alliance Partners, St Andrews Healthcare, had recently undergone a CQC inspection of its medium secure wards and received a rating of 'Requires Improvement' – this was brought to Board's attention for awareness. Jean Knight reported that no Health and Wellbeing Board (HWB) meetings had taken place since the last LPT Board meeting. However, she highlighted that board members had conducted twenty visits across various services, about which positive feedback had been received. Follow up discussions are taking place within the Executive Management Board (EMB) to consider any resulting actions. Faisal Hussain queried whether any issues arising from the St Andrews CQC report required further attention and whether support was being provided in relation to their action plan. Angela Hillery stated that the IMPACT Collaborative, led by Nottinghamshire Healthcare, would be working directly with St Andrews on the improvement plan. Additionally, as a Group, any action plans emerging from this process would be reviewed to identify and apply any relevant learning.
TB/25-6/011	**Board Assurance Framework (Paper G)** Kate Dyer presented this report which contained strategic risks and was presented as part of a continuing risk review process. The report identified the area of the Thrive strategy which has the highest amount of risk as 'E' (efficient and effective) and within that, there were three areas of high risk; estates and capital funding and financial position but also there are high risks across some other elements of the strategy including access to services, patient safety, workforce and digital. The Chair sought clarification on recommendation 6.4, specifically whether the organisation is yet in a position to assess the implications and potential risks associated with the corporate cost reduction which may in turn introduce additional risk. In response, Sharon Murphy explained that while the corporate cost reduction forms part of the overall financial plan, it is not being treated in isolation. The associated risks are considered collectively within the broader context of the financial plan but emphasised the importance of being able to demonstrate to NHS England the measures taken to meet the financial targets that have been set. Faisal Hussain commended the clarity and structure of the report, noting the new layout made it easier to follow and effectively aligned with the new THRIVE strategy and expressed thanks for the work undertaken.

	Josie Spencer requested clarification regarding reporting mechanisms specifically in relation to escalation to the Group trust board. Kate Dyer confirmed that Level 1 committees would continue to receive the full Board Assurance Framework (BAF) until such time as governance arrangements are formally revised. **Resolved:** The Board received this report for information and assurance.
TB/25-6/012	**Risk Appetite Statement 2025-26 (Paper H)** Kate Dyer presented this report which outlined the refreshed board appetite for risk management in 2025-26 determined by the Board at its development session in April 2025. She explained that risk appetite refers to the type and amount of risk the organisation is willing to accept in pursuit of its strategic objectives. A tailored matrix has been developed to ensure it is relevant, understandable, and applicable to decision-making across the organisation. As an organisation, LPT had chosen to consolidate the previous categories of 'quality' and 'safety' into a single 'quality' category. This reflected the Trust's embedded approach to patient safety, which is considered a fundamental factor in all decision-making, regardless of the risk type. She further explained that an 'open' risk appetite provides flexibility to be innovative and adaptive while still maintaining appropriate controls. The matrix narrative reflected the range and rationale for this approach. Hetal Parmar sought clarification regarding the interpretation of open risk appetite noting that while it represented the maximum level of risk tolerance there will be situations – particularly those involving compliance with legislation – where the organisation may choose to take a more cautious stance. Additionally, there may be exceptional circumstances where a more eager approach is necessary due to external pressures. Hetal emphasised the importance of recognising that the open appetite is a maximum threshold and should be applied contextually across different risk types. In response, Kate Dyer confirmed that the Trust's risk appetite framework allowed for flexibility up to the level of 'open' appetite and was intended to support innovation and adaptability while ensuring risks are assessed comprehensively, as risks rarely occur in isolation. The aim is to enable the organisation to make difficult decisions where appropriate while continuing efforts to minimise existing risks. The Chair emphasised the risk appetite matrix should be viewed as a decision-making tool for the Board. The key aspect is to provide clear rationale – how and why the defined appetite is being applied in specific situations – to support effective governance and assurance. **Resolved:** The Board received this report and supported the risk appetite approach for 2025-26.
TB/25-6/013	**Audit and Risk Committee AAA Highlight Report: 17 April 2025 (Paper I)** Hetal Parmar introduced this report and advised this particular Audit and Risk Committee (ARC) was primarily focused on reviewing the draft annual governance statement and draft annual accounts. There was a good level of scrutiny and ARC members felt a high level of assurance around

	financial processes and governance. **Resolved:** The Board received this report for information and assurance.
TB/25-6/014	**Step up to Great Strategy Close Down Report (Paper J)** Alison Gilmour presented this report which formally closed down the Trust's legacy strategy, Step up to Great (SUTG). SUTG was launched in 2019 with a refresh post-Covid in 2021. A few examples of the achievements were highlighted as:- Great Outcomes: • Access to services • Attainment of Group Associate University Hospital Trust status Great Care: • Patient Care and Race Equality Framework governance and the approval of a programme of transformation and quality improvement work. • Implementation of the Privacy and Dignity Standard. • Completion of the Dormitory Eradication Programme. Part of the Community: • Commitment to the role as anchor organisations • New Social Value and Sustainable Procurement Policy recently developed. • Pressure ulcer improvement work. Great Place to Work: • NHS Staff Survey results evidenced improvements. • Successful Together Against Racism work tackling racism and discrimination. Angela Hillery commended the progress made through the development and implementation of SUTG noting that it helped staff feel connected across the organisation. She expressed her appreciation to all those involved and highlighted the importance of both reflecting on past achievements and looking forward with enthusiasm to the new THRIVE strategy. Manjit Darby acknowledged the strong narrative that demonstrated the extent of work undertaken and achievements delivered. However, she raised the importance of learning from the strategy's implementation – specifically, identifying which objectives were successfully delivered and which were not. The Board's continued engagement with the strategy and its understanding of the progress made was noted whilst a key challenge moving forward will be to remain agile, ensuring the strategy continues to address the right areas and remains responsive to the evolving context in which the organisation operates. Liz Anderson remarked on the strength of integration within the strategy's thematic threads, describing the transition as both seamless and

	meaningful noting it did not feel like a sharp departure but rather a thoughtful evolution. The Chair also reinforced this view, stating that the strategy reflects where the organisation stands today compared to five years ago. She highlighted the importance of retaining learning from the previous strategy, SUTG, while recognising THRIVE as a strong platform to focus on new priority areas and celebrate recent achievements. Faisal Hussain shared that he derived significant assurance from the learning journey through SUTG and the transition to THRIVE, which began during Board Development sessions. He noted that key performance indicators (KPIs) and the outcomes of strategic actions had been captured throughout the process and recognised the extensive stakeholder engagement led by David Williams and his team, noting that feedback was regularly reported to the Board and had played a crucial role in shaping the strategy. Alexander Carpenter felt that retrospective perspectives could be explored particularly in relation to how different populations and groups experienced the transition from SUTG to THRIVE. It was noted that a recurring theme throughout the development of the THRIVE strategy was the positive engagement, with many expressing they did not feel a sense of loss in the transition. The shared responsibility across the organisation to ensure THRIVE is understood, consistently communicated, and embedded in individual roles and daily practice was emphasised. The Chair concluded by formally thanking all individuals and teams who contributed to the development of the THRIVE strategy. **Resolved:** The Board received this report and approved the closure of the Step up to Great strategy.
TB/25-6/015	**Quality and Safety Committee AAA Highlight Report: 15 April 2025 (Paper K)** Josie Spencer introduced this report and drew attention to the following:- • The publication of a new 'staying safe from suicide' guidance by NHS England – with Bhanu Chadalavada taking this work forward. • The ongoing work around the quality and safety dashboard was coming to fruition and it was anticipated the live data would be received at its next meeting in June. • Two sets of Terms of Reference were approved; one for the Safety Forum and one for the Quality Forum. • The safety assurance report highlighted an item around work in terms of substance misuse and homicides and a quality summit is planned with Turning Point to try and identify individuals who have substance misuse as part of their clinical presentation. • Community health services having had no category 4 pressures sores in 2025 – this was a fantastic achievement. • Work with the CAMHS services and ChatHealth had also received positive feedback. • The Quality and Safety Committee now holds an additional meeting to look at various annual reports; this was held on 20 May 2025 which was too late for this Board meeting, but formal assurance will be provided for

	the next Board in July. **Resolved:** The Board received the report for information and assurance.
TB/25-6/016	**Safe Staffing Report (Paper L)** James Mullins introduced this report which provided a full overview of nursing safe staffing during the month of March 2025, including a summary and update of new staffing areas to note, potential risks and actions to mitigate the risks to ensure safety and care quality are maintained. This report triangulated workforce metrics; fill rates, Care Hours Per Patient Day (CHPPD), quality and outcomes linked to Nurse Sensitive Indicators (NSIs) and patient experience feedback. Key points highlighted were:- • The temporary workforce utilisation rate has decreased by 0.32% and trust wide agency usage has decreased overall. Any continued agency usage was due predominantly to acuity dependency and enhanced observations. • A review of the Nurse Sensitive Indicators had seen an increase in the number of falls incidents; one of those falls was reported as moderate harm and the remaining were reported as either low or no harm. • There is some work ongoing to review falls data and reduce harm to patients • The Registered Nurse (RN) vacancy position saw a decrease since February and turnover rate remained at 5.6% which was below the trust target of 10% • The Healthcare Support Worker (HCSW) vacancy position saw a decrease of 1.9% since February with the turnover rate being below the internal trust target of 10%. Josie Spencer was encouraged by the information contained within this report and acknowledged the progress made. She raised a query concerning the community nursing safer staffing tool and the ongoing community nursing improvement project, specifically she sought an update on key developments or areas of concern. In response, James Mullins confirmed the piece of work was currently undergoing due diligence to identify any challenges, opportunities and potential financial implications. He added the safer staffing matron is actively involved in a regional group focussing on the development of the tool facilitating valuable learning and sharing across the region. Further updates would be presented to EMB and QSC as the project progressed. Sam Leak informed members that a pilot had recently commenced in one of the community hubs and once data was available from the pilot, more detail would be shared. Liz Anderson queried the section on health and wellbeing particularly regarding support for staff redeployed from one ward to another. She observed that the report did not include information on the participation of these staff members in Schwartz Rounds at LPT which are intended to support wellbeing, and asked whether this data could be made available. James Mullins confirmed this could be included in future reports. Noting the challenges presented, Faisal Hussain raised how the trust was supporting the wellbeing of leaders who, even in fully staffed areas, must dedicate time to mentoring newly qualified staff. James Mullins responded

	that directorate level support structures were in place to provide space and support for leaders. Sam Leak added that a supernumerary induction process was in place for new staff, meaning they are not counted in staff numbers until they have completed their induction and achieved the required competencies for ward-based work. **Action:** Data on participation of staff in Schwartz Rounds to be included in future reports. **Resolved:** The Board received this report for information and assurance.
TB/25-6/017	**Patient Safety Report (Paper M)** James Mullins presented this report which provided assurance of the efficacy of the incident management and Duty of Candour compliance processes. Incident reporting supporting this paper had been reviewed and refreshed to assure that systems of control continued to be robust, effective, and reliable thus underlining the commitment to continuous improvement of incident and harm minimisation. The report also provided assurance around Being Open, numbers of investigations and the themes emerging from recently completed investigation action plans, a review of recent Ulysses incidents and associated lessons learned. Key areas were highlighted as:- • The highest number of reported patient safety issues was tissue viability during March and April with 732 incidents in total; this was not just about pressure ulcers but about skin tears, wounds and moisture associated skin damage - lots of targeted improvement initiatives were taking place. • There had not been any category 4 pressure ulcers for 12 months which is phenomenal. • There were 255 falls during March and April which was 8.42% of all reported incidents. • Improvement work was taking place to look at the correlation between falls and medicine prescribing. An audit was undertaken in the Mental Health Services for Older People and Community Health Services (CHS) wards which demonstrated a clear causal link between prescribing and falls. The Falls Reduction Group and Pharmacy were progressing this work. • There were 221 incidents reported during March and April. Incidents reported under the category of 'medication omissions without medical guidance' made up 6.5% and the directorate teams and medication safety group have been asked to review this to understand the circumstances and actions required. • Challenges continued in relation to incidents, with 55 reports (at 17 April 2025) having not been completed within timescales. Most of these were in draft stage and very close to completion. A new trust wide tracker tool had been developed for the patient safety reports. Sam Leak queried what would be considered a 'normal' level in terms of reported incidents, acknowledging the aspiration to achieve zero harm but questioning whether benchmarking with other organisations was currently being undertaken. She posed the same question in relation to tissue viability incidents noting that while the report indicates normal variation, the definition of 'normal' remained unclear. James Mullins clarified he was not raising a specific concern and explained that statistical process control

	(SPC) charts are used to monitor incident trends focusing on mean scores to identify variation. He agreed that benchmarking would provide additional context and offered to include benchmarking data in future reports. With regard to tissue viability, similar principles applied and lots of pressure ulcer groups worked together across NHFT and LPT which offered valuable opportunities for benchmarking and concluded that the best way to provide assurance going forward would be through the inclusion of benchmarking data in reports. The Chair noted the reference to 'normal' in the report related to internal data trends and was therefore consistent with patterns previously observed within the organisation and felt it would be beneficial to cross-check this internal 'normal' against data from other organisations to ensure it is not out of alignment externally. She emphasised that while the prevention and minimisation of incidents remained a priority, it was equally important to recognise that the number of incidents reported is not, in itself, the most critical metric. Rather, the level of harm resulting from those incidents was of greater significance. Additionally, the Chair highlighted the importance of maintaining a culture that encourages incident reporting. Faisal Hussain raised the importance of prevention in relation to tissue viability emphasising that prevention is better than treatment or cure and asked whether education support is incorporated into the wider wraparound care provided to patients and carers. Liz Anderson enquired about the learning outcomes resulting from investigations noting that while learning is taking place, there was currently limited visibility on how many staff have undertaken relevant training and sought assurance that staff are attending the necessary courses and that the training is translating into improved practice. Josie Spencer added that once the Quality Dashboard is fully operational, it would provide data to help measure the effectiveness of learning and the extent to which it is driving change. With regard to prevention, education and measuring learning effectiveness, James Mullins advised of a quality improvement project currently underway between NHFT and LPT that included input from families and service users which was focussed on prevention and education. That project was expanding with increasing data and assessing the effectiveness of learning remained an ongoing priority. Josie Spencer referred to the section of the report which outlined patient deaths and 45 reported incidents. The figure was concerning and highlighted the absence of contextual information including how the number compared to other organisations. James Mullins acknowledged the point and confirmed that further analysis would be required. He advised that the figure would be reviewed and brought to QSC for further scrutiny. **Action** 1. Benchmarking data in relation to reported incidents/tissue viability to be included in future reports. 2. Analysis of data on patient deaths to be reviewed at QSC and reported back to Board through Committee Highlight Report. **Resolved:** The Board received this report for information and assurance.

TB/25-6/018	**Independent Mental Health Homicide Review into the tragedies in Nottingham – actions and next steps (Paper N)** James Mullins presented this report which provided an update on the learning from the Section 48 review of homicides in Nottinghamshire Healthcare Foundation Trust. It was noted that this report (Paper N) and the next report (Paper O) dovetailed, however for clarity, this report described the work undertaken internally whereas the next report described work undertaken as a system. James Mullins explained the background to this review and highlighted the summary of key actions detailed in the report. He drew particular attention to the 'DNA/Was not brought' policy and risk assessment training which has been updated noting this was a significant and key part of the learning. **Resolved:** The Board received the report for information and assurance.
TB/25-6/019	**Progress Update – Midlands Region Clinically Led Review of LLR ICB Intensive and Assertive Community Mental Health Treatment Action Plan (Paper O)** Tanya Hibbert presented this report which provided an update on progress made against an action plan that was developed following a request by NHS England in 2024. The action plan was in response to a local self-assessment undertaken by Leicestershire Partnership NHS Trust (LPT), Leicester, Leicestershire and Rutland (LLR) Integrated Care Board (ICB), Local Authorities (LAs) and wider stakeholders in July 2024, of policies and practices in place for patients with serious mental illness requiring intensive community treatment and follow-up, but where engagement is a challenge. NHS England requested ICB and provider boards to maintain oversight of action plans underway. The action plan remains incomplete with several actions still in progress alongside associated risks and mitigations that are being actively managed. It was important to note that LLR are only one of three mental health organisations that have a dedicated assertive outreach team which means that LPT scored strongly when the NHS England team did a review of the self-assessment against services but nonetheless, continuous improvement remained a priority. It was acknowledged that NHSE had set a clear expectation for provider boards to maintain ongoing oversight of the action plan and progress against it. Following discussion, it was agreed that updates would be provided to QSC which in turn would ensure board is kept informed via its AAA highlight report. **Resolved:** The Board received the report for information and assurance.
TB/25-6/020	**Finance and Performance Committee AAA Highlight Report: 15 April 2025 (Paper P)** Alexander Carpenter introduced this report and drew attention to the following:-

	• The pressure on waiting lists particularly the over 52wk waits continued - the committee discussed undertaking a deep dive to improve this position and this would be taken forward. • The delivery of the 2024-25 financial position was formally recognised and thanks were offered to the finance team to help deliver that position. • An information sharing agreement with LPT and three Universities was positive in relation to bringing through students. **Resolved:** The Board received the report for information and assurance.
TB/25-6/021	**Finance Report – Month 1 (Paper Q)** Sharon Murphy introduced this report which provided an update on the Trust financial position for the period ended 30 April 2025. Key points were highlighted as:- • This was a high-level summary report as teams were still focusing on closing the 2024-25 annual accounts. • For month one of 2025-26, income and expenditure was reporting a £601k deficit which is delivering the financial plan. • All the clinical directorates are showing overspends but it was too early in the year to draw conclusions from this performance. • The cost efficiency plan this year is set at £28.4m which is the highest level of CIPs ever included in a financial plan - £5m of schemes were still outstanding. • The aim was to identify £8m worth of mitigations to give some headroom to manage any in-year pressures. • The positive downward trajectory continued relating to agency spend. • The initial plan for capital approved by board was £15.6m – this is now currently £18.7m but this was pending final confirmation from NHSE around some bids (with total £4.9m). • There was more risk around the cash position this year so more detail was included within the report. In lieu of a statutory target around external financial limits, LPTs own internal target to maintain number of operating days cash, has been set at 11 days. Faisal Hussain referred to the Better Payment Standards noting the 87% of delayed invoice payments and queried whether systems were in place to improve performance. Sharon Murphy responded that the matter had been discussed at ARC in the context of 2024-25 accounts performance and explained that where a single item on an invoice is disputed, it can delay payment of the entire invoice. The finance team was currently engaging with external auditors to explore whether approval dates can be separated by individual invoice components which would allow for a more accurate reflection of payment performance. The Chair acknowledged that delivery of CIP remained the biggest risk and requested Sharon Murphy's perspective on the current position. Sharon Murphy explained that discussions continued to maintain focus on CIP delivery but while efforts were underway, known gaps persist – particularly in relation to workforce reductions. She expressed confidence that the gap can be reduced but acknowledged whether it can be fully closed remained uncertain.

	Resolved: The Board received this report for information and assurance.
TB/25-6/022	**Performance Report – Month 1 (Paper R)** Sharon Murphy presented this report which provided an overview of the Trust's performance against Key Performance Indicators (KPIs) for April 2025. The information contained within the exception reports matrix summary showed six special cause concerns, however three of the metrics had been removed as they were linked to disaggregation of children and young people metrics - which will include more detail this year so will be put back in for next month's report along with the associated SPC charts. There has been some positive movement in terms of stroke and neuro performance which is reflected in the exception matrix. All of the changes proposed for the performance report were highlighted in the cover sheet and all other metrics remained stable. Josie Spencer explained it was necessary to search through the report to locate key data and requested future cover sheets include a more detailed narrative to improve accessibility and clarity. Sharon Murphy agreed and confirmed she would provide this feedback to the relevant team. Hetal Parmar referred to the reduction in inappropriate out of area placement bed days and whether the cause of this significant shift was known. Sharon Murphy confirmed the reduction was primarily due to the closure of the Belvoir Unit and seasonal winter pressures. She also noted that works currently underway on the Belvoir Unit were likely to result in these numbers remaining steady in the near term. She advised there was a trajectory to reduce inappropriate out of area placements, which is a key metric included in the planned submissions to NHS England for the current year. Performance would be monitored against this trajectory moving forward. **Action:** Future cover sheets to include a more detailed narrative summary. **Resolved:** The Board received this report for information and assurance.
TB/25-6/023	**People and Culture Committee AAA Highlight Report: 9 April 2025 (Paper S)** Manjit Darby introduced this report and drew attention firstly to the good assurance from both the Workforce Development Group and the Accountability Framework Meeting related to areas of non-compliance. Secondly, a detailed review of Our Future Our Way took place where the whole team provided an overview of work undertaken, its achievements, delivery and ambition moving forward. Thirdly the first Freedom to Speak Up report was received and the PCC/QSC chairs were clear on how the interface will be managed moving forward. Finally, it was greed that PCC should focus on early warnings in relation to dashboard and indicators to understand the impact on the workforce of future cost efficiency plans. In relation to the staff survey findings, Angela Hillery noted the people promise indicators being above average, which is phenomenal. Manjit Darby acknowledged this should have been included in the celebratory

	section of the report. **Resolved:** The Board received the report for information and assurance.
TB/25-6/024	**Review of risk – any further risks as a result of board discussion?** No further risks were identified as a result of the discussions in today's meeting.
TB/25-6/025	**Any Other Urgent Business** There was no other business.
TB/25-6/026	**Papers/updates not received in line with the work plan:** • Trust Board Development Programme *(deferred)* and Joint (Group) Development Programme – *transferred to Group Trust Board Workplan* • Trust Board Annual Effectiveness Review and Terms of Reference – *deferred* • East Midlands Alliance Common Board paper – *transferred to Group Trust Board Workplan* • Provider Licence Compliance – *transferred to Audit and Risk Committee* • THRIVE Strategy Update – *transferred to Group Trust Board Workplan* • Charitable Funds Committee AAA Highlight Report: 18 March 2025 – *deferred*
Close – date of next public meeting: 29 July 2025	

C

Leicestershire Partnership NHS Trust

TRUST BOARD 29th July 2025

MATTERS ARISING FROM THE PUBLIC TRUST BOARD MEETING HELD 27th May 2025

All actions raised at the Trust Board will be included on this Matters Arising action log. This will be kept and updated by the Deputy Trust Secretary. Items will remain on the list until the action is complete and there is evidence to demonstrate it. Each month a list of matters arising will be provided with the Board papers, for report under this item. The list will not include where evidence has been provided (and therefore can be closed). Red = incomplete, amber = in progress, green = complete

Meeting date and minute ref	Action/issue	Lead	Due date	Outcome/evidence - actions are not considered complete without evidence
TB/24-5/216	How the voice of patients/experts by experience - feedback to be provided following scheduled meeting with the People's Council on 17 June 2025.	Faisal Hussain	21.07.25	The People's Council meeting for 17th June was postponed. FH was unable to attend the rearranged meeting owing to prior commitments. Therefore, FH met with Alison Kirk to ensure feedback was provided to the People's Council on this. She advised that at the rearranged meeting a full discussion was had on this matter and People's Council was agreed on ensuring feedback of patients/ service users was given through the existing and established mechanisms rather than placing additional burdens on them. Action Complete.
TB/25-6/016	Safe Staffing Report – data on participation of staff in Schwartz Rounds to be included in future reports.	James Mullins	21.07.25	Schwartz rounds included in the Safe Staffing report presented to Q&S Committee (June 2025).
TB/25-6/017	Patient Safety Report - 1. Benchmarking data in relation to reported	James Mullins	21.07.25	Emma Wallis confirmed she has asked report author to incorporate data in future reports.

Meeting date and minute ref	Action/issue	Lead	Due date	Outcome/evidence - actions are not considered complete without evidence
	incidents/tissue viability to be included in future reports. 2. Analysis of data on patient deaths to be reviewed at QSC and reported back to Board through Committee Highlight Report.	James Mullins/ Josie Spencer	21.07.25	Analysis presented to Q&S Committee in June 2025. Deep dive scheduled to be presented to Safety Forum (July 2025) and further analysis at Q&S Committee (August 2025)
TB/25-6/022	Performance Report – future cover sheets to include a more detailed narrative summary.	Sharon Murphy	21.07.25	Front sheet has been updated to include key SPC metric exceptions movements. Action Complete

D

Leicestershire Partnership NHS Trust

LPT Trust Board Workplan 2025/26 v8

(Workplan last approved 27 May 2025 Trust Board)

Date of Meeting	Frequency/ Lead	27-May-25	24-Jun-25	29-July-25	30-Sep-25	25-Nov-25	27-Jan-26	31-Mar-26
Theme		Enabling	EGM (LPT Dev)	CHS	DMH	FYPCLDA	Enabling	CHS
Standing Items								
Service Presentation (20mins)	Every meeting	X		X	X	X	X	X
Patient and Carer Voice (10mins)	Every meeting	X		X	X	X	X	X
Staff, Student (University Focus) and Volunteer Voice (10mins)	Every meeting	X		X	X	X	X	X
Questions from the Public	Every meeting	X		X	X	X	X	X
Declarations of Interest Report	Every meeting	X		X	X	X	X	X
Declarations of Interest in respect of items on the agenda	Every meeting	X		X	X	X	X	X
Minutes of the previous Meeting	Every meeting	X		X	X	X	X	X
Matters Arising (Action Log)	Every meeting	X		X	X	X	X	X
Trust Board Workplan	Every meeting	X		X	X	X	X	X
Chair's Report	Every meeting	X		X	X	X	X	X
Chief Executive's Report	Every meeting	X		X	X	X	X	X
Environmental Analysis *(internal and external factors impacting on the Trust & risk-based items)*	Every meeting	X		X	X	X	X	X
Chief Executive's Verbal Update ***(Confidential Agenda)***	Every meeting CEO	X		X	X	X	X	X
Environmental Analysis	Every meeting	X		X	X	X	X	X

T H R I V E

Date of Meeting	Frequency/ Lead	27-May-25	24-Jun-25	29-July-25	30-Sep-25	25-Nov-25	27-Jan-26	31-Mar-26
Theme		Enabling	EGM (LPT Dev)	CHS	DMH	FYPCLDA	Enabling	CHS
(Confidential Agenda)	CEO/MD							
Governance and Assurance								
Board Assurance Framework	Every meeting Dir Gov & Risk	X		X	X	X	X	X
Audit and Risk Committee AAA Report	Quarterly Chair, ARC	X (17.4.25- ARC EGM)		X *(13.06.25)*	X (12.09.25)		X (05.12.25)	X (06.03.26)
Audit and Risk Committee Annual Effectiveness Review, ToR and Workplan	Annual Chair, ARC				X			
Trust Board Annual Effectiveness Review, Terms of Reference	Annual Dir Gov & Risk	~~X~~ Deferred to July		~~X~~ Deferred to Sept	X			
Trust Board Development Programme	Annual Dir Gov & Risk	~~X~~ Deferred to July		X				
Annual Review of Board Assurance Framework and Risk Appetite	Annual Dir Gov & Risk							X
Remuneration Committee Annual Effectiveness Review *(Confidential Agenda)*	Annual Chair			X				
LPT well led action plan - time limited item *(Confidential Agenda)*	Every meeting Dir Gov & Risk	X		X	X	X	X	X
Strategy and System Working								
No items								
Quality, Safety and Compliance								

Date of Meeting	Frequency/ Lead	27-May-25	24-Jun-25	29-July-25	30-Sep-25	25-Nov-25	27-Jan-26	31-Mar-26
Theme		Enabling	EGM (LPT Dev)	CHS	DMH	FYPCLDA	Enabling	CHS
Quality and Safety Committee AAA Report	Every meeting Chair, QSC	X *(15.04.25)*		X *Year-end 20.05.25 mtg and 17.06.25*	X *(19.08.25)*	X *(21.10.25)*	X *(23.12.25)*	X *(17.02.26)*
Safe Staffing Monthly Report	Every meeting Interim DoN	X		X	X	X	X	X
Patient Safety Report (to include learning from deaths)	Every meeting Interim DoN	X		X	X	X	X	X
Freedom to Speak Up Annual Report *(FTSU Guardian to attend to present)*	Annual Managing Dir			X				
Complaints and compliments Annual Report	Annual Interim DoN				X			
Confidential Patient Safety Report ***(Confidential Agenda)***	Every meeting Interim DoN	X		X	X	X	X	X
Finance and Performance								
Finance and Performance Committee AAA Report	Every meeting Dir Fin & Perf	X *(15.04.25)*		X *(19.06.25)*	X *(21.08.25)*	X *(23.10.25)*	X *(22.12.25)*	X *(19.02.26)*
Finance Report	Every meeting Dir Fin & Perf	X		X	X	X	X	X
Performance Report	Every meeting Dir Fin & Perf	X		X	X	X	X	X
Charitable Funds Committee AAA Report	Quarterly Chair, CFC	~~X~~ ~~18.03.25~~ Deferred to July		X 18.03.25 and 26.06.25	X 11.09.25		X 19.12.25	X 13.03.26
Approval of Annual Financial Plan ***(Confidential Agenda)***	Annual Dir Fin & Perf							X
People and Culture								

T H R I V E

Date of Meeting	Frequency/ Lead	27-May-25	24-Jun-25	29-July-25	30-Sep-25	25-Nov-25	27-Jan-26	31-Mar-26
Theme		Enabling	EGM (LPT Dev)	CHS	DMH	FYPCLDA	Enabling	CHS
People and Culture Committee AAA Report	Every meeting Chair, PCC	X *(09.04.25)*		X *(11.06.25)*	X *(13.08.25)*	X *(08.10.25)*	X *(10.12.25)*	X *(11.02.26)*
National Staff Survey Results	Annual Dir HR & OD							X
Risk Based Items When Required								
Outline/Full Business Cases	As required							
CQC Inspection Reports	As required							
National/Local Reports	As Required							
Externally Commissioned Reports	As required							
System-wide Winter Planning	As required							
Award of legal contracts	As required							
Maintaining High Professional Standards in the NHS (MHPS)	As required							
Appointment of Senior Independent Director, Deputy Chair, Chairs of Committees	As required							
EGM Agenda								
Going Concern Assessment	Annual Dir Fin & Perf		X					
Audited Financial Accounts	Annual Dir Fin & Perf		X					
Letter of Representation	Annual Dir Fin & Perf		X					
KPMG ISA 260 and Auditors Annual Report	Annual Dir Fin & Perf		X					
Head of Internal Audit Opinion	Annual Dir Gov & Risk		X					
Annual Governance Statement	Annual Dir Gov & Risk		X					

Date of Meeting	Frequency/ Lead	27-May-25	24-Jun-25	29-July-25	30-Sep-25	25-Nov-25	27-Jan-26	31-Mar-26
Theme		Enabling	EGM (LPT Dev)	CHS	DMH	FYPCLDA	Enabling	CHS
LPT Quality Account 2024/25	Annual Interim DoN		X					
LPT Annual Report 2024/25	Annual Dir of HR & OD		X					

E

Leicestershire Partnership NHS Trust

Trust Board 29 July 2025

Chair's Report

Purpose of the Report

This is a regular report for information and accountability, summarising Chair and Non-Executive Director (NED) activities and key events relating to the Well-Led framework for the period June-July. Activities relating to formal Committees of the Board are reported through custom reports.

Analysis of the issue

Fit and Proper Person Test

The required Fit & Proper Persons checks for Board members have now been completed and taken through the appropriate internal governance channels in the Trust. Our submission to NHSE was made by 27 June deadline.

Chair/NED Appraisals, Recruitment and Succession Planning

Chair/NED appraisal discussions are now complete and a submission regarding the Chairs appraisal was made to NHSE ahead of 30 June deadline.

Having held the role of Chair at NHFT since 2016 and LPT since 2023, at the end of October 2025, I finish my final term and due to governance rules will need to stand down.

NHFT's Council of Governors is responsible for the recruitment of Chairs and Non-Executive Directors in NHFT; NHS England (NHSE) is responsible for recruitment in LPT. Together they made the decision to appoint Faisal Hussain as Interim Joint Chair of NHFT/LPT, taking up the position from November 2025. Faisal and I will work together over the coming months to ensure a smooth transition including succession planning for the roles and responsibilities that Faisal currently undertakes.

Board Development

We held a Board Development Workshop on 24 June focusing on the CQC Well-Led Quality Statements, which explored key themes and evidence in each area including Freedom To Speak Up; Capable, Compassionate and Inclusive Leaders and our Partnerships and Communities.

Working with Partners and Stakeholders

There have been many opportunities for System/ Group collaboration and learning from other organisations, for example, through:

- Leicestershire & Northamptonshire Academic Health Partners meeting
- Midlands NHS Leadership Meeting
- LLR Quality NEDs Network
- LLR UEC Collaborative

Public, Patient and Staff Engagement

Boardwalks and other Chair/ NED engagement activities in the period include attending/visiting:

- South Asian Heritage Month Celebration Event
- Long Service Awards
- Consultant Interviews
- Health & Wellbeing Champions Meeting
- Service Visit: Pharmacy
- Service Visit: MHSOP Therapy Team

All relevant meetings, events and visits for the period are detailed in Appendix A.

Proposal

The Board of Directors is invited to highlight any areas for discussion or clarification.

Decision required – Please indicate:

Briefing – no decision required	**Y**
Discussion – no decision required	
Decision required – detail below	

Governance table

For Board and Board Committees:	Trust Board July 2025	
Paper sponsored by:	Crishni Waring, Chair	
Paper authored by:	Sinead Ellis-Austin, Crishni Waring	
Date submitted:	2025	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	N/A	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	N/A	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	One off	
LPT strategic alignment:	**T** - **T**echnology	
	H – **H**ealthy Communities	
	R - **R**esponsive	Yes
	I – **I**ncluding Everyone	Yes
	V – **V**aluing our People	Yes
	E – **E**fficient & Effective	Yes
CRR/BAF considerations *(list risk number and title of risk):*	N/A	
Is the decision required consistent with LPT's risk appetite:	N/A	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	Incorporated in approach to recruitment and other activities	

Appendix A

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to Trust (I/E)
Chair	02/06/2025	NHSE Director of Strategic Transformation	E
Chair	02/06/2025	Leicestershire & Northamptonshire Academic Health Partners	E
Chair	02/06/2025	Director of Corporate Governance	I
Chair/Deputy Chair	02/06/2025	LPT/NHFT Deputy Chairs meeting	I/E
Chair	02/06/2025	Trust Board Agenda setting	I
Chair	03/06/2025	Midlands NHS Leadership Meeting	E
Melanie Hall	03/06/2025	Induction with Raising Health Charity Lead	I
Chair	03/06/2025	F2SU Guardian Meeting	I
Melanie Hall	04/06/2025	Monthly Team Brief	I
Melanie Hall	05/06/2025	THRIVE Masterclass	I
Chair	09/06/2025	Consultant Interviews	I
Deputy Chair/NEDs	09/06/2025	LPT NED Catch Up	I
Josie Spencer	10/06/2025	Service Visit: MHSOP Therapy Team	I
Josie Spencer	10/06/2025	F2SU Guardian Meeting	I
Chair	10/06/2025	UHL/UHN/LLR ICB/Northants ICB Chairs	E
Melanie Hall	10/06/2025	Induction with Comms Director	I
Manjit Darby	10/06/2025	REACH Network	I
Josie Spencer	11/06/2025	Celebrating Excellence Shortlisting	I
Faisal Hussain	11/06/2025	Boardwalk: Estates & Facilities at Loughborough Hospital	I
Chair	11/06/2025	NHS Confed Expo	E
Faisal Hussain	12/06/2025	Mental Health Chairs Weekly Conference call	E
Hetal Parmar	13/06/2025	Board Walk: PIER Team	I
Melanie Hall	13/06/2025	Site visit with FYPCLDA Executive Director	I
Chair	16/06/2025	Director of Corporate Governance	I
Faisal Hussain	16/06/2025	NHFT Associate NED Stakeholder Panel	E
Melanie Hall	20/06/2025	Induction with Managing Director	I
Faisal Hussain/ Hetal Parmar	20/06/2025	Seacole Group Meeting	E
Chair	23/06/2025	Long Service Awards	I
Faisal Hussain/ Chair	23/06/2025	Midlands Regional Chairs Briefing with Regional Director	E
Hetal Parmar	25/06/2025	GGI Events: Governing for public purpose in times of socio-political change	E
Faisal Hussain	25/06/2025	Aspirant Chairs Talent Programme Module 2	E
Melanie Hall	26/06/2025	Induction with MH Executive Director	I
Melanie Hall	26/06/2025	Induction with HR Executive Director	I

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to Trust (I/E)
Liz Anderson	27/06/2025	Board Walk: Paediatric Phlebotomy service Braunstone Health and Social Care Centre	I
Manjit Darby	27/06/2025	WeImproveQI Team	I
Chair	30/06/2025	Director of Corporate Governance	I
Chair	30/06/2025	Trust Board Agenda setting	I
Faisal Hussain	30/06/2025	Consultant Interviews	I
Liz Anderson	30/06/2025	LPT Associate Status Group Workstream Meeting for Improving Care We Deliver	I
Manjit Darby	30/06/2025	Long Service Awards	I
Faisal Hussain	02/07/2025	Business support meeting with Raising Health Fundraising Manager	I
Chair	03/07/2025	Group CYP Interview Panel	I/E
Melanie Hall	03/07/2025	Group CYP Stakeholder Panel	I/E
Chair	03/07/2025	10 Year Health Plan Town Hall	E
Melanie Hall	07/07/2025	Service Visit: Recovery College	I
Melanie Hall	09/07/2025	Service Visit: Pharmacy	I
Chair	14/07/2025	1:1 with CEO	I
Chair	14/07/2025	NHSE Director of Strategic Transformation	E
Chair/NEDs	14/07/2025	LPT NED Catch Up	I
Faisal Hussain	15/07/2025	NHFT Corporate Governance Meeting	E
Chair	15/07/2025	LLR ICB Chair	E
Josie Spencer	*15/07/2025	Service Visit	I
Josie Spencer	*16/07/2025	LLR Quality NEDs Network	E
Manjit Darby	*17/07/2025	LLR UEC Collaborative	E
Chair	*18/07/2025	South Asian Heritage Month	I
Chair/Deputy Chair	*21/07/2025	LPT/NHFT Deputy Chairs meeting	I/E
Faisal Hussain	*21/07/2025	Midlands Regional Chairs Briefing with Regional Director	E
Faisal Hussain	*21/07/2025	NHS Confed All Members Chairs Group	E
Faisal Hussain	*21/07/2025	NHFT NEDs Meeting	E
Melanie Hall	*22/07/2025	Service Visit: Estates	I
Chair	*22/07/2025	Director of Corporate Governance	I
Chair	*22/07/2025	UHL/UHN/LLR ICB/Northants ICB Chairs	E
Chair	*22/07/2025	UHL/UHN Chair	E
Chair	*22/07/2025	CEO 1:1	I
Faisal Hussain	*23/07/2025	Aspirant Chairs Talent Programme Pathway Group Meeting	E
Melanie Hall	*24/07/2025	Health & Wellbeing Champions Meeting	I
Faisal Hussain	*24/07/2025	NHFT Trust Board Development Workshop	E
Faisal Hussain	*24/07/2025	NHFT CoG/ Board Workshop	E

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to Trust (I/E)
Faisal Hussain	*31/07/2025	NHFT Trust Board Public Meeting	E
Faisal Hussain	*31/07/2025	NHFT Trust Board Private Meeting	E

*Planned at time of writing

Abbreviations:

CEO = Chief Executive Officer
CoG = NHFT Council of Governors
FYPCLDA = Families, young people and children's, learning disabilities and autism services
ICB = Integrated Care Board
ICS = Integrated Care System
LLR = Leicester, Leicestershire & Rutland
NED = Non-Executive Director
NHFT = Northamptonshire Healthcare NHS Foundation Trust
NHSE = NHS England
QI = Quality Improvement
REACH = Race, Ethnicity and Cultural Heritage
UEC = Urgent & Emergency Care
UHL = University Hospitals of Leicester
UHN = University Hospitals of Northamptonshire
UoL = University of Leicester
FTSU = Freedom To Speak Up

F

Leicestershire Partnership NHS Trust

Trust Board of Directors – July 2025 (Public)

Chief Executive's Report

Purpose of the Report

This paper provides an update on current local issues and national policy developments since the last meeting. The details below are drawn from a variety of sources, including local meetings and information published by NHS England (NHSE), NHS Providers, the NHS Confederation, and the Care Quality Commission (CQC).

Analysis of the issue

National Developments

10 Year Health Plan for England: fit for the future

Over the past 8 months the government have carried out a national engagement event with NHS staff and members of the public and considered over 250,000 contributions to the Change NHS website. On 3rd July 2025 the "Fit for the Future: 10-Year Health Plan for England" was published and sets out a transformative vision to address the NHS's critical challenges and ensure its sustainability. The plan proposes an overhaul centred on three core shifts: moving care from hospitals to communities, transitioning from analogue to digital systems, and focusing on prevention over treatment. It introduces the Neighbourhood Health Service to deliver integrated, localised care, expands digital access via the NHS App, and leverages AI and genomics to personalise and predict healthcare needs. The plan also aims to tackle health inequalities, empower patients with more control, and position the NHS as a global leader in innovation and economic growth.

As a Trust, we are supporting colleagues to understand what the 10 Year Health Plan means for us and how our recently launched THRIVE strategy aligns closely to its aims.

Further information can be found here: 10 Year Health Plan for England: fit for the future - GOV.UK

National Neighbourhood Health Implementation Programme

NHS England has launched an open invitation for local health and care systems to join the first wave of the National Neighbourhood Health Implementation Programme (NNHIP), a key initiative under the 10-Year Health Plan. The programme aims to shift care from hospitals to

communities, prioritise prevention, and integrate services to better support individuals with complex needs. It encourages collaborative applications from local provider organisations to co-develop neighbourhood health systems, initially focusing on adults with multiple long-term conditions. The NNHIP will adopt a "test, learn, and grow" approach, enabling local flexibility while driving national learning and improvement. Oversight will be provided by a joint DHSC-NHSE Task Force chaired by Sir John Oldham.

Further information can be found here: NHS England » Your invitation to be involved in the National Neighbourhood Health Implementation Programme

Safety report from Penny Dash

Dr Penny Dash's independent review of patient safety across the health and care landscape has now been published. The review maps the broad range of organisations that impact on quality and focuses on six key national organisations that have an impact on safety;

- Care Quality Commission
- National Guardian's Office
- Healthwatch England and the Local Healthwatch network
- Health Services Safety Investigations Body (HSSIB)
- Patient Safety Commissioner
- the patient safety learning aspects of NHS Resolution

Based on the findings, the review makes 9 recommendations on whether greater value could be achieved through different approaches or delivery models

Further information can be found here: Review of patient safety across the health and care landscape - GOV.UK

NHS Oversight Framework 2025/26

The NHS Oversight Framework 2025/26 outlines NHS England's updated approach to assessing and supporting Integrated Care Boards (ICBs), NHS trusts, and foundation trusts. Developed through extensive consultation, the framework promotes transparency, consistency, and accountability in performance management. It introduces a segmentation model for providers based on delivery against key metrics across six domains, including access, safety, workforce, and finance. While ICBs will not be segmented this year due to ongoing structural changes, they will still undergo statutory annual assessments. The framework prioritises financial discipline, requiring all systems to achieve a balanced financial position, and links performance to regulatory intervention where necessary. It also supports the delivery of the 10-Year Health Plan by aligning oversight with national priorities and encouraging local autonomy and improvement through tailored support.

Further information can be found here: NHS England » NHS Oversight Framework 2025/26

Urgent and emergency care plan 2025/26

The government has set out a pack of investment and reforms aimed at improving patient experience for those accessing urgent and emergency care. The plan aims to deliver:

- Around 40 new Same Day Emergency Care and Urgent Treatment Centres – which treat and discharge patients in the same day, avoiding unnecessary admissions to hospital.
- Up to 15 mental health crisis assessment centres to provide care in the right place for patients and avoid them waiting in A&E for hours for care, which is not the most appropriate setting for people who are experiencing a crisis. These centres will offer people timely access to specialist support and are directed to the right care.
- Almost 500 new ambulances will also be rolled out across the country by March 2026
- Increased paramedic-led care in the community – which means patients will receive more effective treatment at the scene of an accident or in their own homes from ambulance crews
- Increasing numbers of patients seen by urgent community response teams – which provide urgent care to people in their homes, helping to avoid hospital admissions and enable people to live independently for longer. Local areas will be told to lay out how they will expand access to these teams, which includes understanding level of needs;
- Better use of virtual wards – which use modern technology to provide patients with hospital-level care at home safely and in familiar surroundings, speeding up their recovery while freeing up hospital beds for patients that need them most

The plan's emphasis will be on shifting more patient care into more appropriate care settings as part of the move from hospital to community under the government's Plan for Change.

Further information can be found here: NHS England » Urgent and emergency care plan 2025/26

24/7 Neighbourhood Mental Health Centre

As part of the 10-Year Health Plan, NHS England has opened its first 24/7 Neighbourhood Mental Health Centre in Tower Hamlets, East London. This pioneering initiative provides walk-in access to mental health support without the need for referrals, targeting individuals with serious mental illnesses. The centre integrates crisis services, community mental health care, and short-stay beds, alongside support for housing, employment, and volunteering. Staffed by multidisciplinary teams including clinicians, peer support workers, and voluntary sector partners, the centre aims to deliver holistic, person-centred care. It is the first of six such centres to open across England in 2025.

Further information can be found here: NHS England » First NHS round-the-clock mental health unit opens under 10 Year Health Plan

National Guardians Office

The National Guardian's Office (NGO) has announced it will close by the end of 2025, following a strategic review and discussions with the Department of Health and Social Care. Established to promote a culture of speaking up in healthcare, the NGO has played a pivotal role in embedding the Freedom to Speak Up (FTSU) initiative across the NHS. While the office itself will close, the FTSU Guardian network will continue, with NHS England taking over responsibility for its oversight and development. The transition aims to ensure continuity and further integration of speaking up practices into NHS systems. The NGO expressed pride in its achievements and committed to supporting a smooth handover to maintain momentum in fostering open, safe, and inclusive healthcare environments.

Further information can be found here: Announcement about the future of the National Guardian's Office - National Guardian's Office

Industrial Action

The British Medical Association (BMA) has issued updated guidance for resident doctors in England regarding upcoming industrial action scheduled from 25 July to 30 July 2025. The strike is part of the ongoing campaign for pay restoration.

CQC Appointments

The CQC have recently announced a number of new appointments including Professor Bola Owolabi (MRCGP, MFPH Hon, FRSPH) as the new Chief Inspector of Primary and Community Services, Dr Toli Onon (BSc MD FRCOG) as the new Chief Inspector of Hospitals and Chris Badger has been appointed as the new Chief Inspector of Adult Social Care and Integrated Care. Dr Arun Chopra, CQC's first Chief Inspector of Mental Health started in his role in May 2025.

Kay Boycott, Alex Kafetz, Michael Mire, Ruth Owen, Melanie Williams and Richard Barker have also all been appointed as Non-Executive members of the CQCs board.

ADHD Taskforce interim report

The independent attention deficit hyperactivity disorder (ADHD) Taskforce was commissioned by NHS England in 2024, as part of a series of measures to address concerns about timely access to diagnosis and support, and the impact of unsupported ADHD on individuals, services and the wider economy.

Part one of the Taskforce's report is now available. Work continues on a final report later in 2025, and to align recommendations with other work across Government.

The report describes that the rates of recognised ADHD in England are lower than the expected prevalence and stresses the need for timely access to needs-based support. The report also emphasises the need of getting ADHD support right across all sectors, to reduce school exclusions, ease pressure on mental health and wider health services, and help more people thrive at home, in work, and in society. It also calls for a simpler more joined-up system of care for patients and for data improvement to be prioritised. A raft of measures to improve ADHD provision have been developed and delivered by NHS England. They are working with local systems who are trialling new and innovative ways to deliver ADHD services, improve patient care and productivity, to better meet the needs of people in need of support.

Further information can be found here: NHS England » NHS England responds to ADHD Taskforce interim report

Commissioner guidance for adult community mental health rehabilitation services

The commissioner guidance for adult community mental health rehabilitation services has now been published. The guidance will support systems with the continued implementation of community mental health transformation programmes of which community mental health rehabilitation services are a critical component. Advocating that all adults have access to support for their rehabilitation needs in their community, providing opportunities to regain or learn skills, lost or not acquired, due to their severe mental illness.

The guidance highlights key messages to providing collaborative holistic support, promoting citizenship and support dynamic strategic commissioning to reduce reliance on inpatient care in the future. It will also support ICBs to deliver on their three year plan to localise and realign mental health inpatient care.

Further information can be found here: NHS England » Commissioner guidance for adult community mental health rehabilitation services

Maternity and neonatal care

The Secretary of State for Health and Social Care has announced a rapid independent investigation into maternity and neonatal services. The investigation will consist of two parts and a report is due back by December 2025. The first element will investigate up to 10

maternity and neonatal units where there are specific issues. The second part will include a system-wide look at maternity and neonatal care, bringing together lessons from past inquiries to create one clear, national set of actions to improve care across every NHS maternity service.

The government is also today establishing a National Maternity and Neonatal Taskforce, chaired by the Secretary of State for Health and Social Care, and to be made up of a panel of esteemed experts and bereaved families.

Further information can be found here: National maternity investigation launched to drive improvements - GOV.UK

Local Developments

New Interim Chair of LPT and NHFT

Crishni Waring will complete her final term as Chair of NHFT and LPT at the end of October 2025, in line with governance requirements. Faisal Hussain, Deputy LPT Chair, has been appointed Interim Joint Chair of LPT and NHFT, and will start in post once current Chair Crishni Waring finishes her final term.

NHFT's Council of Governors is responsible for the recruitment of Chairs and Non-Executive Directors in NHFT; NHS England (NHSE) is responsible for recruitment in LPT. Together they made the decision to appoint Faisal as a joint interim Chair. This decision was made to ensure consistency and focus on operational delivery at a time the Group is embedding their recently launched Group strategy and considering changes in the NHS at a national level.

This is an exciting appointment for both Trusts and us as a Group. Faisal brings a wealth of experience to the role, which will help continue the excellent contributions to the Group Crishni has made in the role.

Executive Team

I would like to take this opportunity to formally thank Paul Williams, Acting Director for Families, Young People, Children, Learning Disabilities, and Autism Services (FYPCLDA) who will be retiring from his post in September. This will be his last public Trust Board meeting, and I would like to thank him on behalf of the Board for his hard work and contribution to the Trust.

CQC Inspection

The CQC visited LPT in May this year and inspected our community mental health services for working age adults, the crisis teams and health-based place of safety. Reports will be received in due course.

ICB

Northamptonshire Integrated Care Board (ICB) and Leicester, Leicestershire and Rutland (LLR) ICB have announced plans to form a joint cluster. As of 1st July 2025, Toby Sanders has been appointed Interim Chief Executive for both organisations. This arrangement, supported by NHS England, will remain in place while NHS England works to establish future leadership and operating models for ICBs.

CQC/NHSP Trust Level Assessment External Reference Group

I have recently been invited to join a national advisory group for clinical and professional leaders to be involved in ongoing co-production of CQCs well-led methodology. I really welcome this opportunity to provide input, challenge and feedback to proposed improvements and changes to the well-led framework and methodology.

Together we THRIVE conference: Trust colleagues deepen understanding of new strategy

Following the recent launch of THRIVE, colleagues came together at conferences in LPT and NHFT to deepen their understanding of our mission, strategy and vision. Our new THRIVE strategy, an ambition that will take us to 2030, equips us for a rapidly changing world and enables us to work through complex challenges together. Many Trust colleagues were not with us last time we launched a strategy. That meant taking the time and space to reflect on what THRIVE means to us, our services, service users, patients, carers and the wider community was a really significant moment. Throughout an insightful agenda, colleagues learnt more about the priorities that will guide them and their crucial role in achieving our vision of Together we thrive; building compassionate care and wellbeing for all.

It is already clear that there is much in common between our own strategy and the new NHS Ten Year Plan announced nationally. We will be working closely as a Group, and with our system partners to realise and continue to embed opportunities for meaningful collaboration, driving efficiencies and delivering quality patient care to all our communities through the three identified priority focuses: analogue to digital, hospital to communities and sickness to prevention.

Angela Hillery ranks 2nd in annual Health Service Journal top 50 NHS CEOs table

Health Service Journal has published its annual top 50 ranking of NHS chief executives across the country, with Angela Hillery listed at number 2 in this year's table. This marks

Angela's seventh consecutive appearance on the list and has now been placed in the top section five times and has previously topped the rankings.

LPT services shortlisted four times in national healthcare patient safety awards

Three LPT teams are in the running for four prestigious HSJ Patient Safety Awards, which recognise commitment to improving patient safety and driving innovation in healthcare.

Our Trust's involvement in the primary care mental health pathway project in North-West Leicestershire and inpatient self-harm reduction project, on the Bradgate Mental Health Unit's Heather Ward, are both shortlisted as 2025 finalists. The projects are shortlisted for the primary care initiative of the year and nursing-led patient safety initiative of the year respectively. The Trust's Waterlily Inpatient Prevention Programme, supporting adults with eating disorders, is also in the running for an award in two categories, including community care initiative of the year and virtual or remote care initiative of the year.

The Waterlily Inpatient Prevention Programme is a pioneering online service, led by LPT on behalf of the East Midlands NHS Provider Collaborative for adults with anorexia nervosa. It aims to reduce hospital admissions and support patients' recovery, while allowing them to live at home and remain involved in aspects of their normal lives. This includes continuing with hobbies and seeing friends and family, which can be a motivating factor in recovery.

Data from the programme has shown those taking part have had significant improvements in weight and psychological wellbeing, due to the practical support, psychoeducational groups and therapeutic interventions offered. The programme lasts for 16 weeks, includes step-down care to increase patient independence, and education for patients' loved ones.

Work to significantly reduce self-harm incidents on LPT's female inpatient Heather Ward was led by the ward's charge nurse and Trust's suicide prevention lead, supported by Health Innovation East Midlands. Following an analytical review of when self-harm incidents took place, the team identified incidents were lower on days where more communal activities took place. As a result, the ward nurses put on a broader range of supportive shared events, such as coffee mornings and craft activities, on days when self-harm incidents were typically higher. They also organised for activity coordinators to actively approach patients to encourage them to take part. By adding in more group patient enrichment to the ward's

activity schedule, the ward saw a 40% reduction in incidents, improving patient safety on the wards.

The North-West Leicestershire Primary Care Mental Health Pathway project was developed in partnership between the local LPT neighbourhood mental health lead and mental health practitioners, the North-West Leicestershire GP Federation and LLR MIND. After recognising gaps in local mental health support, the partnership saw an opportunity to develop a primary care mental health pathway that streamlines and enhances the mental health offer to local people in need of support. By bringing together professionals involved in providing mental health support in the local area and supporting them to work in a joined-up team approach, the project helped to reduce waiting times for patients and increased the number of patients able to be seen, making sure patients see the right professional at the right time. Over 1,300 patients have been through the pathway, which has delivered 3000 appointments in the last year.

LPT's Mental Health Response Vehicle marks milestone in community crisis support

We have recently marked the one-year anniversary of our pioneering Mental Health Response Vehicle (MHRV) service, an initiative providing timely, compassionate and person-centred support for people in mental health crisis in the community. Launched last year, the MHRV has responded to more than 260 referrals, offering on-scene assessment, support and guidance for adults aged 18 and over.

The service operates Thursday to Sunday, working in close partnership with East Midlands Ambulance Service (EMAS), NHS 111, local police, and social care professionals to divert people from unnecessary emergency department visits and provide care in more appropriate settings.
The vehicle is staffed by trained mental health practitioners, including registered mental health nurses and healthcare support workers, who provide a blend of "Hear and Treat" telephone support, screening and advice and "See and Treat" on-the-scene urgent face-to-face mental health advice, support and signposting as appropriate.

The service aims to respond within two hours of referral and supports individuals who are not in need of urgent physical health treatment.

Tanya Hibbert, executive director for mental health services at LPT, said: “We’re incredibly proud of the difference the Mental Health Response Vehicle has made in its first year. The vehicle is helping people receive the right support at the right time and in the right setting, which is what good and responsive mental health care should be.”

One patient’s relative shared: “What a great service. Came out to see my really unwell daughter very quickly. The staff handled the situation very well and there was no need to go to A&E.”

A spokesperson from EMAS added: “A well-needed service. Helps prevent patients going to a busy A&E, causing more distress and [also] helps with decision making for what’s best for the patient.”

By reducing avoidable A&E attendances and enabling ambulances to return to physical health emergencies more quickly, the MHRV has improved outcomes across the system. On the back of this success, it is hoped the service can soon be expanded to seven days a week.

Long service awards celebrated for staff and volunteers

Over 230 LPT staff members and volunteers were celebrated through our annual long service awards to commemorate their dedication and many years of service to the National Health Service (NHS).

Staff members ranging from nurses to therapists and dieticians to administrators joined volunteers to celebrate their outstanding achievement at three, fully sponsored LPT Long Service Awards events. The celebrations took place on Monday 23 and Monday 30 June. Those who registered to attend the events collectively racked up over 4,765 years’ worth of service to the NHS, achieved between 1 April 2024 and 31 March 2025.

The award ceremonies, which took place at the NSPCC National Training Centre in Leicester, celebrated staff who have worked for the NHS for either 15, 20, 25, 30 or 40 years. Volunteers were also recognised for their five, 10 or 20 years of service with LPT and the NHS. The Trust is also marking staff who have achieved 10 years of service in the NHS by posting them a special certificate and pin badge.

Psychiatric ward reopens after £1.6m upgrade

Belvoir Ward is a psychiatric intensive care unit, providing care for patients with some of the greatest mental health needs in Leicester, Leicestershire and Rutland. It was opened as part of the Bradgate Mental Health Unit on the Glenfield Hospital site in 1998, and this is its first significant refurbishment. Leicestershire Partnership NHS Trust has spent £1.6 million on improvements.

Last year inspectors from the Care Quality Commission said the ward was “tired and in need of updating” but noted that there were plans for changes.

The ward had been temporarily reduced to a capacity of six before the refurbishment, due to damage in one area. That has been put right, and the capacity has been increased to its original ten. Each patient has their own room, with an ensuite toilet and shower. The rooms and ensuite doors have been decorated with images of Leicestershire landmarks to instil a sense of hope.

The ward has been completely re-decorated, with all new flooring, new windows, upgraded doors, and new furniture for patients as well as new drinks station and improved heating. Security is an important consideration on the ward because some people are detained under the Mental Health Act, so the work has included improvements to the safety systems, personal alarms and fire alarms.
A new mental health tribunal room has been created. This is where patients who are detained under the mental health act and their representatives can apply to be discharged from their section.

Because of the extent of the works, patients were transferred for the duration to another psychiatric intensive care unit in a neighbouring county.

A significant proportion of the money for the work was provided in a grant from NHS England.

New healthy living toolkits to help tackle health inequalities for people with learning disabilities

A new set of healthy living toolkits have been launched to help support people with learning disabilities to lead healthier and happier lives. The toolkits, developed by the Leicester, Leicestershire and Rutland (LLR) Learning Disabilities and Autism (LDA) Collaborative, aim to address longstanding health inequalities and improve outcomes for people with learning disabilities through better nutrition, hydration and physical activity. They were launched as part of Learning Disabilities Week, which this year focused on 'Do you see me?' an opportunity for all people with a learning disability to be seen, heard and valued.

Research shows that people with learning disabilities are significantly more likely to experience health conditions which are linked to factors such as poor nutrition and low levels of physical activity. In Leicester, Leicestershire, and Rutland, more than one-in-ten (11%) of people with a learning disability are underweight, while one-in-three (33%) are living with obesity.

The Healthy Living Toolkits provide clear, accessible guidance tailored to three key audiences:

- Health professionals – with role-specific advice on identifying and monitoring concerns.
- Family and friend carers – offering practical tips and nutritional information.
- Individuals with lived experience – empowering people to take an active role in their own health.

The resources also highlight the importance of inclusive community facilities, such as the availability of wheelchair-accessible scales, to ensure accurate health monitoring for all.
The full set of toolkits are now available for free download through the Leicester, Leicestershire and Rutland Health and Wellbeing Partnership website.

Mental health nurse receives international DAISY award for treating patient with 'dignity and kindness'

Anjana Sajeev, an LPT registered mental health nurse who treated her patient with 'dignity and kindness' at a challenging time has received the international DAISY Award for the outstanding compassionate care she provides to her patients. The DAISY Awards are an

international recognition programme that honours and celebrates the exceptional care that many nurses and midwives provide every day.

The nomination, from the patient, reads: “I was suicidal, fighting an infection which could have led to me losing my leg and Anjana took the time to talk to me and convince me my life was valued and worth living. I had an accident in my bed which at 29 years old and has never happened before was mortifying. No problem, Anjana (younger than me) thought nothing of it made me feel at ease, changed the bedding and then helped me to shower. She treated me with so much dignity and kindness and went above and beyond to ensure I was okay.

“Anjana always has a smile on her face and takes everything in her stride, she deserves this award because although she will be ‘strict’ when the job needs doing, in her own words she is “human and has a heart too and cares deeply with it. “Anjana regularly checked in on me (between allocated checks) and tries to help me in any way feasible. For such a young nurse she has so much life experience that she uses to help mentally unwell people and when you’re poorly, that human element means everything.”

Anjana shared: “I want to make everyone feel safe, secure, accepted, heard and cared for and this award ensures me that I did that. This award isn’t just mine, it’s a reflection of every patient who’s trusted me, every team member who’s supported me, and every moment that reminded me why I became a nurse in the first place. “You will be there for people on their best and worst days. You will witness both incredible joy and profound sorrow — and your presence will often make all the difference.”

You can thank your nurse by making a DAISY Award nomination here www.leicspart.nhs.uk/about/daisy-award/

Relevant External Meetings attended since last Trust Board meeting

Chief Executive and Deputy Chief Executive external meetings

June 2025	July 2025
East Midlands Alliance CEO Meetings	East Midlands Alliance Lead
Midlands NHS Leadership Meeting	Joint Corporate Governance meeting with NHFT
Mental Health Trusts CEOs with Regional Leads and SROs	NHSE 10 Year Health Plan
LPT Carers Event	NHSE 10 Year Health Plan launch
Mental Health Trusts CEOs with Regional Leads and SROs	Mental Health Trusts CEOs with Regional Leads and NHSE MH CEOs
Recovery & Sustainability Committee	NHSE Midlands Director of Nursing
LLR Integrated Care Board	NHSE Leadership Event
Together Against Racism Group meeting with NHFT	NHS National Operating Framework Segmentation Dashboard Webinar
LLR ICB System Executive Committee	East Midlands Alliance CEO Meetings
BCG Director	CQC/NHSP Trust well led reference group
Joint CQC Workshop with NHFT	LLR & Northamptonshire Quarterly System Review NHSE 16/07
CEO Mersey Care NHS Foundation Trust	LLR Urgent & Emergency Care Collaborative
East Midlands Alliance Board	
	Midlands and East Mental Health CEO Network
Midlands Mental Health Quarterly Review	South Asian Heritage Month Celebrations 18/07
Midlands CEOs with Regional Director NHSE Midlands	Weekly Urgent & Emergency Care
LLR ICB System Executive Committee	Trust legal team meetings
CEO Norfolk and Suffolk NHS Foundation Trust	Group Interview Panel
I&I Ph2 SRO/Execs Meeting	*Joint Executive Workshop with NHFT 22/07
Weekly Urgent & Emergency Care	* Midlands CEOs with Regional Director NHSE Midlands 23/07
LLR Urgent & Emergency Care Collaborative	* CEO Northants & LLR ICB 23/07
Monthly Urgent & Emergency Care Collaborative Transformation Group	
Local Resilience Forum Executive Board	* Recovery and Sustainability Group 24/07
LLR CEO meeting	* LLR ICB System Executive Committee 25/07
ICB Change Director introduction	*LLR MP Meeting 25/07
Urgent & Emergency Care SRO meeting	
Group interview shortlisting panel	
Monthly COO/MD/DoN with NHSE	
Pan ICS Strategic Ransomware Incident Exercise	

Abbreviations:

CEO = Chief Executive Officer
CFO = Chief Finance Officer
COO = Chief Operating Officer
DoN = Director of Nursing
ICB = Integrated Care Board
ICS = Integrated Care System
LHRP = Local Health Resilience Partnership
LLR = Leicester, Leicestershire & Rutland

T H R I V E

MD = Managing Director
MH = Mental Health
NHFT = Northamptonshire Healthcare NHS Foundation Trust
NHSE = NHS England
REACH = Race, Ethnicity and Cultural Heritage
SRO = Senior Responsible Officer
UEC = Urgent & Emergency Care
UHL = University Hospitals of Leicester
UHN = University Hospitals of Northamptonshire
UoL = University of Leicester

Proposal

It is proposed that the Board considers this report and seeks any clarification or further information pertaining to it as required.

Decision required – Please indicate:

Briefing – no decision required	**Y**
Discussion – no decision required	
Decision required – detail below	

The Board is asked to consider this report and to decide whether it requires any clarification or further information on the content.

Governance table

For Board and Board Committees: Paper sponsored by:	Trust Board Angela Hillery, Chief Executive	
Paper authored by: Date submitted: State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s): If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured: State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Sinead Ellis-Austin, Head of Chair/CEO Office July 2025 None n/a Routine Board Report	
LPT strategic alignment:	**T** - **T**echnology	Y
	H – **H**ealthy Communities	Y
	R - **R**esponsive	Y
	I – **I**ncluding Everyone	Y
	V – **V**aluing our People	Y
	E – **E**fficient & Effective	Y
CRR/BAF considerations *(list risk number and title of risk):* Is the decision required consistent with LPT's risk appetite: False and misleading information (FOMI) considerations: Positive confirmation that the content does not risk the safety of patients or the public Equality considerations:	 Yes None Confirmed None	

G

Leicestershire Partnership NHS Trust

LPT Trust Board 29 July 2025

Board Assurance Framework

Purpose of the report

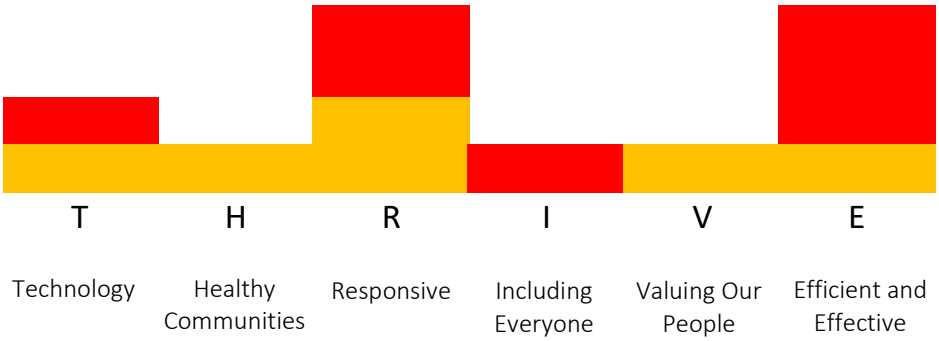
The Board Assurance Framework (BAF) contains strategic risks that may prevent us from achieving our objectives. It is presented as part of a continuing risk review process.

Analysis of the issue

An effective BAF supports the understanding and discussions around delivery of the Trust's strategic objectives (underpinning our overarching strategy THRIVE) by identifying the principal risks that may threaten the achievement of those objectives. The full BAF is presented in a separate paper.

T H R I V E

By way of summary, the risk profile for the 13 BAF risks by THRIVE domain is provided below:



The highest scoring risks include;

- **T**: BAF1.1 Digital Transformation (16)
- **R**: BAF3.2 Timely Access (20), BAF3.3 Patient Safety (15)
- **I**: BAF4.1 Workforce (20)
- **E**: BAF6.1 Estate (20), BAF6.3 Capital Funding (20) and BAF6.4 Financial Position (16)

There has been a re-adjustment to the risk score for BAF3.2 timely access, the current score was revised from 15 back up to 20 to better reflect the risk environment relating to waiting times.

Proposal

- Going forward, approval of, and oversight for Group BAF risks will be held by the Group Trust Board. These are subject to change to ensure alignment with Northamptonshire Healthcare NHS Foundation Trust and the Group Trust Board approval.
- There will continue to be monthly executive director oversight and update of strategic risk.
- Ongoing oversight of the BAF through the Trust's governance.

T H R I V E

Decision required

- Approval of the readjustment to BAF3.2 timely access risk score from 15 to 20
- To be assured by the risk management process and that Board remains sighted on key strategic risks relevant to the Trust.

Governance Table

For Board and Board Committees:	Trust Board 29 July 2025	
Paper sponsored by:	Kate Dyer, Director of Governance and Risk	
Paper authored by:	Kate Dyer, Director of Governance and Risk	
Date submitted:	21 July 2025	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Strategic Executive Board Monthly	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	n/a	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Routine board report	
STEP up to GREAT strategic alignment*:	**T** - **T**echnology	All
	H – **H**ealthy Communities	
	R - **R**esponsive	
	I – **I**ncluding Everyone	
	V – **V**aluing our People	
	E – **E**fficient & Effective	
Board Assurance Framework considerations:	List risk number and title of risk	
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed	
Equality considerations:	None	

Leicestershire Partnership NHS Trust

Leicestershire Partnership and Northamptonshire Healthcare Group

Board Assurance Framework

LPT and Group Strategic Risks

July 2025

BAF 2025/26 Quick Guide

1. Strategic Risk

The BAF enables the Board to identify and understand the principal risks to achieving its strategic objectives. We have a strategy in common with our Group partner Northamptonshire Healthcare NHS Foundation Trust (NHFT). Our risks are structured around our 'THRIVE' strategy.

This BAF presents strategic risk relating to Leicestershire Partnership NHS Trust, it is owned by the Trust Board and is reviewed by our Strategic Executive Board and our Level 1 Committees.

This BAF also contains strategic risk in common with NHFT, presented as Group BAF risks which are owned by both Trust Boards and are reviewed by each board, together in the Group Public Board meetings, each of our Strategic Executive Boards, and our Level 1 Committees.

2. Aligning controls and assurances

The format presents the controls, assurances, gaps and actions together. This means that we can provide assurance over whether existing controls are working. Where they are not, we can be clear about the action required to resolve this. We are also able to clearly identify where additional controls and assurances are required and what actions we need to include.

3. Three lines of assurance model

The Trust uses the three lines of assurance model. The assurance provided on the BAF is split by each of the three lines so that we can be clear which part of the organisation is providing assurance and undertaking mitigating action. This also helps us to identify and rectify any gaps.

4. Cause, Risk and Effect

The cause, risk and effect format allows us to see controls, assurances and actions by the cause and effect of each risk, so that we can be sighted on how we are reducing the likelihood and the consequence. Risk descriptors are written using the cause, risk, and effect model to help shape the way we present risk on the BAF.

BAF 2025/26 Quick Guide

5. Clarity over scoring stages

Scoring terminology is defined as;

- Inherent Score. This is the score of a risk based on there being no controls in place. This would apply if the BAF were to identify that current controls are not working effectively.
- Current score. This is the score considering the controls currently in place, assuming that they are working. This can also be termed as residual risk by some organisations, due to this, we are avoiding the use of this term.
- Target score. This is the score once any new mitigating controls have been put in place; this will need to be within our target appetite or will need to be tolerated and justified as such in the covering risk report.

6. 5x5 multiplication methodology

The Trust uses the 5x5 multiplication scoring methodology.

7. Risk Appetite - Open

The Trust Board has applied an open appetite for each category of risk for 2025/26. This means that we have a willingness to make decisions which may impact on our current business as usual for longer term reward and improvement if appropriate controls are in place. This will require a focus on assurance over the strength of our existing internal control framework, as well as identifying and embedding any new controls.

Appetite	None	Minimal	Cautious	Open	Eager
Appetite tolerance	0-3	4-8	9-12	13-16	17-25

BAF 2025/26 Summary: Together we THRIVE

BAF No.	Risk Title	Score
Section 1 - T Technology [Finance and Performance Committee Oversight]		
GROUP BAF1.1	If we do not continue to engage in **digital transformation**, we will not be digitally mature. This will affect our ability to deliver safe care to our service users.	16
BAF1.2	If we are not sufficiently prepared, we may be impacted by **digital disruption** which will affect our ability to access our electronic systems and provide safe care to our service users.	12
Section 2 - H Healthy Communities [Finance and Performance Committee Oversight]		
GROUP BAF2.1	If we fail to evolve our **partnerships and collaboratives**, we will not reduce health inequalities and deliver improved outcomes for our populations NEW TITLE JUNE 2025	8
Section 3 - R Responsive [Quality and Safety Committee Oversight]		
GROUP BAF3.1	If we are unable to build a sustainable approach to the continual development our **research and innovation capability**, our ability to attract the best people, operate on the leading edge of service delivery and exert influence within the sector will decline over time.	12
BAF3.2	Without **timely access** to services, we cannot provide high quality safe care for our patients which will impact on clinical outcomes.	20 ↑
BAF3.3	If we do not continue to review and improve our systems and processes for **patient safety**, we may not be able to provide the best experience and clinical outcomes for our patients and their families.	15
BAF3.4	If we do not have appropriate **emergency preparedness**, resilience and response controls in place, we may be impacted by accidents, disruption and system failures affecting our ability to maintain continuity of services.	8
Section 4 – I Including Everyone [People and Culture Committee Oversight]		
BAF4.1	If we do not adequately utilise **workforce** resourcing strategies, we will have poor recruitment, retention and representation, resulting in high agency usage.	20
Section 5 – V Valuing people [People and Culture Committee Oversight]		
BAF5.1	If we do not lead with compassion, we will not promote an **inclusive culture**, resulting in unwanted behaviours and closed cultures.	12
Section 6 – E Efficient and Effective [Finance and Performance Committee Oversight]		
BAF6.1	If we cannot maintain and improve our estate, or respond to maintenance requests in a timely way, there is a risk that our estate will not be fit for purpose, leading to a poor-quality **environment** for staff and patients.	20
GROUP BAF6.2	If we do not continue to strive for **sustainability**, we will be impacted by adverse weather events and environmental factors impacting on the health of our population, resulting in poorer health outcomes.	12
BAF6.3	Inadequate **capital funding** for LLR system will impact on LPT's ability to manage financial, quality & safety risks related to estates and digital investment in 2025/26 and in the medium term	20
BAF6.4	Inadequate control, reporting and management of the Trust's **2025/26 financial position** could mean we are unable to deliver our financial plan and adequately contribute to the LLR system plan, resulting in a breach of LPT's statutory duties and financial strategy (including LLR strategy)	16

GROUP BAF **1.1**	If we do not continue to engage in **digital transformation**, we will not be digitally mature. This will affect our ability to deliver safe care to our service users.	
Date	Included 1 April 2025	Last updated 10.07.2025
Strategic Link	THRIVE: **TECHNOLOGY**	
Governance	**GROUP** Finance and Performance Committees, Group Strategic Executive Board, Group Trust Board	
Context	Moving from analogue to digital, where digital healthcare becomes the enabling centre of clinical care	

Score	Consequence	Likelihood	Combined
Initial Risk	4	5	20
Current Risk	4	4	16
Target Risk	4	2	8

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: Lack of capacity, resources and commitment to support all Trust Digital needs					
• LPT Digital plan • National Digital plan • Digital maturity assessment • Digital Prioritisation Process • ICB Digital plan/Strategy • Local, system and national efficiency plans limit staff availability to digital delivery across our organisation. • Joint LPT / NHFT digital lead and LLR ICB CIO	• Lack of capital funding for Digital • Capacity and resources • Ability to recruit and retain Digital workforce. • Digital not always committed to as an organisational priority • Effectively supporting digital reasonable adjustments for staff • Availability and quality of data for reporting & analysis • Lack of funding for digital solutions to improve data & productivity	**1st Line:** The capital planning committee decides the level of digital capital spending by evaluating investments in technology infrastructure and initiatives, such as new equipment and system upgrades, alongside other non-digital capital programs. The committee ensures that this capital spending is aligned with the Trust's long-term strategic goals and system partners. **2nd Line:** The Information Management & Technology Committee ensures the relevance of the Digital Plan & commitment to delivery on behalf of the Trust Finance & Performance Committee in line with the Trust's strategic priorities and system partners. The Committee ensures that mechanisms are in place to assure the operational delivery of the Digital Plan for the Trust through robust reporting and monitoring arrangements. The Committee provides the strategic approval of IM&T systems, projects, and work programmes to which Trust resources (financial and staffing) are to be committed. **3rd Line:** The Finance and Performance Committee are provided with a copy of the Digital Plan and the LHIS annual report to offer assurance on the strategic direction and execution of digital initiatives. By receiving these documents, the committee can assess whether digital investments align with organisational goals, are delivered within budget, and have achieved the expected results. This oversight allows the committee to provide feedback, ensure accountability, and confirm that digital initiatives contribute to the organisation's long-term objectives	Additional capacity to further develop the LPT digital strategy and deliver its implementation. Clear timeline for the delivery of digital transformations.	• Deliver the Group Digital Transformation plan. **Joint Director of Digital (as SRO) 2025/26 with quarterly updates.** • Clear timelines for delivery of digital transformation (TQIG). **Joint Director of Digital July 2025 – EMB Aug 25** • Gap analysis of capacity to deliver plan. **Joint Director of Digital July 2025 – EMB Aug 25** • Joint Digital Plan to be drafted – Sept 25	LPT Digital transformation group in place to oversee delivery with AAA report into FPC. Inclusion within Group Trust Board workplan.
Effect: Unable to support service transformation.					
• Digital transformation programme. • Digital Transformation Group • Digital Prioritisation Process	• Finance • Capacity • Digital engagement	**1st Line** The digital prioritisation Process will ensure that the most impactful initiatives receive the focus and resources required. This process is owned by the Trust's PMO (Project Management Office), which works closely with the various directorates to score and evaluate digital projects based on factors such as local and national strategic alignment. By collaborating with the directorates, the PMO ensures that priorities reflect organisational goals and the directorate's needs. **2nd Line** The scored digital prioritisation will be regularly reported to the Transformation Committee to provide oversight and ensure that the Trust can make informed decisions, monitor progress, and adjust priorities to keep Digital transformation on track **3rd Line** Clinical Focus and Engagement: The Trust considers clinical engagement and involvement in decisions to be an essential element of its governance arrangements. As such, the Trust's integrated governance approach aims to mainstream clinical governance into all planning, decision-making, and monitoring activities.	Prioritisation process to undertake retrospective scoring & become BAU Lack of clinical leadership	Prioritisation **process Joint Director of Digital July 2025.** to be presented to LPT digital transformation group and assurance to FPC. Gap analysis of clinical leadership to deliver plan. **Joint Director of Digital July 2025.** to be presented to LPT digital transformation group and assurance to FPC.	LPT Digital transformation group in place to oversee delivery with AAA report into FPC. Inclusion within Group Trust Board workplan.

BAF **1.2**	If we are not sufficiently prepared, we may be impacted by **digital disruption** which will affect our ability to access our electronic systems and provide safe care to our service users.
Date	Included 1 April 2025. Last updated 10.07.2025
Strategic Link	**T**hrive **TECHNOLOGY**
Governance	**LPT** Finance and Performance Committee, Strategic Executive Board, Trust Board
Context	Access to electronic systems, configuration is fit for purpose, cyber attack

Score	Consequence	Likelihood	Combined
Initial Risk	4	4	16
Current Risk	4	3	12
Target Risk	3	3	9

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: Lack of capacity and resources to mitigate sources of digital disruption					
• HIS provide a small team of qualified Cyber security experts with the required accreditation • Multiple technical counter measures including firewalls, honeypots, InterceptX, IDS/IPS, anti-malware, etc. • Microsoft MDE is active on all endpoints and servers • Only privileged user accounts are able to install or run programmes • MDM in use on all mobile devices • Back-up procedure in place and regularly checked • Patches automatically deployed to all devices • Quarterly penetration tests undertaken by LHIS • Have access to the ICB CISO for advice and guidance • MFA enabled on user accounts • VPN are monitored and restricted	• **Lack of capital funding for Digital and Cyber** • **Capacity and resources provided to HIS** • **There is no SIEM (security information and event management) solution** • **No pro-active management of security outside core business hours (no cyber on call)** • **There are times we are reliant on EOL software to run systems outside of our control (ESR)**	**1st Line:** The capital planning committee decides the level of digital capital spending by evaluating investments in technology infrastructure and initiatives, such as new equipment and system upgrades, alongside other non-digital capital programs. The committee ensures that this capital spending is aligned with the Trust's long-term strategic goals and system partners.	Group (LPT/NHFT) level Digital committee, Plan, Road map.	• Implement InTune as the new Trust MDM • Complete DSPT/ CAF submission for 24/25 • Replace end of support mobile devices • Review NHSE offerings to identify opportunities to improve the Trust's level of security • Collaboration with cyber security teams across LLR. • Adoption and deployment of strategic cyber security solutions. **Joint Director of Digital throughout 2025/26**	• Pillar under the new Digital Transformation Group in place to review Cyber opportunities • DSPT CAF being worked on and evidence provided • LLR & Northants cyber exercise 26.6.25 • Cyber Group being formed across LLR/NICB byt eh ICB CISO • Mobile phone replacement programme being started along with rollout of InTune
		2nd Line: DSPT Compliance and quarterly audit and penetration test with executive summary and action plan provided to the Data Privacy group. LHIS is ISO27001 accredited which provides assurance that the Information Security Management System (ISMS) operates effectively. Audited twice yearly. Routine reporting, review and escalation of cyber security threat/risk through Data Privacy Group (DPG). Incident reporting to DPG, including root cause and lessons-learned reviews. NHSE monitoring of our environment and MDE reporting	• **Assurance of security posture/compliance from core IT service suppliers.**		
		3rd Line: Training is provided to staff to raise cyber awareness as well as regular communications and events. NHSE Board level cyber training provided by external provider Feb 2024	Impact of training and phishing campaigns		
Effect: unable to access electronic systems which are fit for purpose					
• Data Privacy Group • Trust CDIO/ HIS Cyber team • NHSE best practice (DMA) to have NED assigned as the cyber lead -Chair of the FPC receives annual update as part of committee workplan.	• Finance • Capacity • Cyber awareness / training	**1st Line** The annual penetration test enables resources to be focused on areas of high and medium impact to the trust and address those issues as a matter of priority.		Raise at the capital management committee when appropriate with ongoing oversight **Joint Director of Digital throughout 2025/26**	Escalation of capital limitations impacting on delivery of digital agenda to EMB
		2nd Line Capital has been obtained from NHSE in previous years for key cyber security requirements as well as the new ICB CISO role.	Capital might not be sufficient and there are no ring-fenced finances for Cyber		
		3rd Line Systems monitored by HIS and NHSE teams via MDE, MDM and secure boundary services LHIS re-accreditation of secure email system [ISO27000] and Cyber Essentials Consultancy			

GROUP BAF **2.1**	If we fail to evolve our **partnerships and collaboratives**, we will not reduce health inequalities and deliver improved outcomes for our populations NEW TITLE JUNE 2025	
Date	Included 1 April 2025.	Last updated 21.07.2025
Strategic Link	THRIVE: **HEALTHY COMMUNITIES**	
Governance	**GROUP** Finance and Performance Committees, Group Strategic Executive Board, Group Trust Board	
Context	Healthy Communities are essential to the delivery of our system strategy, preventing ill-health and reducing demand on NHS services	

Score	Consequence	Likelihood	Combined
Initial Risk	4	5	20
Current Risk	**4**	**2**	**8**
Target Risk	4	2	8

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: **Not working closely with our community**					
• Services working in partnership across LPT and from LPT with the VCSE and other stakeholders • Organisational monitoring of system meetings • Named executive leads attending place-based meetings • LLR ICB and ICS meetings • East Midlands Alliance • Learning Disability and Autism Collaborative • Mental Health Collaborative • National Provider Collaborative Innovator	Changes in other organisations impact on system ability to deliver plans	**1st Line**: Discussions in Strategic Executive Board and other internal LPT formal meetings . Leadership support within Collaboratives / DMT oversight Directorate delivery plans **2nd Line:** Assurance and discussions in the integrated care board meetings, in our system quarterly review meetings with NHS England and the outcomes from the collaboratives we are involved with Collaborative and Commissioning Delivery Group Transformation Committee / engagement in formal ICB meetings - feedback into the Strategic Executive Board. **3rd Line:** Feedback from our well-led review, the CQC and other organisations; Shadow Mental Health Collaborative Joint Project Engagement meetings with CQC, NHS England, ICB Regional & national recognition of effective joint working 3rd Line: Feedback from our well-led review, the CQC and other organisations; Shadow Mental Health Collaborative Joint Project	Consistent feedback from system meetings Self-assessment / gap analysis SMART actions / KPIs Success reporting Effectiveness of Collaborative, Commissioning and Contracting Delivery Group / Escalation via SEB	Action learning within directorates to identify opportunities using DNA data to improve equity. **update to be provided August 2025 Director of Strategy** Work to implement high impact actions for LeDeR to reduce premature age of death in people with LDA **update to be provided August 2025 Group Director of Strategy** System working on integrated neighbourhood teams, **submission July 2025 Group Director of Strategy**	Strong progress in LDA, and Mental Health through our collaboratives. Good engagement and emerging LPT leadership support to CYP, including SEND. Strong engagement in system working in UEC. MH collaborative approved ICB Board June 25. LPT Joint leadership of system SEND work commences June 25
Effect: **Limited contribution to social value, and providing place-based care**					
• Social Value Charter • LLR Green Plan • People Plan • Social Value Community of Practice • NHSE national policy on integrated care • Social value charter • LLR ICB 5-year strategy • LPT strategy • Co-production programme	• Evidencing the impact of learning • Evidencing the impact of the social value charter • Directorate plans for 25/26 • Transformation plans	**1st Line :** Individual programmes of work identified to support new workforce into the organisation, health inequalities actions and the development of training through greater partnerships with our universities. **2nd Line** Group social value programme in place with development meetings. Reporting into our annual report. Updates at Strategic Executive Board and the Joint Working Group. **3rd Line** LLR Health Inequalities Meetings	Success reporting (longer term)	Alignment of directorate delivery plans and the Trust transformation programme with the ICB 5-year strategy **LPT & NHFT Round Table** planned for summer 2025 – **Director of Strategy**	Action Plan approved

GROUP BAF **3.1**	If we are unable to build a sustainable approach to the continual development our **research and innovation capability**, our ability to attract the best people, operate on the leading edge of service delivery and exert influence within the sector will decline over time.
Date	Included 1 April 2025. Last updated 21 July 2025
Strategic Link	THRIVE: **RESPONSIVE**
Governance	**GROUP** Quality and Safety Committees, Group Strategic Executive Board, Group Trust Board
Context	Innovation, research for new treatments, redesign of care delivery models with a focus on patient outcomes and experience

Score	Consequence	Likelihood	Combined
Initial Risk	4	4	16
Current Risk	**4**	**3**	**12**
Target Risk	4	2	8

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: **Not engaging in improvement activity, research and innovation**					
• Group Programme • SORT self-assessment • University Hospitals Teaching Status • Leicestershire Academic Health Partners Board (LAHP) • Health Innovation East Midlands • ICB Research Strategy Group • Nursing & Midwifery AHP&P Cabinet • Research Policy – hosting conducting & collaborating • LPT integration with system and • LAHP partnership working • Web-based platforms to support QI activity and QI Training Programme • PSIRP	• Research Strategy and delivery plan • Funding for academic posts • Clarity over remit for Group roles • Funding for research projects • Funding for Innovation (Dragon's Den) • Capacity of the LPT research team to support succession planning	**1st Line:** Participant Research Experience Survey (PRES) Research activity and income	Assurance over uptake and PRES survey outcomes	• Research Strategy and delivery plan **Medical Director August 2025** • Group Joint Roles with clinical/AHP research element – 'Principal Investigators' **Medical Director August 2025** • Assurance over uptake and PRES survey outcomes **Medical Director August 2025** • SORT self-assessment action plan **Medical Director September 2025**	Generation of New Knowledge Workstream – 1st meet 25.9.2; 2nd meet 18.10.24 (NHFT, UoL Partners) Oversight of research participant recruitment numbers to form part of reporting to AFM
		2nd Line: Joint Working Group oversight of Group research and innovation programme Research programme to Quality and Safety Committee Local clinical research network Transformation and QI Delivery Group Oversight of LAHP papers at SEB NHS IMPACT Self Assessment 2025 June 2025	Assurance over success rate for attracting high quality commercial trials		
		3rd Line: University Led Non-Executive Director			
Effect: **Quality and Design of Services**					
• QI programme • Transformation Programme • Directorate objectives aligned to strategy • Deputy Medical Director for R&D • Trust Lead for QI and Quality Governance	• Innovation strategy • Success measures	**1st Line** QI programme uptake and feedback, Learning boards		• Develop and deliver Innovation Strategy **Medical Director & Director of Strategy** October 25 • Success measures and measuring impact to be determined **Medical Director tbc**	DMD for R&D recruited Sept 24 Ongoing discussions with Health Innovation East Midlands re translating national projects to local needs.
		2nd Line QI and Transformation Committee AAA report to Finance and Performance Committee and the Strategic Executive Board	Impact of learning from research into service redesign		
		3rd Line CQC inspection feedback and ratings			

BAF **3.2**	Without **timely access** to services, we cannot provide high quality safe care for our patients which will impact on clinical outcomes.
Date	Included 1 April 2025. Last updated 21 July 2025
Strategic Link	THRIVE: **RESPONSIVE**
Governance	**LPT** Quality and Safety Committee, Strategic Executive Board, Trust Board
Context	Minimising harm while waiting, improving access to diagnosis and treatment, best clinical outcomes

Score	Consequence	Likelihood	Combined
Initial Risk	5	5	25
Current Risk	5	4	20
Target Risk	5	2	10

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: **timeliness of access to services**					
• Access Policy • Performance Management Framework • Urgent and Emergency Care Framework • Medical Workforce Plan • LLR ICB 5-year strategy and LPT strategy / Annual Plan • Keeping Patients Safe Whilst Waiting T&F Group • Close monitoring NHS111/2 activity and performance in directorate and shadow MH collaborative meetings	• National strategy for neurodiversity demand • Local commissioning plans for addressing significant increases in neurodiversity demand • Global shortage of ADHD medication	**1st Line:** Directorate attendance at Access Group and AFM WL trajectories and initiatives by service Operational risk profile AFM/EMB	Linkage of health inequalities to access group actions Clarity over policy compliance measures and rates	• Health Inequalities work to support Access Group actions. **Director of Strategy - Ongoing** • Policy compliance with Access policy **– Director of Nursing / Medical Director – August 25** • Raising awareness of neurodiversity demand at system level through System Execs and regionally through regional MH oversight group (RMHOG) and through Quarterly system review meetings (QSRM) – **Director of FYPCLDA ongoing – complete – remains ongoing** • Clinical Task and finish group workplan to be established **Director of Nursing August 2025**	
		2nd Line: • Access Group with AAA to AFM/EMB			
		3rd Line: • Internal Audit – Patient Observations 24/25 significant assurance • Internal Audit – Remote Consultations March 2023 significant assurance • CQC feedback and ratings	ADHD Solutions closure – reduction in support across LLR		
Effect: **Clinical Outcomes**					
• Reducing Harm Whilst Waiting Policy & compliance oversight • Clinical Outcome performance measures • PSIRF • Incident reporting • Implementation of PSIRF	Full implementation of PSIRF Challenge of clearly identifying harm whilst waiting	**1st Line** Directorate attendance at Access Group and AFM for escalation	Clarity over policy compliance measures and rates	• Quality & Safety Operational dashboard which will enable teams and services to have oversight of their key quality and safety metrics as defined by the CNO **Director of Nursing Ongoing** • Strategic oversight dashboard of the key safety metrics as defined by the CNO (in line with insightful board guidance) for oversight at QSC **Director of Nursing Ongoing**	Quality dashboard delivery framework developed (3-year programme)
		2nd Line Monthly performance report with clinical outcomes measures to Quality and Safety Committee and AFM	• Comprehensive quality dashboard focusing on outcome measures, including those attributed to waiting		
		3rd Line Internal audit patient experience August 2022 significant assurance	External review of waiting times on patient safety		

BAF **3.3**	If we do not continue to review and improve our systems and processes for **patient safety**, we may not be able to provide the best experience and clinical outcomes for our patients and their families.
Date	Included 1 April 2025. Last updated 21 July 2025
Strategic Link	THRIVE: **RESPONSIVE**
Governance	**LPT** Quality and Safety Committee, Strategic Executive Board, Trust Board
Context	PSIRF, Just Culture, Prevention of harm, learning

Score	Consequence	Likelihood	Combined
Initial Risk	5	5	25
Current Risk	**5**	**3**	**15**
Target Risk	5	2	10

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: Patient safety systems, processes and governance improvement & learning, CQC outcomes					
• Service safety checks/huddles & escalation • CQC mock inspections & quality visits • Safety Forum • Patient safety improvement programme board • Psychological Safety Workstream	• Workforce disruption (Safeguarding Lead gap) • Consistent monitoring of policy adherence	**1st Line:** Patient Safety Improvement Programme – phase 2 of RIPB; Executive Service Visits & feedback; NED Board Walks; Compliance Team visits	Consistent use of PSIRF templates & methodology	• Delivery of Patient Safety Improvement Programme, including consistent use of PSIRF templates & system thinking methodology **Director of Nursing, monthly update to PSIP with any escalations to EMB – ongoing in 2025/25** • Suicide prevention work & training **Medical Director, update August 25** • Onboarding of Head of Safeguarding **Director of Nursing Aug 2025** • Policy improvement programme with reporting of policy compliance. **Director of Governance March 2026**	• Safeguarding ICB overview • Staff booked onto STORM training
		2nd Line: SEB/Q&S Committee, Safety Forum. Recruited substantive Head of Safeguarding current support provided by Deputy Director of Nursing and Quality	• Suicide prevention training		
		3rd Line: External reporting (ICB); HOSCs; CQC Visits & outcomes; MHA Visits & reports, including ICB deep dive workshops (*safeguarding). Learning from national reports			
Effect: Poor outcomes for patients, carers, families					
• Incident reporting systems & processes • PSIRF • Access & patient flow • Patient experience • Reputational risk • Patient Safety Team • Quality/CQC Compliance/IPC monitoring • Recruitment of a Family & Patient Liaison Officer	• Consistency in incident reporting • Trust wide Discharge Policy	**1st Line:** Directorate oversight of local quality & safety systems and processes.		Quality Dashboard development **Director of Nursing ongoing 2025/26**	Phase 1 complete with minimal viable product complete
		2nd Line: • Patient Safety Improvement Programme • Notts HC Section 48 - sharing & embedding learning improvements via directorate governance & T&F Group	Comprehensive oversight of quality measures		
		3rd Line: Coronial feedback/NHSE oversight; HOSCs			

BAF **3.4**	If we do not have appropriate **emergency preparedness**, resilience and response controls in place, we may be impacted by accidents, disruption and system failures affecting our ability to maintain continuity of services.
Date	Included 1 April 2025. Last updated 21.07.25
Strategic Link	THRIVE: **RESPONSIVE**
Governance	**LPT** Health and Safety Committee, Quality and Safety Committee, Strategic Executive Board, Trust Board
Context	Maintain organisational resilience. External factors, social, environmental and economic impact

Score	Consequence	Likelihood	Combined
Initial Risk	4	5	20
Current Risk	4	2	8
Target Risk	4	2	8

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: **A lack of Emergency Preparedness, Resilience and Response Controls**					
• EPRR Policy • EPRR Group Collaborative • EPRR business continuity workplan including co-production of response plans for cyber risks • LPT representation at the Local resilience forum – feedback back into LPT governance • LPT representation at the Local health resilience partnership - feedback back into LPT governance		**1st Line:** Task letter return logs & actions	EPRR policy compliance	• EPRR policy compliance **Dan Adamson Group EPRR Lead October 2025** • Developing LPT winter plan to feed into LLR winter plan to be agreed by NHSE later in the year**. Managing Director – LPT winter plan for approval at EMB in July 2025.**	Joint EPRR lead in place and in process of reviewing all related policies
		2nd Line: • Oversight at Audit and Risk Committee and the Finance and Performance Committee • LPT Business Continuity Management System (BCMS) Audit • Post Incident /Exercise Reports • Joint EPRR Lead in post			
		3rd Line: • ICB and system assessment against NHS England EPRR Core Standards • IA audit 24/25	LLR winter plan 25/26 – yet to be agreed by NHSE		
Effect: **Continuity of Services**					
• Business continuity plans • Disaster recovery exercises • Industrial Action plans • Director on Call arrangements • Training of strategic, tactical and operational responders • ICC assurance flow via EMB • System wide countermeasure and mass casualty plans • LPT participation in National, regional and local exercises • Checks via on call directors		**1st Line** Business Continuity plans reviewed & agreed within EPRR Group Operational Hub	Completeness and robustness of trust wide continuity plans	• Ongoing review of continuity plans, reported into EPRR Group with an escalations to the Health and Safety Committee. **Managing Director ongoing 2025/26** • Preparation for EPRR core standards assessment 2025/26 **Managing Director ongoing.**	Taken part in industrial action audit for national review.
		2nd Line: Training oversight and management	Preparation for EPRR core standards assessment for 2025/26		
		3rd Line • Internal Audit – Business Continuity August 2022 Significant Assurance			

BAF **4.1**	If we do not adequately utilise **workforce** resourcing strategies, we will have poor recruitment, retention and representation, resulting in high agency usage.	
Date	Included 1 April 2025.	Last updated 21 July 2025
Strategic Link	THRIVE: **INCLUDING EVERYONE**	
Governance	**LPT** People and Culture Committee, Strategic Executive Board, Trust Board	
Context	Talent management, OD, growth and retention	

Score	Consequence	Likelihood	Combined
Initial Risk	5	4	25
Current Risk	**5**	**4**	**20**
Target Risk	5	3	15

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: **Not utilising workforce resourcing strategies**					
• Directorate Objectives and Planning linked to workforce plan • Staff Survey action plan • National and local People Plan • Recruitment Pipeline Management • Medical Workforce Plan • Recruitment and retention premium scheme for medical workforce • International recruitment • Nursing Recruitment & Retention High Impact Actions • LLR AHP faculty & Council • L2 Committee Workforce Development Group in place • Benchmarking against workforce metrics	• High vacancies with supply issues • Vacancy Control • Link to transformation planning • Structure of NHS pay award	**1st Line:** Operational risk profile for staffing – oversight at AFM and EMB/SEB; Recruitment weekly Gold Calls; Agency reduction Group	• Directorate objectives and planning linked to workforce plan – awaiting planning guidance • Actions resulting from recent staff survey findings when available • Impact of band 2/3 HCSW changes	• Delivery of the workforce and agency reduction plan 2025/26 **Ongoing Director of HR/OD** • Jobtrain/time to recruit monitoring & user satisfaction to be reviewed – benefits realisation to report to AFM EMB WDG & **PCC Aug 25 Director of HR/OD** • WDG to monitor time to hire Ongoing **Director of HR/OD** • Directorate level time to hire reports starting **Dec 24 Director of HR/OD**	Engagement with the NHSE price cap work for medical agency costs commenced Feb 2025 People Dashboard launched through PCC
		2nd Line: Workforce Development Group; Directorate Workforce groups & HCA Retention Working Group Strike Action Group (as required) including organisational debriefs; People & Culture Committee	• Delivery of the medical workforce plan • Delivery of the workforce and agency reduction plan • Jobtrain effectiveness including time to hire rates		
		3rd Line: System people and culture board System CPO meetings			
Effect: **High Agency Usage**					
• Agency Reduction Plan	None	**1st Line** EQIAs DRA and break glass criteria to stop deployment of Thornbury HCA		• Delivery of the workforce and agency reduction plan 25/26 Ongoing - **Director of HR/OD**	• No off-framework usage outside of break glass • THP numbers reducing • Bank incentives stopping agreed subject to EQIA
		2nd Line Agency reduction group AAA to People & Culture Committee	Delivery of the workforce and agency reduction plan		
		3rd Line • LLR People Programme Delivery Group • Internal Audit Agency Staffing April 2023 Advisory (no high-risk actions) • Internal Audit Supporting Timely Recruitment April 2023 Limited Assurance			

BAF **5.1**	If we do not lead with compassion, we will not promote an **inclusive culture**, resulting in unwanted behaviours and closed cultures.	
Date	Included 1 April 2025	Last updated 21 July 2025
Strategic Link	THRIVE: **VALUING PEOPLE**	
Governance	**LPT** People and Culture Committee, Strategic Executive Board, Trust Board	
Context	Innovation, research for new treatments and redesign of care delivery models with a focus on patient outcomes and experience	

Score	Consequence	Likelihood	Combined
Initial Risk	4	4	16
Current Risk	**4**	**3**	**12**
Target Risk	4	2	8

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: **Not leading with compassion**					
• Medical Leadership Programme • Accountability Framework • EDI policy • People Plan • WRES and WDES • Cultural competency programme • Group TAR programme (including PCREF) • Culture of Care • Staff Safety in the workplace • L2 Workforce Development Group	None	**1st Line:** • Appraisals with wellbeing element, speak up process, sickness management • Anti racism listening events • Campaign to embed leadership behaviours	Civil unrest	Cultural work to address civil unrest and wider including; • Delivery of TAR actions **Ongoing Director of HR/OD** • Delivery of the Our Future Our way Programme of work & 4 priorities & leadership behaviours embeddedness **Ongoing Director of HR/OD** • Staff Survey 24-25 – actions & implementation of priority areas **Ongoing throughout 2025/26 Director of HR/OD** • Development of reasonable adjustments framework – **Ongoing Maple & ND Staff Networks**	Anti racism listening events & FAQS following civil unrest/racist riots Workplace Safety & Security Sessions planned in Medical Trainees Inductions December 24 Leadership Programme for medics - planning underway Team Time Out year 2 launched
		2nd Line: • Reasonable adjustment clinics & meetings established • Leadership Development Conferences • F2SU Guardian, NED F2SU role • Learning from speaking up and sickness review • Workforce Development Group; People and Culture Committee • Schwartz Rounds • Group programme reporting to SEB every month for oversight	• Staff survey Oct 24 • Meeting reasonable adjustment requirements		
		3rd Line: • Internal Audit Freedom To Speak Up October 2023 significant assurance • Internal Audit Fit and Proper Persons Test due Q2 2024/25 • Health & Wellbeing 360 Audit rated significant assurance			
Effect: **Unwanted behaviours and closed cultures**.					
• Our Future Our Way • Leadership Behaviours Framework • Wellbeing, sickness management policy • Counselling service • Anti bullying harassment and advice service • Occupational health service wellbeing strategy	• Training on leadership and culture on induction • Closed cultures training	**1st Line** • Annual staff survey results • Deloitte staff survey and focus group feedback • Closed cultures covered in staff inductions • Reverse Mentoring cohort 6	• Delivery of recommendations from quality and safety review • Closed cultures not currently in staff inductions • Impact of leadership development	• Delivery of recommendations from quality and safety review. **Interim Director of Nursing 2024/25 - complete** • Leadership Conferences – focussed on psychological safety & speaking up within the 25/26 programme **Director of HR/OD**	• 4 Leadership Conferences taken place during 2024 • Jan 25 Team Leadership Conference
		2nd Line • Mental health and Wellbeing Hub • Health and wellbeing champions and wellbeing NED role • Health and Wellbeing Lead • People and Culture Committee			
		• **3rd Line** • CQC inspection findings • System mental health HWB hub	Audit outturn 25/26 CQC reports		

BAF **6.1**	If we cannot maintain and improve our estate, or respond to maintenance requests in a timely way, there is a risk that our estate will not be fit for purpose, leading to a poor-quality **environment** for staff and patients
Date	Included 1 April 2025. Last updated 10.07.2025
Strategic Link	THRIVE: **EFFICIENT AND EFFECTIVE**
Governance	**LPT** Finance and Performance Committee, Strategic Executive Board, Trust Board
Context	Therapeutic, fit for purpose, meet standards, agile working

Score	Consequence	Likelihood	Combined
Initial Risk	4	5	20
Current Risk	**4**	**5**	**20**
Target Risk	4	3	12
Risk Appetite – Open (upper limit of tolerance 16)			

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: **Unable to maintain and improve our estate**					
• Estates Strategy and Delivery Plan • Group Strategic Estates Plan • Accommodation & Space Policy • Estates Annual Plan 24-25 • Statutory Compliance continues to be maintained during 24-25 • Capital prioritisation process embedded • Clinical representation at Strategic Property Group	• Lack of capital funding • Aging estate with limited options for improvement • Having adequate space for clinics and supervision and training	**1st Line**: Capital Prioritisation process **2nd Line:** Estates and medical equipment group **3rd Line:** System estates groups, Capital prioritisation criteria , CQC engagement meetings and inspection feedback		• Identify alternative sources of capital Engagement internal to prioritise estates safety **Chief Finance Officer – August 2025** • Medical Directorate rep at relevant Estates meetings to be identified – **Medical Director**	Space Utilisation Study started Sept 24 – Feb 25 full completion – awaiting sign off – EMEG 16th July 25 – EMB Aug 25
Cause: **Unable to respond to maintenance requests in a timely way**					
• Maintenance Logging System • Performance monitoring (soft & hard FM) data (12 months) • Jobs logged monitored & tracked monthly – monthly reports to DMTs breaking down outstanding jobs	Financial constraints – capital and revenue	**1st Line:** Feedback and use of the maintenance logging system **2nd Line:** KPIs in place for soft FM **3rd Line:** CQC feedback		Oversight of financial constraints ongoing – **Chief Finance Officer and Director of Finance via SEB and Trust Board**	Continued reduction in number of outstanding maintenance jobs
Effect: **Poor quality environment**					
• Environmental checklist • Operational risk management • Environmental checklist • Operational risk management • Health & Safety inspections • Estates Annual Plan	• Governance oversight of all quality and risk issues relating to environment • Regulatory standards for buildings	**1st Line:** Directorate Management Teams for escalation and oversight of risk **2nd Line:** Estates and Medical Equipment Committee; Estates log **3rd Line:** CQC feedback	Adherence to systems and processes (detailed in actions) for identifying and logging environmental concerns	• Governance route escalations • EMEG – review risks & escalate • AFM clarified escalation process • Annual Estates Plan approved • Escalation of Health & Safety issues • Oversight of estates risks on Ulysses • Review building compliance standards with DoN **Chief Finance Officer – August 2025**	Ongoing CRR/ directorate risk reviews taking place

GROUP BAF **6.2**	If we do not continue to strive for **sustainability**, we will be impacted by adverse weather events and environmental factors impacting on the health of our population, resulting in poorer health outcomes.	
Date	Included 1 April 2025.	Last updated 10.07.25
Strategic Link	THRIVE: **EFFICIENT AND EFFECTIVE**	
Governance	**GROUP** Finance and Performance Committees, GROUP Strategic Executive Board, Group Trust Board	
Context		

Score	Consequence	Likelihood	Combined
Initial Risk	4	3	12
Current Risk	**4**	**3**	**12**
Target Risk	4	3	12

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: adverse climate change and sustainability factors					
• Green Plan 2022-25 • Estates Strategy and Delivery Plan • Partnerships Manager as resource for Green Plan oversight	• Green Plan for upcoming three-year period in line with ICB plan in draft. • Oversight of climate change and sustainability factors impacting on our population	**1st Line:**	• Plans to start Group Sustainability Forum July 25	• To present refreshed green plan (for upcoming three-year period) with the Trust Board for approval and publish on Trust website. **Chief Finance Officer July 2025** • To share revised green plan with NHSE and DHSE. **Chief Finance Officer July 2025** • To draft the Trust's response to the TCFD and include within annual report 2025/26. **Chief Finance Officer May 2025** • Gap analysis of available funding and impact of any resource gap on delivery of the revised green plan. **Chief Finance Officer July 2025**	• Funding secured for solar panel installations at Hinkley & Bosworth and Loughborough
		2nd Line: Finance & Performance Committee Estates & Medical Devices Group, SEB	• Specific sustainability group for oversight of draft revised green plan and oversight of climate change and sustainability factors • Green plan refresh to receive board level approval July 25 and then be published on the Trust's website.		
		3rd Line: CQC feedback NHSE oversight of green plans	• Revised green plan yet to be shared with NHSE and DHSC. • Provision of information to support the Task Force on Climate related financial disclosures (TCFD)		
Effect: Poorer health outcomes due to climate change and sustainability factors					
Green Plan • Group Sustainability Forum oversight of green plan delivery	• Understanding the impact of climate change and sustainability on our local population	**1st Line**	• Plans to start Group Sustainability Forum July 25		
		2nd Line Finance & Performance Committee Estates & Medical Devices Group, SEB	• Specific sustainability group for oversight of impact of green plan delivery on our local population, and oversight of key climate change and sustainability factors impact on population health.		
		3rd Line NHSE and DHSC oversight of green plan and TCFD			

BAF **6.3**	Inadequate **capital funding** for LLR system will impact on LPT's ability to manage financial, quality & safety risks related to estates and digital investment in 2025/26 and in the medium term	
Date	Included 1 April 2025.	Last updated 17.07.25
Strategic Link	THRIVE: **EFFICIENT AND EFFECTIVE**	
Governance	**LPT** Finance and Performance Committee, Strategic Executive Board, Trust Board	
Context	Delivery within available capital resources. Estates, digital regulatory, constitutional and legal requirements.	

Score	Consequence	Likelihood	Combined
Initial Risk	5	4	20
Current Risk	**5**	**4**	**20**
Target Risk	5	2	10

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: **Inadequate Internal Control**					
• SFIs / SORD • Scheme of delegation • Capital bid approval process	• None	• **1st Line:** Capital management committee management of capital plan; Clear capital bid approval process; SEB & Board approval of capital opening plan & subsequent revisions • 2024/25 accounts – CRL delivered	• Ensure adequate senior clinical representation in prioritisation meetings	• Policy compliance audit and oversight **Director of Finance and Performance.**	
		2nd Line: Accounting policies / SFIs and SORD [Audit and Risk Committee]	Policy compliance		
		3rd Line: External Audit 2023/24 annual accounts unqualified opinion	24/25 annual accounts audit	• External audit of 24/25 accounts **Director of Finance and Performance.**	Unqualified opinion issued
Cause: **Inadequate reporting and management**					
• Monthly finance report with exec level oversight • Capital management committee 3A report • ICS capital Committee		**1st Line**: Capital management committee triple A report		Appropriate escalation of specific LPT risks via EMB **Medical Director – starting February 2025**	In progress
		2nd Line: Monthly corporate report EMB/SEB/FPC and oversight at the System Finance Meeting & system capital committee	Escalation of risk		
		3rd Line: 2024/25 system wide capital audit completed; 3 low risk findings across all partners			
Effect: **Breach of Statutory Duty (CDEL)**					
• National guidance	• None	• **1st Line** monthly finance report assurance on CDEL delivery year to date & forecast	Approval of medium-term capital plan	Develop medium term capital plan, aligned to ICS plan	
		2nd Line			
		3rd Line KPMG 2024/25 annual accounts and VFM conclusion		**Sharon Murphy, DoF / March 26**	
Effect: **Non achievement of capital strategy (LPT and System)**					
• National planning guidance – LPT & ICS delivery plan	• LLR ICB medium term capital strategy	• **1st Line:** ICS Capital committee reviews organisational delivery & ICS Finance committee		• LLR infrastructure 10 year plan; LPT 25/26 & 5 year plan • Manage Trust's capital plan **DoF / March 26** • Policy compliance audit and oversight **Director of Finance and Performance.**	In progress
		2nd line:			
		3rd line:	24/25 annual accounts audit	• External audit of 24/25 accounts **Director of Finance and Performance.**	Unqualified opinion issued

BAF **6.4**	Inadequate control, reporting and management of the Trust's **2025/26 financial position** could mean we are unable to deliver our financial plan and adequately contribute to the LLR system plan, resulting in a breach of LPT's statutory duties and financial strategy (including LLR strategy)
Date	Included 1 April 2025. Last updated 17.07.25
Strategic Link	THRIVE: **EFFICIENT AND EFFECTIVE**
Governance	**LPT** Finance and Performance Committee, Strategic Executive Board, Trust Board
Context	Delivery within available financial resources. Use of resources, productivity and value for money–Performance measures, constitutional and legal requirements.

Score	Consequence	Likelihood	Combined
Initial Risk	4	5	20
Current Risk	**4**	**4**	**16**
Target Risk	4	2	8

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: **Inadequate Internal Control**					
• SFIs / SORD • Treasury Mgt policy • Scheme of delegation • Code of conduct • Declarations of interest	None	**1st Line:** Expenditure control forms for all relevant non pay spend over £150; vacancy control process; DRA agency approval process; No PO no pay policy; segregation of duties in finance teams • 2024/25 accounts – break even plan delivered	Additional Belvoir decant costs Reducing cash balances Supplier challenge of contract awards	• DMH to manage private provider costs **Director of DMH July 2025** • Enhanced cash reporting • Ensure transparent & compliant contract awards • Policy compliance audit and oversight **Director of Finance and Performance tbc**	Ongoing In place Review processes Being scheduled
		2nd Line: Accounting policies / SFIs and SORD [Audit and Risk Committee]	Policy compliance		
		3rd Line: External Audit 2023/24 annual accounts unqualified opinion	24/24/25 annual accounts audit	• External audit of 24/25 accounts **Director of Finance and Performance**	Unqualified opinion issued
Cause: **Inadequate reporting and management**					
• Monthly Reports with exec level oversight • Value Programme to deliver local efficiencies	CIP programme	**1st Line**: Directorate finance reports; bi-monthly DoF service level run rate reviews; Enhancing value CIP delivery review	CIP plan not fully identified Plan gap c£7m	• CIP – identify & deliver CIP programme **Director of Finance and Performance ongoing** • Close plan gap **– Director of Finance and Performance** • Deep dive reporting **Director of Finance and Performance ongoing** • DoF/service financial escalation meetings • Include agreed I & I improvement actions in 25/26 plan **Director of Finance and Performance**	Ongoing Workforce controls work prioritised As required Completed
		2nd Line:	Beacon Unit viability; non recurrent CIP; In year overspends & funding gaps.		
		3rd Line: Annual Internal Audit – scheduled Q3 2025/26			
Effect: **Breach of Statutory Duty**					
• National guidance	None	**1st Line** monthly finance report assurance on break even delivery year to date & forecast	Approval of medium-term recovery plan	Medium term recovery plan, using value in healthcare approach **Sharon Murphy, DoF / March 26**	Unqualified opinion issued
		2nd Line			
		3rd Line KPMG 2024/25 annual accounts and VFM conclusion	24/25 annual accounts audit		
Effect: **Non achievement of financial strategy (LPT and System)**					
• LPT financial strategy & plan	• LLR ICB revenue strategy • 24/25 non delivery of ICB plan	• **1st Line:** Organisational reports to ICS Finance Committee	• In year LLR plan delivery materially off plan	• LLR ICS financial strategy - Mitigate ICS financial delivery **Director of Finance ongoing** • Manage delivery of 2025/26 financial plan **DoF / March 26**	Via recovery & Sustainability Committee
		2nd line: System wide internal audit of financial systems			
		3rd line: Internal Audit – System wide financial controls & NHSE submissions	Audit outturn – all partners		

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NHS Leicestershire Partnership NHS Trust

LPT and Group Development Programme 2025/26

(Board Development Programme last approved at 25 March 2025 Trust Board)

Date	LPT/Joint Session	Topics to be covered
10 April 2025 *(Moved to pm on 29.04.25)*	~~Q1 Joint Board Development~~ ~~*(Hosted by NHFT)*~~	
29 April 2025 9.30am-1.00pm Executive Boardroom, CH	LPT Board Development and Q1 Joint Board Development	Morning (LPT Development) 1. Confidential Item (Financial Plan submission) 2. Medium to long term financial planning 3. Well Led Evidence and Self-Assessment 4. Revised BAF and Risk Appetite Afternoon (Q1 Joint Development) 5. Insightful Provider Board self-assessment 6. CQC State of Care 7. Group board meetings
24 June 2025 9.30am-4.00pm Executive Boardroom, CH	LPT Board Development PLUS EGM	EGM Agenda: Normal agenda items plus contract approval item for Cygnet Elowen Workshop Agenda: Environmental update Introduction and self-assessment (Kate) Shared Direction and Culture (Kate) Capable, Compassionate and Inclusive Leaders (Sarah) Freedom to Speak Up (Jean) Workforce, Equality, Diversity and Inclusion (Sarah) Governance, Management and Sustainability (Kate/Sharon) Partnership and Communities (David) Learning, Improvement and Innovation (Bhanu/James) Environmental Sustainability (Paul Sheldon)
26 August 2025 *9.30am-4.00pm*	Q2 Joint Board Development *(Hosted by LPT)*	1. Fitness to Practice for Executive Directors – training from Browne Jacobson Solicitors 2. NHS Benchmarking – understanding data story

Date	LPT/Joint Session	Topics to be covered
Venue: NSPCC		3. Hate Crime Presentation - MH Chairs Call 4. Strategic Defence Review 5. LLR/Northants Clustering 6. Well Led 7. Group BAF
28 October 2025 9.30am-4.00pm Executive Boardroom, CH	LPT Board Development	1. Run through of Board Effectiveness 2. Leadership Competency Framework 3. Active Bystander Programme 4. Our Future Our Way 5. Valuing High Standards Accreditation Programme 6. Health and Safety Deep Dive 7. People's Council (Mark Farmer) 8. Freedom to Speak Up self-assessment (reflection tool) 9. Keeping People Safe (QSC/FPC) 10. Staffing and Recruitment (PCC)
13 November 2025 1.00pm-5.00pm (half day) Venue: tbc	**Q3 Joint Board Development** *(Hosted by NHFT)*	1. Mental Health Training for LPT/NHFT Boards 2. Artificial Intelligence and Cyber Security
16 December 2025 9.30am-4.00pm Executive Boardroom, CH	LPT Board Development	1. Sustainability: our strategic direction 2. Capital and Estates 3. EPRR 4. Raising Health Charity
24 February 2026 *9.30am-4.00pm* *Venue: NSPCC*	**Q4 Joint Board Development** *(Hosted by LPT)*	

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Leicestershire Partnership NHS Trust

3As Highlight Report
Meeting Name: Audit and Risk Committee
Meeting Chair & Report Author: Hetal Parmar / Val Glenton
Date: 13 June 2025
Quorate: Yes
Policies & expiry date: Policy Management Policy

Agenda Item:	Reference:	Lead:	Description:	BAF Ref:
ALERT: Alert to matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the Trust's strategy				
There were no items to alert the Board to.				
ADVISE: Advise the Board of areas subject to on-going monitoring or development or where there is negative assurance				
There were no items to advise the Board of.				
ASSURE: Inform the Board where positive assurance has been received				
Auditor's Annual Report 2024/25	ARC/25/034	Audit Manager KPMG	LPT's external auditors expected to issue an unqualified opinion on LPT's accounts for 2024/25 as in their opinion the accounts give a true and fair view of the financial performance and position of the Trust. ARC noted the good working relationship between LPT's finance team and its external auditors. Thanks were given to both teams for the hard work that had gone into the year end accounts process.	BAF 6.4
Policy Management Policy	ARC/25/035	Director of Governance and Risk	ARC approved the updated policy which provided guidance for authors to ensure policies were set out in a standardised way. The main changes were the inclusion of accessible standards and revised monitoring indicators.	N/A
Governance & Risk Report	ARC/25/036	Director of Governance and Risk	ARC received a high level of assurance on systems and processes in place to secure an effective governance and risk framework.	N/A
Annual Review of Committee Effectiveness	ARC/25/038	Director of Governance and Risk	A review of ARC effectiveness had been undertaken and concluded that the committee had been effective during the year as it had fulfilled its terms of reference.	N/A

Agenda Item:	Reference:	Lead:	Description:	BAF Ref:
Losses and Special Payments	ARC/25/041	Director of Finance	ARC received the annual summary of losses and special payments made by the Trust.	BAF 6.4
Standard Financial Instructions	ARC/25/042	Director of Finance	ARC reviewed and approved the proposed changes to the SFIs.	BAF 6.4
Going Concern Assessment 2024/25	ARC/25/043	Director of Finance	ARC agreed the Going Concern Assessment be submitted to Board to request support of the assertion that the Trust was formally recognised as a Going Concern.	BAF 6.4
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding				
2024/25 Head of Internal Audit Opinion	ARC/25/030	Director of 360 Assurance	A 'significant assurance' opinion was given that there was generally a sound framework of governance, risk management and control in place designed to meet the organisation's objectives. ARC noted the Trust had a robust process and proactive culture on the completion of internal audit actions, the implementation rate reported for 2024/25 was 100% for first follow up high and medium risks. In terms of benchmarking against other Trusts, LPT was in the top two organisations within 360 Assurance's portfolio.	N/A
Annual Financial Accounts Overview 2024/25	ARC/25/039	Director of Finance	ARC noted the Trust had achieved its two statutory duties, the first was the NHSE control total which was delivered with an end of year surplus of £11k, and secondly the Trust presented a balanced capital position against its capital resource limit allocation of £19.9m. ARC approved the submission of the accounts and full annual report to Trust Board on the 24th June for final approval with the intention of submitting the accounts prior to the submission deadline of 30th June.	BAF 6.3 BAF 6.4

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Leicestershire Partnership NHS Trust

3As Highlight Report Meeting Name: Extraordinary meeting of the Quality and Safety Committee Meeting Chair & Report Author: Josie Spencer Non-Executive Director Meeting Date: 20th May Quorate: Yes						
Agenda Item Title:	Minute Reference	Lead:	Description:	BAF Ref:	CRR Ref:	Directorate Risk Ref:
ALERT: Alert to matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the Trust's strategy						
Sexual Safety Annual Report 2024-25 Safeguarding Annual Report 2024-25			Due to unforeseen circumstances these reports were not received at this meeting. They will be received at the next meeting of the committee which will be June 2025.			
ADVISE: Advise the Board of areas subject to on-going monitoring or development or where there is negative assurance						
Review of Clinical Plan 2022-24 – Development of new Clinical Plan 2025-30	Item 3	Bhanu Chadalavada	The committee received two papers summarising progress against the current Clinical Plan (2022-24) and plans for transition to a new clinical plan for 2025-30. The Trusts current Clinical plan 2022-24 was developed through a process of reflection and engagement with stakeholders to reset and rebuild the strategy with the learning and experience gained during Covid-19. The plan had now reached its conclusion and a further paper was presented outlining plans to develop a new Clinical Plan for 2025-30. Feedback from the consultation and engagement process has been triangulated with the THRIVE Group Strategy, the NHS Operational Plan, the Darzi review, the ICB Clinical Strategy and LPT's Quality Account. The consultation process is underway with an anticipated timeline for completion of August 2025. In terms of reporting on the Clinical Plan, it was agreed that the Committee will receive a progress report in six months and the final position reported via the Annual Report for the Clinical Plan 2025-30. Noting that the process in underway, but that the consultation period is due to conclude in August 2025 the committee will be updated on progress in October 2025.	3.1 3.3		
Mental Health Act Annual Summary Report 2024-25	Item 4	Bhanu Chadalavada	The committee received the Mental Health Act Annual Summary Report 2024-25 which provides information on the use of the Act across LPT Services. The report contains details of the MHA dashboard, manager's hearing, tribunals	3.3		

			and MHA activity. The new Mental Health Bill remains at the report stage and there is currently no timescale for planned implementation, although it is anticipated this will take a significant period of time. The committee noted an increase in the use of the act within acute hospital settings and a total of 48 detentions within the period. The dashboard continues to report 100% compliance with statutory requirements of the Act, namely Consent to Treatment Provisions, Section 132 Provision of Information at the Point of Detention and Section 17 authorisation by Responsible Clinician. A decrease in the use of MHA on admission to hospital was noted as well as a decrease in Section 2 admissions for assessments. There was an increase in Section 3 admissions. The most significant increase was around the use of Section 17a Community Treatment Orders (CTO) with an increase of 35 patients. Compliance was 100% for MHA Census, which monitors statutory paperwork and scrutiny forms, Section 132 – Statutory Duty to Provide Information, Section 17 – Leave of Absence and Consent to Treatment. In reference to gaps highlighted by the CQC in relation to Section 132 and 17 the committee requested a narrative around the improvement work underway and planned was provided. In addition the committee requested the inclusion of some benchmarking with other Trusts to understand our alignment to the national picture. Also, in regard to section 4 patient rights, further explanation of how LPT performs compared to other Trusts across the Country would be useful. It was agreed that the report would be updated to reflect these changes and a revised report would be submitted to the committee in June 2025.			
ASSURE: Inform the Board where positive assurance has been received						
Policies approved/ extensions granted:			Nil			
Same Sex Accommodation Annual report and Declaration of compliance –	Item 5	James Mullins	The committee received Same Sex Accommodation Annual report 2024-25. In 2024-2025 there was one justified mixed sex accommodation breach. LPT's Statutory Annual Declaration of Compliance was noted.	3.3		
Research and Development Annual Report 2024-25	Item 6	Bhanu Chadalavada	The committee received the Research and Development Annual Report 2024-25 and highlighted several areas of note. The committee commended the significant work underway in the organisation but would like to see a clearer demonstration of how research impacts delivery of patient care. It was	3.1		

			suggested that some of the excellent activity underway identified in the report could be presented at a public facing section of the Trust Board.			
Infection Prevention and Control six monthly report –	Item 7	James Mullins	The committee received the Infection Prevention and Control Report six monthly report for the period 1st October 2024 – 31st March 2025. The report provided assurance that LPT has a robust, effective and proactive Infection Prevention and Control strategy and work programme in place and this complies with the Health and Social Care Act 2008, also referred to as the Hygiene Code.	3.3		
Controlled Drugs Accountable Officer Annual Report 2024-25	Item 8	Bhanu Chadalavada	The committee received BC presented the Controlled Drugs Accountable Officer Annual Report 2024-25, which details the number of incidents (occurrences) involving controlled drugs in the Trust during 2024/25 to provide assurance that controlled drugs are managed in a safe and secure manner. During the period, 134 incidents involving controlled drugs were recorded, which is an increase of 26% on the previous year, but in line with comparator organisations. It was reported that none of these incidents was felt to have health community wide implications. The committee considered that increased reporting of incidences is a positive thing and indicates evidence of increased knowledge and confidence in the reporting process. The committee received full assurance from the report.	3.3		
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding						
			None			

3As Highlight Report
Meeting Name: Quality and Safety Committee
Meeting Chair & Report Author: Josie Spencer Non-Executive Director
Meeting Date: 17th June 2025
Quorate: Yes

Agenda Item Title:	Minute Reference	Lead:	Description:	BAF Ref:	CRR Ref:	Directorate Risk Ref:
ALERT: Alert to matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the Trust's strategy						
Accountability Framework Meeting AAA report	Item 6	Jean Knight	There continues to be a high and growing number of over 52- week waiters across a number of services which has materially increased since April 2024. Whilst the movement in April is in part due to the resolution of some data quality issues, the upward trend remains unaltered. Waits are occurring in a range of services. With the exception of community paediatrics and adult ADHD, over 52-week waits are predominantly for treatment rather than for first appointment	3.2		
ADVISE: Advise the Board of areas subject to on-going monitoring or development or where there is negative assurance						
Accountability Framework Meeting AAA report	Item 6	Jean Knight	The Access Delivery Group reviewed the 'Keeping Patients Safe Whilst Waiting' report, agreement on the appropriate measures remains with the Interim Director of Nursing and Quality. Directorates shared the measures they take within their own areas. The next meeting will focus on evidence that the measures are consistently being applied. Post meeting note- agreement was reached at the Board Development Session that a workshop considering all aspects of 'Keeping Patients Safe Whilst Waiting' would be reviewed at an upcoming Board Development Session to include not only the quality and safety aspects alongside the impact of workforce issues , and operational management of waiting lists.	3.2 3.3		
Level 2 Quality Forum AAA reports (April & May 2025)	Item 10	James Mullins	Waiting times are increasing for Nutrition and Dietetics referrals, with the longest wait at 39 weeks. It was noted that a new risk (5952) has been added to the Risk Register to reflect this. Additional funding has been received from Local Authority to increase capacity to manage emergency tube changes within the service. In addition there is an emerging issue in relation to increasing	3.2 3.3		

			referrals predominantly from UHL. Conversations are underway with the ICB about capping caseloads which will in turn increase pressure in the system and there was acknowledgement of the complexities around this issue. It was agreed to add this issue to the action log, the committee will receive a further update in October 2025.			
Complaints performance assurance	Item 17	Emma Wallis	The Committee received the report in response to an action (751) from Aprils meeting. There has been a focus on some of the Trust's key performance indicators (KPIs) around complaints management, namely that 90% of complaints are acknowledged within 3 working days and 90% of complaints are closed within 40 working days. The latter KPI has not been achieved for some years and the performance for 2024/25 was 53%. The Complaints Review Group have commissioned a piece of work to explore this at depth and actions to address have been agreed. Analysis of the themes for late completion has shown that 69% were due to documentation, 19% due to director sign off and 2% case complexities. The complaints team has arranged weekly drop-in sessions to support investigators and complaints training is co-delivered by somebody with lived experience. There was clearly more work to do to resolve this issue. It was agreed to receive an update on progress at the Committee in December 2025.	3.3		
Quality summit-overview paper	Item 18	Michelle Churchard	The Committee received a summary report of Quality Summits held in LPT in the last year. These have been held across the following four service areas: Crisis Pathway, PIER team, The Willows and Substance Misuse. Quality Summits are undertaken for a variety of reasons, including following a request by the Directorate or via incident trends and the process is a positive way of addressing complex issues around quality and safety, ways to identify learning to address issues and implement Quality Improvement projects. The Committee received the report, which described the process. The Committee requested that evidence of the learning and triangulation with improved outcomes be included in future reports.	3.3		
Level 2 Safety Forum AAA Reports and Terms of Reference	Item 20	Bhanu Chadalavada	The Committee received the lengthy report which highlighted a number of areas that were being worked upon but identified no alerts. The following areas were identified for escalation as advisory to the Trust Board: The patient safety information group advised on the ongoing issue of access to electronic patient records across services which could potentially lead to delays in accessing information and is being addressed through the IM&T group.	3.3		

			The variability in practice for clozapine medication management has been noted through an internal review and Head of Nursing for DMH is leading on the establishment of satellite clinics in CMHTs to address this issue. The issue relating to the National patient safety alert on annual risk assessment for patients no longer under the care of LPT has been escalated to the ICB.			
Learning from Deaths Report	Item 25	Bhanu Chadalavada	The Committee received the Learning from Deaths report for Q4 24-25. All three clinical directorates have their own Learning from Deaths meeting and these feed into a centralised Learning from Deaths group, where learning is shared, and an action log held for each case. The Committee asked for more assurance about the backlog of 48 child deaths and also about communication with families. It was noted that all child deaths go to the Child Death Overview Panel (CDOP) for review. This is a multi-agency review that considers the circumstances and learning. There is no separate screening undertaken, however within the Policy, all deaths are expected to be screened, so this impacts the numbers being reported. Options to introduce a new screening tool are being considered. It was requested that the narrative around the process for child death reporting to be captured more explicitly in the next iteration of the report in addition to the data. It was noted that in 2024 there was a backlog of death reviews in DMH and MHSOP and a piece of work undertaken to provide assurance on how this was being addressed, there now appears that a similar picture is emerging in FYPCLD. The Committee were advised that this is due to the separate process for Child deaths being reviewed at CDOP and LPT Policy not aligning to this. It was agreed that a review of the Policy to ensure there is greater clarity and confidence in the process. The Learning from Deaths Report is delegated to the Committee from Trust Board and as such the report is appended to this report for sight of the Board.	3.3		
Audiology Update	Item 26	Paul Williams	The Committee received an update on the desktop review undertaken in LPT in response to the Lothian review of Paediatric audiology services, which found systemic failings. LPT's review identified actions across four domains: Clinical governance, Equipment and clinical environment, Incidents and risk and staff training and education. The report provided evidence of significant waiting list improvement, changes to the Estate, improvements in training and pathway to prevent future inappropriate referrals. It was noted that the service is still fragile, and sickness remains an issue. The Committee was advised that the	3.2 3.3		

			service and directorate has decided to proceed with a pre assessment and benchmarking in readiness for possible IQIPS accreditation application in 2026. Noting the anticipated trajectory for ongoing planned work it was agreed to receive a final report in December 2025.			
Staying Safe from suicide guidance-LPT position	Item 27	Bhanu Chadalavada	The Committee received an overview report on the NHS England guidance "Staying Safe from Suicide" and the LPT position in regard to this. The guidance promotes a move towards a person-centred, holistic approach with ten key principles, and away from the reliance on risk prediction tools. The guidance has been considered by the Trust Suicide prevention Group (which reports to Safety Forum and there are links with the LLR ICB suicide prevention strategy). The Trust Lead is exploring training packages. The Committee asked for assurance around any overarching self-assessment against the gap analysis it was agreed that the Committee would receive a further report in October.	3.3		
ASSURE: Inform the Board where positive assurance has been received						
Policies approved/ extensions granted:			Nil			
Quality and Safety Dashboard	Item 8	James Mullins	The Committee received an overview of the development of the Quality and Safety Dashboard and the trajectory for implementation from the pilot phase. The changes in incident reporting were highlighted due to Learn from Patient Safety Events (LFPSE) and associated NHSE guidance have impacted on the special cause variation. The recording of harm for expected deaths (previously reported as no harm) even if the incident had occurred outside of the organisations care, is impacting on this metric. A deep dive is underway through the Safety Forum to scrutinise the incident reporting and data validation in line with NHSE guidance and will link to the Learning from Deaths process and Quality and Safety Committee will receive an update in August 2025. The Committee we assured on progress in relation to the dashboard development and implementation timeline.	3.3		
Safeguarding Annual Report 2024-25	Item 14	Michelle Churchard	The Committee received the Annual Safeguarding report summarising LPT's responsibilities and duties in terms of Safeguarding compliance with statutory requirements and activities undertaken by the Trust on behalf of the health community in LLR, including Safeguarding Children strategy calls and partnership involvement with the Children's and Adult Safeguarding boards in Leicester. The report was presented for sign off by the Quality and Safety Committee under delegation from the Trust Board. The report will be shared	3.3		

			with the ICB and in terms of accountability for organisations, this is currently completed through an annual online portal submission to NHS England, and this has been completed. The Committee approved the Annual Safeguarding Report.			
LPT Sexual Safety Annual Report 2024-25	Item 15	Michelle Churchard	The Committee received the LPT Sexual Safety Annual Report 2024-25 There has been a re-launch of the Sexual Safety subgroup and there are now three separate workstreams, one relating to patient safety on our wards, another relates to staff Sexual Safety (and delivering the NHS Sexual Safety Charter commitments) and the third workstream which supports patients and staff disclosing domestic abuse and or sexual violence. LPT now has a Sexual Misconduct policy and anonymous reporting process for staff. Work is underway with patients around expectations around sexual behaviour on wards. The Trust's Domestic Violence policy is being reviewed and added to. The Committee was assured with the work done to date.	3.3		
Level 2 Safeguarding Group AAA Report	Item 21	Michelle Churchard	The Committee were assured by the report from the May 2025 Safeguarding Committee. The Committee had previously raised an alert relating to a significant backlog in receiving the minutes from Children's safeguarding Strategy meetings, from the Local Authority. This has now been addressed. It was noted that the majority of the actions in the Quality Improvement Plan for Safeguarding have been completed.	3.3		
Mental Health Act Annual Report	Item 23	Bhanu Chadalavada	Following a request from the Committee in May 2025, an addendum report to the Metal Health Act Annual report 2024 was received. . The Committee had requested some additional narrative around Quality Improvement activity for Section 132 and Section 17, inclusion of comparative data against other Trusts, increases to be reported as percentages, inclusion of any available data around increase in use of the Act in ethnic minorities and if not available how this can be addressed and additional information about increasing demand for CTOs. The Committee was assured that the Addendum report provides additional detail against all areas and requested sight of the final report for information at the August 2025 Quality and Safety Committee.	3.3		
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding						
Level 2 Quality Forum AAA reports (April & May 2025)	Item 10	James Mullins	The Healthy Living Toolkit for People with Learning Disabilities has been developed by the Leicester, Leicestershire and Rutland (LLR) Learning Disability and Autism Collaborative, led by LPT. The toolkit is designed for adult social care staff who support individuals with learning disabilities. A comprehensive			

			resource to promote healthier lifestyles, with a focus on nutrition, hydration, and physical activity. The toolkit addresses prevalent health concerns and disparities often experienced by individuals with learning disabilities, to support the delivery of equitable and person-centred care. This was shared widely as a resource for LPT staff working outside of LDA teams.			

Leicestershire Partnership NHS Trust

Trust wide Learning from deaths report

Safety and Quality in Learning from Deaths Assurance (Quarter 4)

1. Purpose of the Report

This report is presented to the Quality & Safety Committee for onward Trust Board assurance of the efficacy of the Learning from Deaths (LfD), Child Death Overview Panel (CDOP), Learning from lives and deaths – People with a learning disability and autistic people (LeDeR), and Patient Safety Incident Response Framework (PSIRF) and adherence to the National Quality Board (NQB) guidance on LfD (2017). This Report presents data from January to March 2025 (Quarter 4: Q4) including learning from Q4 and previous quarters not captured in previous reports.

Patient deaths within scope for the trust's mortality review are those where, at the time of death the patient was and been in contact with the following LPT services:

- Any inpatient setting – including community hospitals.
- Community Health Services (CHS): any patient discharged from a community hospital within 30 days where known. It does not include any patient deaths where LPT is not classed as the main provider.
- Directorate of Mental Health (DMH) & Mental Health Services for Older People (MHSOP) patients on active caseloads or were discharged from the service in the 6 months prior to their death.
- Any patient death where the relatives/carers, staff, medical examiner (ME) or coroner raise concerns about the death.

The information presented in this report is based on reports submitted from the directorates and collated by the LfD Governance and Quality Assurance Coordinator within the corporate patient safety team (CPST). LfD meetings are scheduled monthly within Directorates.

2. Analysis of the issue

LfD Policy – Dr Neelofar Bargir, CAMHS Consultant and Undergraduate Clinical Tutor is leading on updating the LfD Policy and presented a first draft at the Trust Wide LfD meeting held in January 2025 which was circulated for further discussion and input from Directorates. A further draft will be presented at April's Trust Wide LfD meeting.

Data:

- **Patient cause of death data** –CPST are working with the ME's office to establish a process for requesting and obtaining the recorded 'Cause of Death' (CoD) for Community and In-Patient In-Scope deaths. In Q4, of the 454 deaths, we have received CoD for 46. The percentage of CoD's received by LPT is expected to increase further over the next quarter. The intention is that when

we have a higher percentage of CoDs future reports, we will be able to include greater detail related to patient deaths.

- **Patient Demographics & Protected characteristics** - Where there are gaps in recording, this is due to absence of treating teams/primary care to capture this in patient's electronic patient record (EPR), SystmOne. CPST are unable to influence this capture of information on SystmOne apart from sharing this as potential gap in our learning.

CHS

- **LfD meetings -** In Q4, all LfD meetings went ahead as planned.

DMH/MHSOP

- **LfD meetings** – In Q4, AMH and MHSOP LfD meetings have combined, and a joint meeting was held in February. Unfortunately, March's meeting was cancelled due to the number of apologies received however as future dates have been set for 2025/2026, it is envisaged that attendance will improve.
- **Screening process / Screening risk (5934)** – Work is being undertaken with the IM&T team to fully automate the screening process which, when complete, will forgo the need for a clinician to undertake the screening and therefore close the risk related to the sustainability of screening being reliant on 1 non-patient facing clinician.
- **Screening backlog** – The screening is up to date with screening taking place within 3 months of the death. There may be deaths that are older than 3 months due to the late reporting of deaths on SystmOne.
- **Complaints** – Due to staffing issues, the Governance team cross referencing the list of deaths with any complaints so that these can be screened in for LfD review has been delayed.
- **Contacting relatives following death** – the role of the ME reviewing every death also includes contacting families as part of that process. Should the relatives/carers raise concerns and positive feedback the ME, they will share with the Trust.

FYPC/LDA

- **LfD meetings** – In Q4, all LfD meetings went ahead as planned.
- **Prevention of Future Deaths Improvement Work** – Prevention of Future Deaths Improvement Work - A new LfD process is being developed with proposed amendments to In and Out of Scope deaths for LfD review. There is a proposal to exclude children from the SJR process in Policy review in line with other Trusts. This will be presented for review and agreement by the Trust Wide LfD Group in April 25.
- **Backlog of Child deaths for LfD review** – There is a backlog of 48 child deaths for LfD review from December 23 up to and including March 25.
- **Independent LfD reviewers** - It continues to be noted that there is a gap in independent clinical review of deaths. A dedicated clinical lead for deaths in FYPC/LDA would be ideal with the role of reviewing LfD mSJRs/CDOP forms and supporting learning as well as being the link with CDOP and LeDeR.

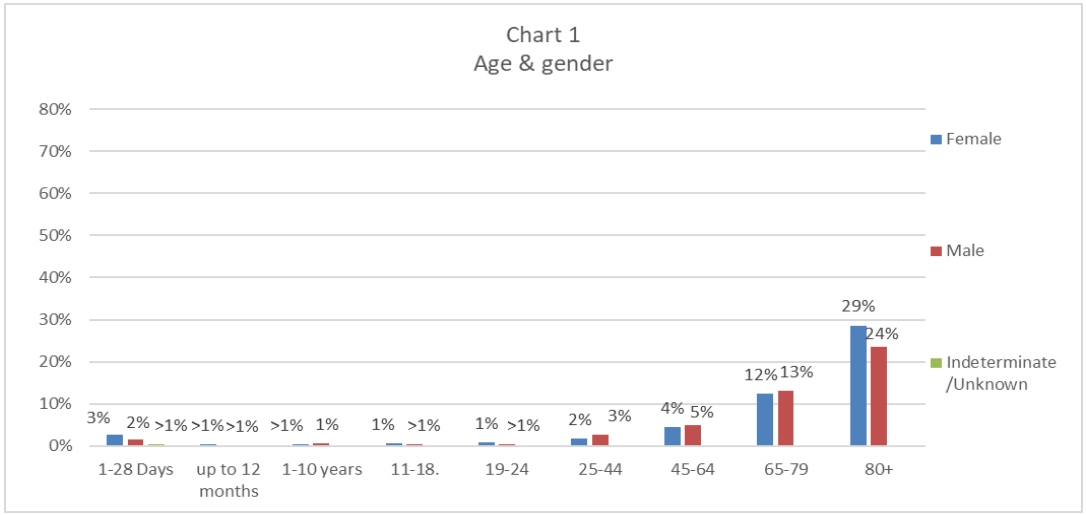
3. Actions

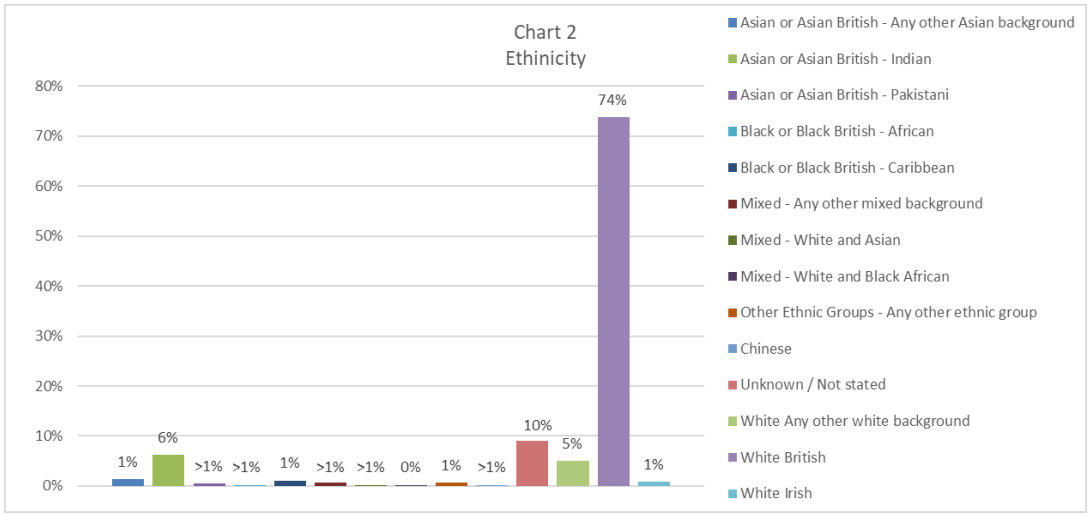
CPST are continuing to work closely with The Information Team to develop the patient death reporting to provide automated meaningful analysis and improve regular reporting requirements for Trust Board.

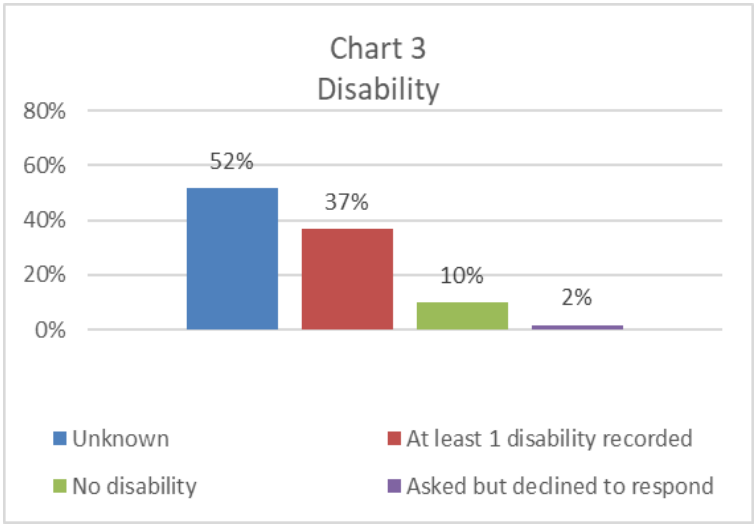
The Safety Committee, as delegated by Board, is also asked to recognise the action and continued progress being made in the LfD process at LPT.

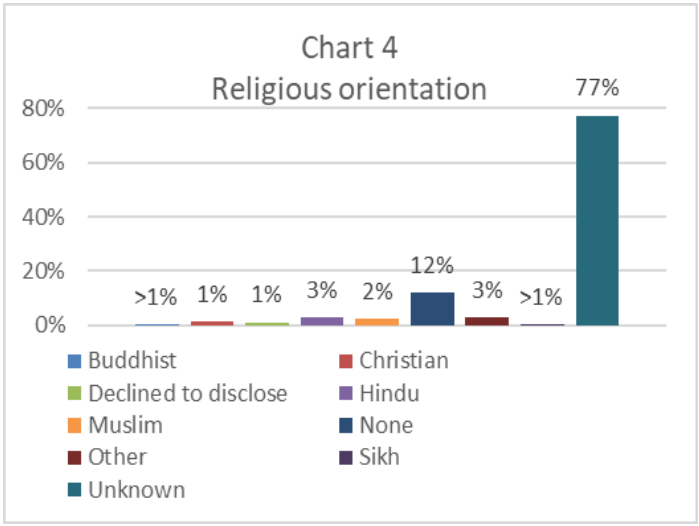
4. Demographics

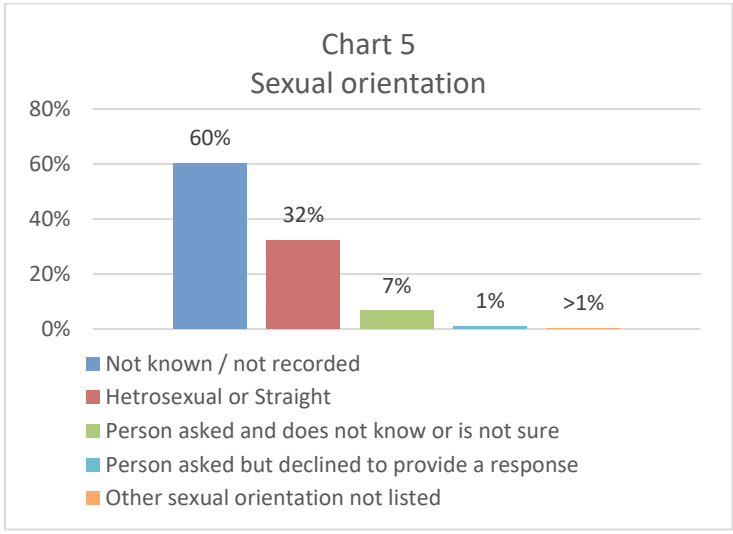
Demographic information is provided in Charts 1-5. CPST are working with the Information Team to understand where the responsibility for the collection of demographic information lies. A Standard operating Policy (SoP) has been developed by the Information Team setting out how the information is collected and a definitive list of 'In Scope and Out of Scope' deaths for each directorate.











CPST remain in discussion with the Information Team to ascertain a meaningful way to analyse patient death health inequalities and mortality data by geographical area.

Ethnicity data has been compared with the Leicester, Leicestershire and Rutland population based on the latest 2021 Census and is comparable.

5. Backlog of reviews of patient deaths

In adherence with NHS/I (2017) Learning from Deaths recommendations, the number and percentages of patient deaths reviewed through mSJR case record review across LPT are shown in Table 2. Table 1 below shows patient deaths data taken from the NHS Spine (national repository of patient data).

The Trust aims to complete Case Record Review's within 3 months of the death as per LfD Policy. Any review not completed within 3 months will be considered a backlog.

The total number of patient deaths may be different to that previously reported due to late reporting of deaths on SystmOne\NHS Spine.

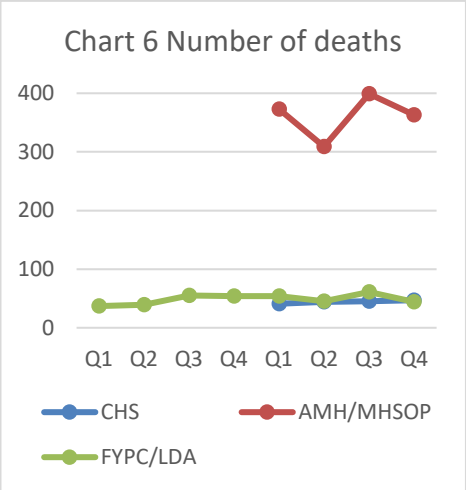
Table 1: Annual backlog of deaths

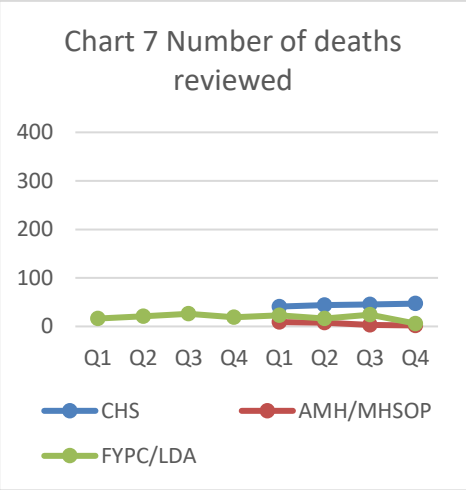
Breakdown by Directorate													
	CHS				DMH/MHSOP				FYPC/LD				
	1.4.24-31.3.25				1.4.24-31.3.25				23/24	1.4.24-31.3.25			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1-Q4	Q1	Q2	Q3	Q4
Number of patient deaths	41	44	45	47	373	309*	399	363	185	54	45	61	44
Total screened (DHM/MHSOP only)	-	-	-	-	373	305	368	201	-	-	-	-	-
Total outstanding to be screened (DMH/MHSOP only)	-	-	-	-	0	4	31	162	-	-	-	-	-
Total not reviewed as Neonates (FYPC/LDA only)	-	-	-		-	-	-	-	37	21	24	24	11
Total LfD reviews completed. (CHS only =ME reviews)	41	44	45	47	9	8	3	2	82	23	16	24	6
Number of deaths outstanding for Directorate review	0	0	0		0	0	1	3	16	10	5	13	27

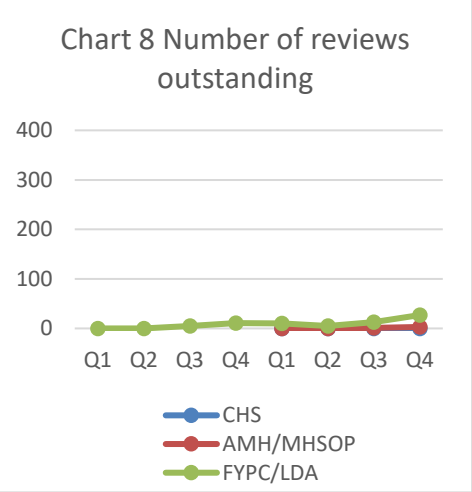
** There was a typographical error ins Q3 report, it should have read 309 as per previous reports.*

***KEY** CHS: Community Health Services; DMH/MHSOP: Directorate of Mental Health & Mental Health Services for Older people; FYPC/LD: Families Young Persons and Children/Learning Disabilities*

Breakdown of backlog per quarter (Q1-Q4 2023/2024 & Q1-Q4 2024/2025)







In adherence with NHS/I (2017) Learning from Deaths recommendations Table 2 also shows the number of deaths reported by each Directorate for Q4 and mSJR case record reviews.

- There were 454 patient deaths considered in Q4.
- There were 8 adult deaths of individuals diagnosed with Learning Disabilities/autism which are undergoing LeDeR review within FYPC/LDA.

Table 2: Number of deaths (Q4)

Table 2 shows the number of deaths per month for Q4.

In Q4 there were 24 patient deaths reviewed at Incident Review & Learning Meeting (IRLM). The outcomes of the IRLM were:

- 9 patient deaths were considered to meet Local Directorate Investigations threshold.
- 2 patient death met the threshold for review via a Patient Safety Incident Investigations (PSII)
- 13 patient deaths were reviewed and were agreed that no further review was required, the Initial Service Manger Review (ISMR) will be reviewed at local LfD meetings, and themes and learning captured, and any actions agreed.

In Q4, in addition to the CHS there were 1 February MHSOP inpatient death on Gwendolen Ward that is being reviewed as a PSII. The final report will be shared with LfD for review and theming.

Q4 Mortality Data										
	Jan			Feb			Mar			Total
	C	D	F	C	D	F	C	D	F	454
Number of patient Deaths	19	149	20	13	119	9	15	95	15	
	Consideration for formal investigation									
	C	D	F	C	D	F	C	D	F	Total
mSJR Case record review*	0	1	2	0	2	7	0	2	8	**22**
Learning Disabilities deaths			4			2			2	**8**
Number of deaths reviewed/investigated and as a result considered more likely than not to be due to problems in care	0	0	0	0	0	0	0	0	0	**0**
	Learning									
	C	D	F	C	D	F	C	D	F	Total
Number of family contacted for feedback	18	1	1	11	0	0	11	0	0	**42**
Number of family feeding back	8	0	0	5	0	0	7	0	0	**20**

KEY

C: *Community Health Services;* ***D:*** *Directorate of Mental Health/Mental Health Service for Older People;* ***F:*** *Families Young Persons and Children Services/Learning Disabilities and Autism*

We are currently reporting on the number of relatives/carers contacted in the same quarter in which the patient death occurred. As reviews may not have been completed within the same quarter that the death occurred, these figures are likely to increase once all completed reviews have been received.

FYPC/LDA The Diana team provide nursing care, support and education for children with acute, complex, palliative and long-term conditions and for those die whilst in their care a designated team member will complete the LfD Quality & Safety form within 48 hours of a child's death. All families/carers where there is involvement from the Diana service at the time of the child's death are contacted as part of post-bereavement care for their service and care feedback. All child deaths are reviewed through the Child Death Overview Panel (CDoP) which will also allow families/carers a further opportunity to feedback in relation to service and care provided.

6. Learning themes and good practice identified

Learning is based on using standardised themes adapted from the University Hospital Leicester (LfD Learning & Good Practice Themes & Theming guidance are available in Directorate reports).

6.1 CHS

Learning

Where a patient's death has been reviewed through an ISMR / patient safety review, the final report is shared with he LfD group for theming.

- **Communication with patients' families (also a theme in Q3)**
  There continues to be a theme where families do not feel that their relative's condition has been accurately described.

- **Documentation**
  Documentation in general has been a recurrent theme.

- **Respect forms**
  RESPECT form not being in place.

- **Adherence to NEWs Policy to recognise and escalate patients' deterioration.**
  The deteriorating patient group are reviewing the use of BRIGID, electronic app used to record observations, to establish if this can be further developed to support escalation.

Feedback from families praising care provided by LPT

In Q4, there was a mixture of feedback from families. Those that were happy with care provided by LPT in our Community Hospitals described it as good, wonderful, amazing, or excellent.

One family reported being very happy with the staff who were very kind to the family and patient. Staff arranged for their relative to be moved into a side room and the family were informed of the deterioration, so they had an opportunity to visit.

Feedback from families where they were unhappy with aspects of care provided prior to their loved one's death.

Learning

Following feedback from patients' relatives or friends who were in our community hospitals, the BSSN has liaised with ward staff and the following learning and actions have been identified:

Loughborough Hospital, Gracedieu Ward
Family friend recalls that the patient was frustrated that their physio for example, was not always at an agreed set time and they found this difficult. The BSSN has shared the feedback with the ward.

- **Learning:** Importance of involving patients in their care and describing clearly expectations of interventions.
- **Action:** As Gracedieu is now closed, feedback has been shared with all Matrons at Loughborough to share with the rest of the team.

Loughborough, Swithland Ward

Following the patient's death the family shared that they had found the communication unclear and insensitive. For example, they had not received verbal information about what happens next, nor the bereavement booklet. They also received 2 calls from ward nurses asking which funeral directors they should 'move the body' to which they felt was insensitive and one nurse said "he was never going to leave the ward".

Nurse comment

- **Learning:** The patient's death was expected and therefore staff should have already communicated with the family around theirs and the patient's wishes on the death.
- **Action:** Matron has discussed with the ward sister, who is providing a reflective session for the staff. The End-of-Life steering group are reviewing how to support staff to have timely sensitive conversations around end-of-life.

Bereavement support

- **Learning:** Ward staff had not initially provide the bereavement booklet. The Matron is reviewing processes to ensure that the bereavement checklist is followed, and the booklet provided in a timely manner.
- **Action:** BSSN has shared with all wards the importance of using the new bereavement check sheet in the updated Care of the Deceased policy, which guides staff through what to do and why and what info to provide for bereaved families.
- **Action:** Supervision for all registered nurses on the ward has been arranged regarding use of 'bereavement checklist' within Care of Deceased Policy, what information to offer families and providing the bereavement booklet to support and reinforce verbal information provided.

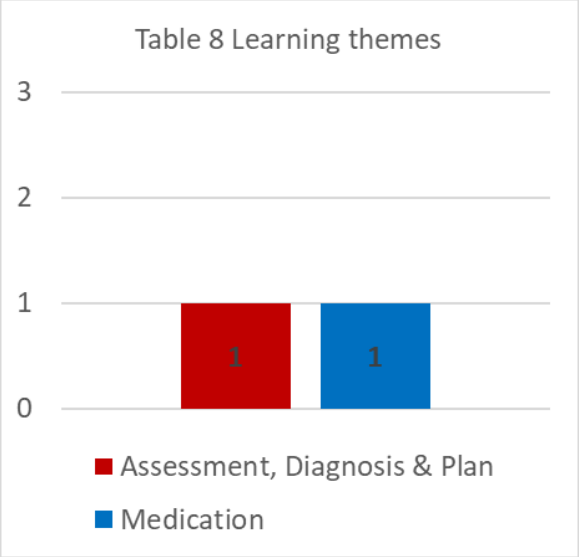
Feedback from the ME process

All patient deaths are now being reviewed by the ME who shares any areas of good practice and/or feedback for improvement. In Q4 there were no areas for improvement identified by the ME's office.

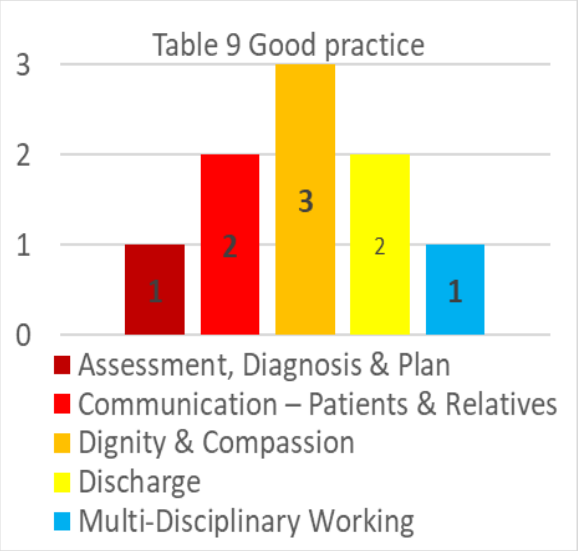
As part of post-bereavement support 6–8 week BSSN contact is offered to all CHS patient bereaved relatives/carers by the ME when they make initial contact related to conversation around death certification process; however, if questions or concerns are raised about the care received during this conversation, the BSSN will make contact the family at around 2-3 weeks or earlier if that is requested by the relatives/carers.

6.1 AMH/MHSOP

Learning (Q4)



Good practice (Q4)



Learning

<u>Assessment and management plan</u>

Patient was admitted to Gwendolen ward with a diagnosis of mixed dementia, not weight bearing and was bedbound. When being assisted by nursing staff and medical staff to assess pressure areas, staff observed wounds that had not been noted on admission.

- **Learning:** Pressure damage was not noticed immediately by ward staff.
- **Action:** Matron to ensure all staff are up to date with their tissue viability training and will have a discussion with TVN Link Nurses to ascertain if they can be more proactive regarding patients who are approaching end of life.

<u>Medication & administration</u>

Patient who was end-of-life was receiving medication via a syringe driver. It was noticed by nursing staff that the correct dose of medication was not being administered.

- **Learning:** Syringe driver unable to administer correct dose of medication as staff incorrectly positioned tube and did not seek further guidance from Palliative team for a solution.
- **Action:** There is a monthly ward round between Mill Lodge's team leads, Matron, Deputy Head of Nursing and palliative care team leads to review and discuss cases as well as any support requirement.

Themes identified at IRLM

- Recurrent theme around people being arrested for sexual offences and going on to self-harm. This has been noted at the suicide prevention group and some work is ongoing around this.

- Other themes identified were also unemployment, poor physical health and drug use.

Action: These themes have been noted and shared with clinicians to be included in the patient's risk formulation. Where there is a gap in service provision, this is also being shared.

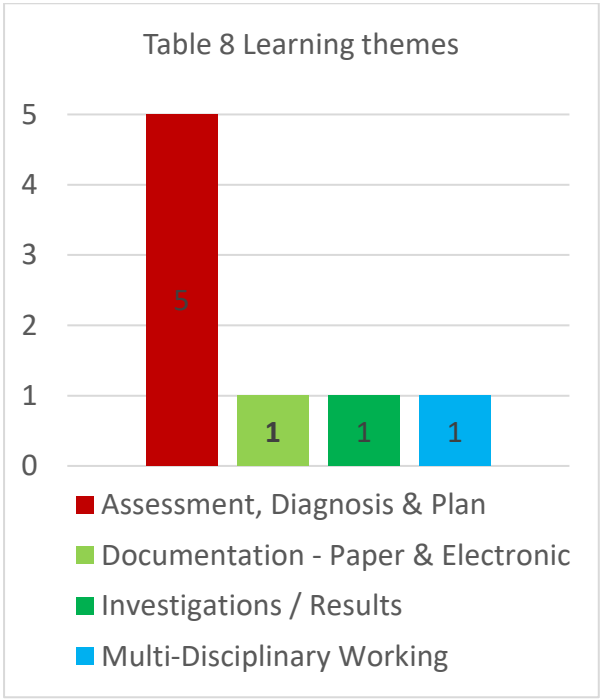
Good Practice

Dignity and compassion

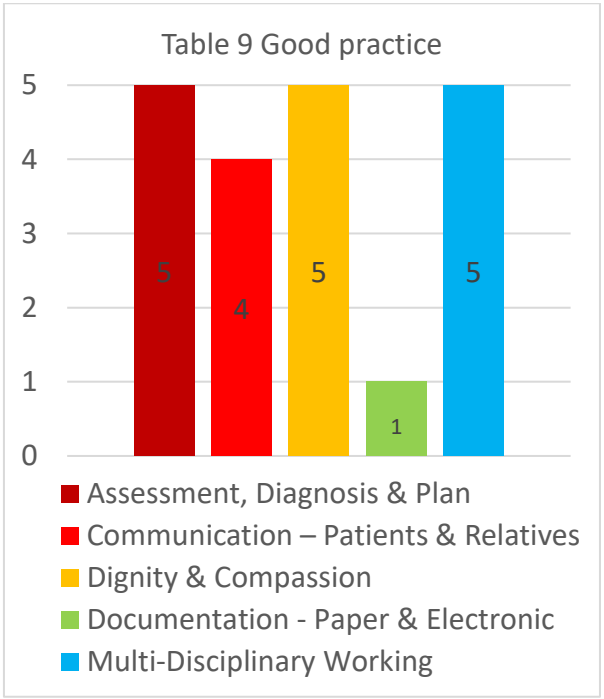
It is noted that there is a recurrent theme of staff upholding the Trust's values by treating patients with dignity and compassion which has also been noted by families.

6.2 FYPC/LD

Learning themes (Q4)



Good practice themes (Q4)



Actions taken in response to identified themes/issues, learning actions planned and an assessment of impact of actions.

Assessment, Diagnosis & Plan

There is a common theme of Assessment, Diagnosis & Plan with 5 out of the 8 pieces of learning identified being around documentation requiring improvement and 5 cases where assessment, diagnosis and plan were identified as good practice.

Action: Directorate are reviewing the areas of good practice to understand how this can be.

7. Decision required

The Quality & Safety meeting, as delegated by the Trust Board is asked to note the improvement in the ability to identify the In-scope deaths and confirm assurance on the implementation of the National Quality Boards LfD guidance within the Trust.

Decision required – Please indicate:

Briefing – no decision required	**X**
Discussion – no decision required	
Decision required – detail below	

8. Governance table

For Board and Board Committees:	Quality & Safety Committee and Trust Board	
Paper sponsored by:	Dr Samantha Hamer	
Paper authored by:	Tracy Ward / Evelyn Finnigan	
Date submitted:		
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	N/A	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	Report provided to the Quality & Safety Committee and Trust Board quarterly	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Report provided to the Safety Committee and Trust Board quarterly	
LPT strategic alignment:	Great Health Outcomes	X
	Great Care	X
	Great Place to Work	
	Part of the Community	
CRR/BAF considerations:	List risk number and title of risk	1, 3
Is the decision required consistent with LPT's risk appetite:		
False and misleading information (FOMI) considerations:		
Positive confirmation that the content does not risk the safety of patients or the public		
Equality considerations:		

K

Leicestershire Partnership NHS Trust

Trust Board – 29 July 2025

Safe Staffing Monthly Report – May 2025

Purpose of the Report

This report provides a full overview of nursing safe staffing during the month of May 2025, including a summary/update of new staffing areas to note, potential risks, and actions to mitigate the risks to ensure that safety and care quality are maintained (table below). This report triangulates workforce metrics; fill rates, Care Hours Per Patient Day (CHPPD), quality and outcomes linked to Nurse Sensitive Indicators (NSI's) and patient experience feedback. (Scorecard, page 2&3).

Analysis of the issue

Right Staff

- Temporary worker utilisation rate decreased this month by 0.28% reported at 23.20% overall and Trust wide agency usage decreased this month by 1.08% to 1.38% overall.
- Registered Nurses
  - Vacancy position is at 271.2 Whole Time Equivalent (WTE) with a 13.5% vacancy rate, a decrease of 0.2% since April 2025.
  - Turnover for nurses is at 5.4% which is below the trusts target of 10%.
  - Sickness reported at 5.4%.
  - A total of 12.0 WTE nursing staff (bands 5 to 8a) were appointed in May.
- HCSW
  - Vacancy position is at 157.2 WTE with an 14.7% vacancy rate, decrease of 0.2% since April 2025.
  - Turnover rate is at 7.5 %. which is below our internal target of no more than 10% turnover.
  - Sickness reported at 6.5%.
  - A total of 11.5 WTE HCSW were appointed in May 2025.

Right Skills

Core mandatory training compliance is currently compliant (green) on average across the Trust. Basic Life Support and Immediate Life Support (clinical mandatory training) topics rated as compliant (green).

Across the Trust, on average Appraisal rates and Clinical Supervision remain consistent at green compliance.

Right Place

The total Trust CHPPD average (including ward based AHPs) is calculated by the Corporate Business Information Team at 11.9 CHPPD (national average 10.8) for May 2025 consistent with April 2025, ranging between 6.1 (Stewart House) and 73.3 (Agnes Unit).

May 2025 Scorecard

Ward	Average no. of Beds on Ward	Average no. of Occupied Beds	Fill Rate Analysis (National Return) – Actual Hours Worked divided by Planned Hours: Nurse Day (Early & Late Shift) – Average % fill rate registered nurses	Nurse Day (Early & Late Shift) – Average % fill rate care staff	Nurse Night – Average % fill rate registered nurses	Nurse Night – Average % fill rate care staff	AHP Day – Average % fill rate registered AHP	AHP Day – Average % fill rate non-registered AHP	% Temporary Workers (NURSING ONLY) – Total	Bank	Agency	Overall CHPPD (Nursing And AHP)	Medication Errors	Falls	Complaints	PU Category 2	PU Category 4
			>=80%	>=80%	>=80%	>=80%	-	-	<20%	<20%	<=6%						
Ashby	14	13	90.1%	245.0%	106.5%	192.3%			35.8%	35.2%	0.7%	11.4	0→	3↓	0→		
Aston	17	17	121.7%	187.0%	106.3%	141.4%			13.9%	13.2%	0.7%	8.2	0↓	0→	0→		
Beaumont	22	21	88.5%	136.5%	105.1%	131.9%		100.0%	21.5%	20.0%	1.5%	8.0	2↑	3→	1↑		
Bosworth	14	14	87.4%	193.6%	99.5%	144.7%		100.0%	17.8%	17.5%	0.3%	10.3	1→	2↑	0→		
Heather	18	18	93.9%	183.1%	96.5%	158.3%			35.2%	33.4%	1.8%	9.3	1↓	5↑	1→		
Watermead	20	18	105.5%	145.5%	111.6%	136.4%		100.0%	24.1%	22.0%	2.1%	9.8	1↓	1↓	0→		
Griffin - Herschel Prins	6	5	102.7%	129.1%	101.0%	136.3%		100.0%	24.9%	24.5%	0.4%	35.3	0→	1↓	0→		
Phoenix - Herschel Prins	12	10	99.1%	91.6%	109.6%	104.5%			13.1%	13.1%	0.0%	13.4	0↓	2↑	0→		
Skye Wing - Stewart House	29	28	102.7%	109.8%	104.9%	119.9%			17.8%	17.8%	0.0%	6.1	0→	4↑	0→		
Willows	9	8	105.5%	115.7%	101.8%	112.2%		100.0%	12.4%	12.4%	0.0%	12.1	0↓	6↑	0→		
Mill Lodge	14	8	98.6%	101.9%	102.9%	136.1%			26.0%	20.8%	5.2%	21.2	3↑	2↑	0→		
Kirby	23	21	102.8%	166.9%	89.9%	175.7%	100.0%	100.0%	27.4%	27.4%	0.0%	10.2	0↓	14↓	0→		
Langley (MHSOP)	19	17	110.7%	206.5%	104.5%	155.0%			35.5%	35.3%	0.2%	10.8	2↑	8↑	1↑		
Coleman	19	18	95.3%	141.0%	104.6%	171.1%	100.0%	100.0%	32.0%	31.4%	0.7%	17.3	3↑	15↑	1↑		
Gwendolen	18	14	81.5%	132.4%	103.2%	147.5%		100.0%	28.3%	27.1%	1.1%	17.5	4↑	13↑	0→		
Beechwood Ward - BC03	24	23	99.6%	103.2%	100.1%	99.2%	100.0%	100.0%	11.3%	11.0%	0.3%	8.6	1↓	2↑	0→	0→	0→
Clarendon Ward - CW01	23	20	87.8%	106.8%	100.0%	100.0%	100.0%	100.0%	3.5%	3.5%	0.0%	9.1	0→	3→	0→	0↓	0→
Dalgleish Ward - MMDW	17	16	101.0%	108.4%	100.1%	99.5%	100.0%	100.0%	25.9%	21.0%	4.9%	9.6	0↓	3↑	0→	3↑	0→
Rutland Ward - RURW	18	16	103.2%	113.0%	106.5%	143.5%	100.0%	100.0%	22.8%	20.8%	2.0%	9.7	1↑	3↑	0↓	1↑	0→
Ward 1 - SL1	21	18	98.9%	112.2%	100.0%	102.8%	100.0%	100.0%	23.5%	21.1%	2.4%	11.7	1↑	0↓	0→	0→	0→
Ward 3 - SL3	14	13	115.0%	109.7%	99.7%	101.0%	100.0%	100.0%	23.3%	21.8%	1.5%	11.6	0↓	2↓	0→	1↓	0→
Ellistown Ward - CVEL	18	17	97.4%	108.8%	100.0%	121.0%	100.0%	100.0%	17.3%	16.2%	1.1%	11.6	0↓	3↑	0→	1→	0→
Snibston Ward - CVSN	19	17	98.9%	110.8%	100.1%	101.9%	100.0%	100.0%	23.7%	21.2%	2.5%	10.3	6↑	3↑	0→	0↓	0→
Ward 4 - CVW4	15	14	97.8%	113.8%	100.0%	114.7%	100.0%	100.0%	12.4%	12.3%	0.2%	11.2	3↑	2↓	0→	1↑	0→
East Ward - HSEW	28	26	91.1%	98.8%	95.7%	98.0%	100.0%	100.0%	21.4%	20.4%	1.1%	9.4	1↑	3↑	0→	0→	0→
North Ward - HSNW	19	18	106.1%	110.5%	98.4%	130.0%	100.0%	100.0%	20.7%	20.7%	0.0%	10.0	0→	3↓	0→	2↑	0→
Charnwood Ward - LBCW	18	17	99.4%	110.7%	99.6%	120.4%	100.0%	100.0%	19.6%	18.1%	1.5%	10.8	2↓	4↑	0→	0→	0→
Swithland Ward - LBSW	21	19	101.4%	89.4%	100.0%	105.3%	100.0%	100.0%	13.7%	13.4%	0.3%	9.4	0↓	3↓	0→	0↓	0→
Welford (ED)	15	13	108.7%	128.8%	100.2%	101.3%	100.0%	100.0%	30.7%	29.6%	1.1%	12.3	1↑	1↑	1↑		
CAMHS Beacon Ward - Inpatient Adolescent	17	5	125.4%	188.8%	105.0%	129.1%	100.0%		50.1%	47.6%	2.5%	51.7	0↓	0↓	1↑		
Agnes Unit	1	1	163.2%	278.9%	148.5%	202.4%			26.5%	22.2%	4.3%	73.3	4↑	5↑	0→		
Gillivers	4	2	109.1%	62.2%	150.8%	92.5%			9.5%	9.5%	0.0%	29.6	2↑	0→	0→		
1 The Grange	2	1	84.3%	99.9%	35.3%	78.1%			9.0%	9.0%	0.0%	54.7	0↓	0→	0→		

T H R I V E

Scorecard key table showing fill rate thresholds for RN, HCA on days and nights shifts and % temporary workers parameters for bank, agency and total.

Score card.	Average Fill Rate Thresholds RN, HCA days and nights			% Temporary Workers Total and Bank			Agency	
	Below <=80%	Above >80%	Above >110%	Below < 20%	Between 20% - 50%	Above >50%	Below <=6%	Above > 6%
Rag rating								
Fill rate will show in excess of 110% where shifts have utilised more staff than planned or due to increased patient acuity requiring extra staff. Highlighted for trust wide monitoring purpose only.				Please see table (page 2) for high level exception reporting highlighting reduced fill rate below 80% threshold and key areas to note due to high bank and agency utilisation.				

The following table below identifies key areas to note from a safe staffing, quality, patient safety and experience review, including high temporary workforce utilisation and fill rate with actions and mitigations.

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
CHS In-patients	**Staffing** High percentage of temporary workforce to meet planned staffing levels on Dalgleish at 25.9 % temporary workforce. This was due to 2 RNs on sick leave and 2 RNs on maternity leave.	**Staffing** Daily staffing reviews, staff movement to ensure substantive RN cover in each area, or regular bank and agency staff for continuity, e-rostering reviewed.	**Amber**
	Fill rate: Fill rate above 110% of RN Day shifts on – ward 3 St Luke's all other wards below. Fill rate above 110% of HCA day shifts – Rutland, Ward 1 St Lukes, Snibston, Ward 4 Coalville, North and Charnwood wards. Fill rate above 110% of HCA night shifts – Rutland, Ellistown, Ward 4 Coalville, North and Charnwood	**Fill rate:** Increased RN fill rate on the day shift on Ward 3 ST Lukes due to additional RN from the Community nursing team (in addition to planned staffing). For wards using over 110% fill rate this is due to increased acuity and dependency, increased one to one supervision/demands from patient transfers from acute providers.	
	Nurse Sensitive Indicators A review of the NSIs has identified a decrease in the number of falls incidents from 36 in April to 34 in May 2025. Ward area to note with the highest number of falls is Charnwood. The number of medication incidents has decreased from 18 in April to 15 in May 2025. Ward area to note with the highest number of medication incidents is Snibston.	**Nurse Sensitive Indicators** **<u>Falls</u>** The falls occurred on 12 wards, an area to note is Charnwood with 4 falls. One fall resulted in a severe harm, which was investigated through the ISMR process. The weekly falls meeting continues across all wards/hospitals discussing themes and to recognise improvements in care. The team continue planning falls link training days including themes recognised across all wards through ISMRS, patient safety team will be assisting. **<u>Medication errors</u>** The main three themes: medication unavailable, incorrect dose and omitted medications. The medication incidents are across 6 wards: Snibston key area to note with 6 medication incidents. Wards continue to use safety crosses to demonstrate safety, whilst carrying out senior conversations and reflections. A daily report is shared with all leads reflecting omissions, which is showing improvement and discussed with ward leads. Focus work has also commenced on	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
	The number of category 2 pressure ulcers developed or deteriorated in our care has decreased from 12 in April to 9 in May 2025. Areas to note are Dalgleish, and North ward. No Category 4 pressure ulcers have developed or deteriorated in LPT inpatient care since March 2024.	Controlled medication and will be captured in a new CHS medication group due to commence in May 2025. **Pressure Ulcers** Pressure Ulcers category 2 developed in our care across 7 wards. Areas to note Dalgleish (3), Hinckley North (2). CHS Pressure ulcer improvement work continues, Deputy Head of Nursing continues to monitor. Weekly meeting, led by the pressure ulcer link Matron continues linking to the trusts strategic pressure ulcer group. The Community Hospital tissue viability nurse continues to increase education together with ward leads for specific training plans. **Staffing Related Incidents** The number of staffing related incidents has decreased from 7 in April (across 4 sites) to 2 in May 2025 due to staff shortages, no harm was recognised or reported.	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
DMH In-patients	**Staffing:** High percentage of temporary workforce to meet planned staffing. Key areas to note are Ashby 35.8%, Langley 35.5%, Heather at 35% and Coleman at 32.0%. Gwendolen, Kirby and Mill Lodge all above 25%.	**Staffing:** Staffing is risk assessed daily through a staffing huddle across all DMH and MHSOP wards and staff moved to support safe staffing levels, skill mix, patient needs, acuity, and dependency. Temporary workforce to meet planned staffing has reduced significantly across the service. High utilisation of temporary workforce was due to patient acuity, increased 1 to 1 therapeutic observation, patient and hospital escorts. Short notice absence of substantive staff and bank cancellations requiring temporary workforce to meet planned staffing.	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
	Fill rate: Fill rate RN Day shifts above 110% on Aston and Langley and on Night shifts on Watermead. Fill rate HCA day shifts above 110% on all wards except Phoenix, Stewart House and Mill Lodge and night shifts on all wards except Phoenix.	**Fill rate:** Fill rate was achieved across all Acute, Forensic, PICU and MHSOP wards. Belvoir unit remains closed for essential works until 16 June 2025. Increased RN fill rate day shift on Aston due to (additional staff from the Belvoir unit) and Langley due to newly qualified RN on preceptorship. On night shifts on Watermead was due to sickness/absence. HCA Fill rate above 110% was due to increased patient acuity and dependency requiring therapeutic observations to manage mental and physical health needs, additional staff to support therapeutic observations for patient transfers to and during acute hospital stays, higher number of patients requiring 2 to 1 continuous observation and increased staff to maintain levels of observation when patients are admitted to a zoned corridor for the opposite gender on a mixed sex ward. Additional staffing due to maternity leave across a number of wards requiring additional backfill to meet planned safe staffing. High rates of violence and aggression incidents requiring high levels of interventions with subsequent increase in patient observations.	
	Nurse Sensitive Indicators: A review of the NSI's has identified an increase in the number of falls incidents from 61 in April to 79 in May 2025.	**Nurse Sensitive Indicators:** **Falls** - Of the fall's incidents: **AFPICU – 17** reported falls incidents occurred in Acute, Forensic and PICU services (AFPICU) in May 2025. Most falls incidents occurring on Heather ward (5), involving 2 patients. Falls in this period were reported as no moderate harm.	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
	The number of medication incidents has increased from 16 in April to 17 in May 2025. 4 complaints were received in May 2025.	**Rehabilitation** – 10 falls incidents reported in DMH rehabilitation services. Willows (6) and Stewart House (4). 1 moderate harm fall incident reported for the month. **MHSOP** – 52 falls incidents were reported in May 2025. Highest falls on Coleman (15) Kirby (14) and Gwendolen (13). It is noted a high number of patients placing themselves on the floor as well as sliding onto the floor (as opposed to falls). One moderate harm fall occurred on Kirby Ward when the patient was on leave in home environment and fractured hip, so not subject to ISMR. Falls huddles are in place and physiotherapy reviews for patients with sustained falls and increased risk of falling. Themes and trends in falls are being discussed in the falls huddles to share, learn and support safe care. <u>Medication errors</u> 5 medication incidents were reported for AMH. Medication incidents were due to; accidental overdose by patient, wrong dose, ECD register and failure of staff to follow medication policy. 12 medication incidents were reported in MHSOP, 4 on Gwendolen, 3 on Mill Lodge and Coleman and 2 on Langley. High risk medication omissions now being reported an increase in CD medication errors and recording. .	
FYPC. LDA in-patient	**Staffing:** High Percentage of temporary workforce, key areas to note – Beacon at 50.1% and Welford ED at 30.7%.	**Staffing:** Mitigation remains in place, potential risks monitored. Beacon unit continue with reliance on high temporary workforce usage with a block booking approach to meet safe planned staffing following temporary move to Thornton ward and acuity levels. Several beds	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
		remain closed, and the unit has an agreed bed opening plan reviewed monthly. Welford ED temporary workforce usage due to increase in patient acuity, increased 1 to 1 therapeutic observations and patient complexity staffing levels reviewed and adjusted accordingly.	
	Fill Rate: Fill rate below 80% for RNs on nights at the Grange Fill rate below 80% for HCAs on nights at the Gillivers and at the Grange. Fill rate above 110% for RN on days – Beacon and Agnes and RN on nights - Agnes and the Gillivers. Fill rate above 110% for HCA on days at the Beacon, Agnes, and the Welford ED and on nights on Beacon and Agnes	**Fill rate:** Gillivers offer planned respite care and the staffing model is dependent on individual patient need, presentation, and associated risks. As a result, this fluctuates the fill rate for RNs and HCAs on days and nights at both Gillivers and the Grange. Agnes unit continues operating on 3 pods. Safe staffing is reviewed daily by charge nurse and matron and staffing reduced accordingly due to reduction in acuity. Beacon unit staffing levels were reviewed and adjusted according to patient acuity and bed occupancy and temporary move to Thornton ward. Welford ED has high acuity and a number of patients requiring additional staff to provide increased therapeutic observations and supervision at mealtimes.	
	Nurse Sensitive Indicators: A review of the NSIs has identified an increase in the number of falls from 3 in April to 6 in May 2025. The number of medication related incidents increased from 4 in April to 7 in May 2025.	**Nurse Sensitive Indicators:** <u>Falls</u> There were 6 falls incidents reported in May 2025, 5 falls on the Agnes unit mainly due to a patient placing themselves on the floor. There was 1 fall on Welford ED. All falls were reported as low or no harm to the patients. <u>Medication errors</u> 7 medication errors were reported, 4 on Agnes unit, 2 at the Gillivers and 1 on Welford ED. Medication errors were due to incorrect storage, incorrect mixing of antibiotic liquid, dispensed medication expired, medication found. There was no harm to any patients.	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
CHS Community	No change to key areas to note - City West, City East, Hinckley, East central, East South, due to high patient acuity, and transition of vacant posts with new starters. Proactive recruitment continues with new starter induction programs in place. Overall community nursing Service OPEL has been level 2/3, working to level 2/3 actions.	Continued daily review of caseloads and of all non-essential activities including review of auto planner and on-going reprioritisation of patient assessments. Ongoing quality improvement work focusing on pressure ulcer and insulin continues and community nursing transformation programme underway.	
DMH Community	The next phase of the CMHT transformation continues and teams re-named as Neighbourhood Community Mental Health Teams. All CMHTs now have substantive team managers. Key areas to note – Northwest Leicestershire CMHT, Assertive Outreach and Perinatal Mental Health service also experiencing significant senior nurse sickness. Recruitment challenges within Crisis Resolution Home Team (CRHT) for registered clinicians and older adults MHLS.	**CMHT** **Planned Care** The CMHT leadership team review staffing daily and request additional staff via bank and agency, mitigation remains in place, including staff movement across the service, potential risks are closely monitored within the Directorate Quality and Safety meetings. Quality Improvement plan continues via the transformation programme. Case load reviews continue, introduction of alternative and skill mix of roles to support service need. Teams continue with peer psychological supervision, team time out days and coordinated team support. **Urgent Care** Recruitment into MHCAP and CJLD once inducted will reduce temporary workforce usage, once all staff are onboarded and signed off. Mental Health Liaison Service (MHLS) continue to recruit into older adults' team, currently supported by backfill with a clinical fellow. Safe staffing supported by use of limited bank staff/agency staff were indicated. **MHSOP Community** No change this month, temporary workforce being used across MHSOP community services to manage long term sickness,	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
		absence, and vacancies across community teams. Vacancies are being filled and awaiting recruitment checks to be complete	
FYPC. LDA Community	Improved position with LD Community Forensic team and Access team sickness reduced. Mental Health School Team (MHST) continues with staffing capacity challenges due to maternity leave, long term sickness and staff on educational programmes. Multiple areas within City and County Healthy Together and School Nursing continue to be below safer staffing numbers. LD Physiotherapy Clinical Lead post out for recruitment. Recent challenge due to recruitment to Children's Wellbeing Practitioner roles (nationally driven), however the BABCP advised they cannot support with the Whole School and College Approach impacting on capacity of the wider team. Working through this with leads and system partners	Mitigation continues in place with potential risks being closely monitored within Directorate. Safer staffing plan initiated including teams operating in a service prioritisation basis. LD Forensic team improving position prioritisation model continues, no adverse impact at this time, other areas of LD service offering additional input to cases and ensuring high risk patients continue to receive input. Mitigation and plans in place for the Access team. MHST continues to cover across localities and review of referral and allocation processes to support capacity. Introduction of a new working model with an increase in clinical activity reported. Healthy Together utilise a safer staffing model reviewed monthly by service leads and CTLs. The safer staffing model is based on percentages of staff in work. Actions are then taken to mitigate any clinical impact dependant on the percentages.	

Challenges/Risks

Considering the triangulated review of workforce metrics, nurse sensitive indicators, patient feedback and outcomes in May 2025 staffing challenges continue to improve with a significant decrease in agency usage and reduction in temporary workforce usage overall.

Whilst there has been no evidence through the in-patient monthly triangulated review of Nurse Sensitive Indicators and quality metrics that staffing numbers (right staff) is a contributory factor to patient harm, we do note some correlation of impact of staffing skill mix, competencies (right skills) as contributory factors in some incident reviews.

Community Nursing Safer Staffing Tool (CNSST) II Relaunch report update was agreed at EMB on 6 May 2025. CNSST II pilot to commence in the Northwest Leicestershire hub in June 2025.

As part of the light (6 monthly) establishment review process, all inpatient wards completed their acuity and dependency data collection utilising evidence-based methodology and tools for 30 days in April 2025.

Decision required – Please indicate:

Briefing – no decision required	**x**
Discussion – no decision required	
Decision required – detail below	

Proposal

The board is asked to confirm a level of assurance that processes are in place to monitor.

Governance table

For Board and Board Committees: Paper sponsored by:	Trust Board James Mullins, Interim Executive Director of Nursing, AHPs and Quality	
Paper authored by: Date submitted:	Elaine Curtin Workforce and Safe Staffing Matron Jane Martin Assistant Director of Nursing and Quality, Emma Wallis Deputy Director of Nursing and Quality 17.07.2025	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	None	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	None	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Monthly report	
LPT strategic alignment:	**T** - **T**echnology	
	H – **H**ealthy Communities	
	R - **R**esponsive	
	I – **I**ncluding Everyone	
	V – **V**aluing our People	
	E – **E**fficient & Effective	x
CRR/BAF considerations *(list risk number and title of risk):*	1: Deliver Harm Free Care 4: Services unable to meet safe staffing requirements	
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	None	

L

Leicestershire Partnership NHS Trust

Public Trust Board - July 2025

Patient Safety & Learning Assurance Report for May and June 2025

Purpose of the Report

This document is presented to the Trust Board bi-monthly to provide assurance of the efficacy of the incident management and Duty of Candour compliance processes. Incident reporting supporting this paper has been reviewed and refreshed to assure that systems of control continue to be robust, effective, and reliable thus underlining our commitment to the continuous improvement of incident and harm minimisation.

The report will also provide assurance around 'Being Open' supporting compassionate and timely engagement with patients and families following a patient safety incident, numbers of investigations and the themes emerging from recently completed investigation action plans, a review of recent Ulysses patient safety incidents and associated lessons learned/opportunities for learning.
The patient safety team have explored the opportunity for bench marking our incident data against other similar organisations. The new National system Learning from Patient Safety Events (LFPSE) does provide some data on overall reporting numbers for different organisations. Due to the diversity and size of organisations this can only give an indication of each organisations reporting culture and NHSE do not recommend its use for bench marking.

Analysis of the Issue

The 'top 5' reported patient safety incidents are considered and reported on in this paper; however, it should be noted that in addition all incident types for the reporting period are reviewed, to establish changes within all categories that may present emerging themes for wider consideration.

Review of Top 5 reported patient safety incidents

During May and June 2025 there were 3641 patient safety incidents reported that were classified as "incidents attributable to LPT" and "Incidents affecting patients". The top five reported incidents account for 63.55% of all patient incidents reported during this period and are explored in order and in more detail below. This equates to an average of 1820.5 incidents per month during May and June 2025.

Top 5 reported patient safety incidents May and June 2025

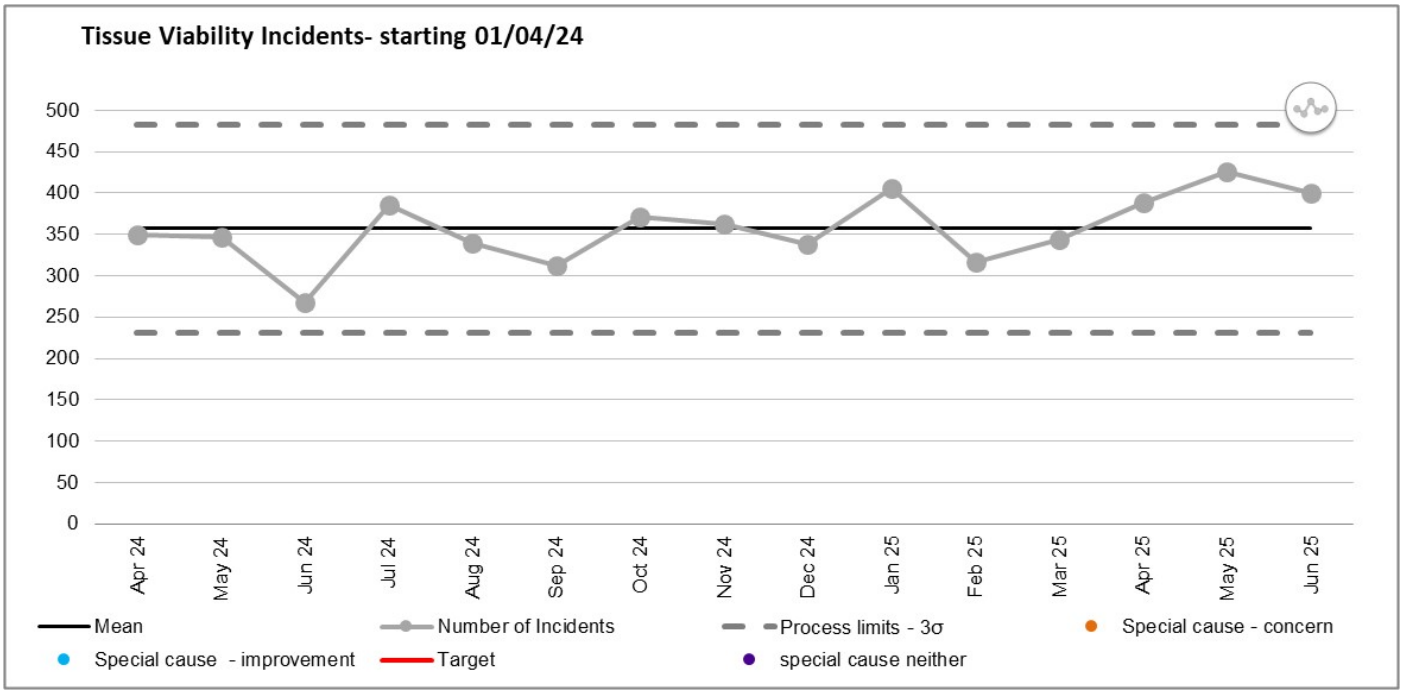
Category	Number of incidents	Directorate with highest % of the total reported
1. Tissue Viability	826	CHS (97.8%)
2. Self-Harm	517	DMH (60.7%)
3. Use of Restraint for Care and Treatment	378	FYPC/LDA (63%)
4. Violence and Assault	339	DMH (84.4%)
5. Falls	254	DMH (60.2%)

Degree of harm recorded for all patient safety incidents for May and June 2025

Reported degree of harm	Number	% of total incidents reported
No Harm	1932	53.1%
Minor/Low Harm	1630	44.8%
Moderate Harm	46	1.3%
Severe Harm	8	0.2%
Death	25	0.7%

NB These incidents were reported in May and June 2025 and will be being reviewed through local and corporate governance structures and the degree of harm may therefore change. Since moving to the national NHSE Learning from Patient Safety Events (LFPSE) system there is a requirement to report incidents by 'harm' to the patient as a result of an incident, even if this does not involve care delivered in your organisation. This accounts for the increase in number of deaths reported compared to the same reporting period in 2024. To note some deaths will be reported by staff that may not have been as a result of an incident, this is to ensure that we do review the care delivered by LPT to identify any opportunity for learning and the degree of harm may be amended after this review.

1. Tissue Viability including Burns/Scalds/Moisture Lesions/Medical Device/ Injury/Podiatry/ all categories of Pressure Ulcers



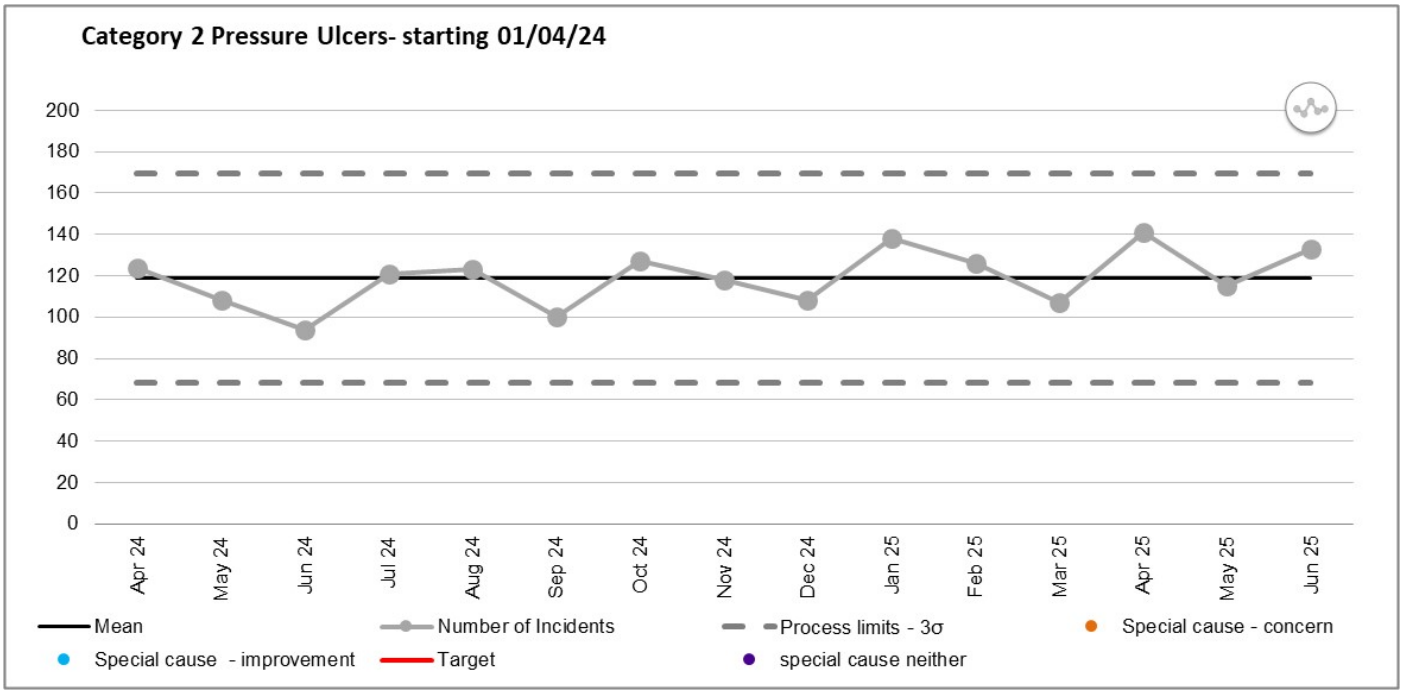
22.69% of all patient safety incidents reported relate to 'Tissue Viability' during May and June 2025; this equates to 826 incidents. This category includes pressure ulcers on admission, developed or deteriorated in our care, skin tears, scalds, wounds, and moisture associated skin damage. As Pressure ulcers (category 2,3,4 and unstageable) represent 67.19% of these, we will focus on this aspect of patient harm.

In May and June 2025 there were 555 reported incidents where patients had been affected by category 2,3,4 and unstageable pressure ulcers reported to have developed or deteriorated in LPT care; this is an 10.78% increase in pressure ulcers reported in comparison to the previous 2 months reporting.

During this period 532 (95.84%) were reported in CHS community nursing services and 20 (3.62%) were reported in community hospitals (inpatients).

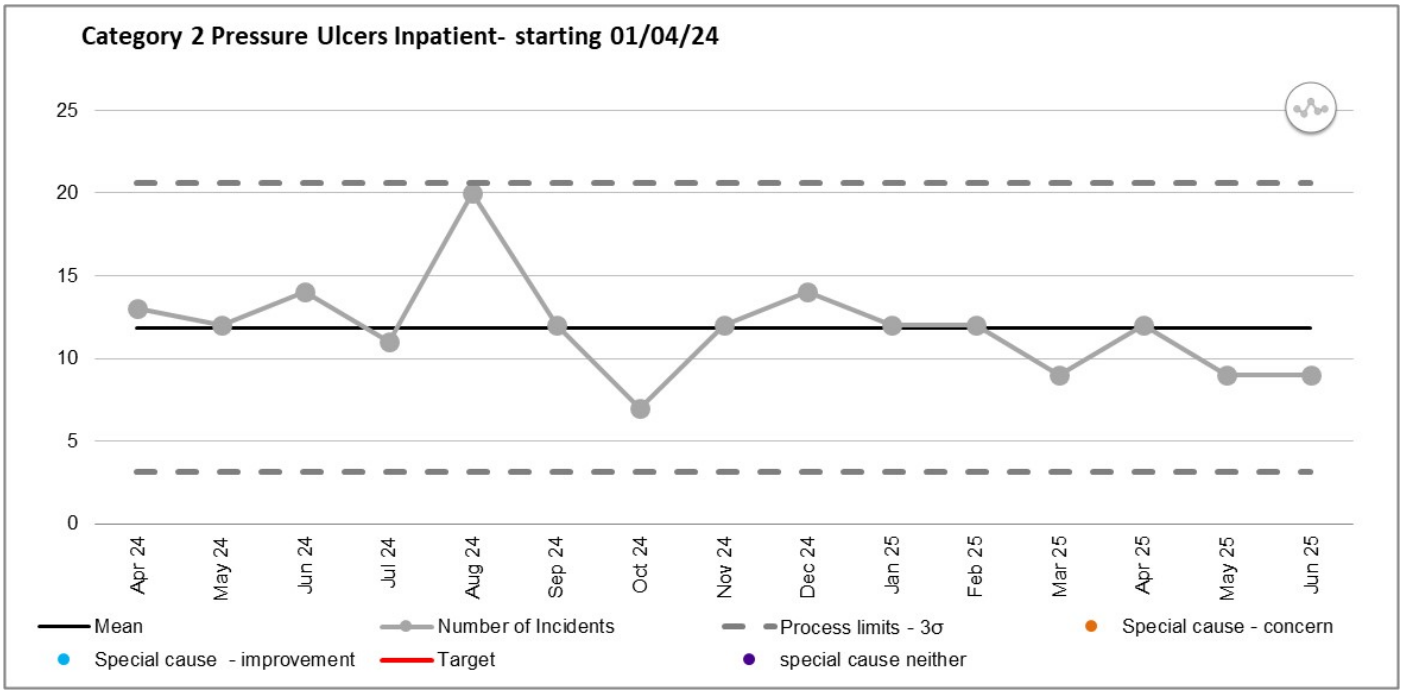
The remaining 0.54% (3 incidents) were reported in DMH, which had 2 Category 2 Pressure Ulcers, one on Bosworth Ward and one on Gwendolen Ward, and FYPC-LDA which had one Category 3 Pressure Ulcer reported by The Gillivers.

Category 2 pressure ulcers developed or deteriorated in LPT care – Trust wide (in patient and community)



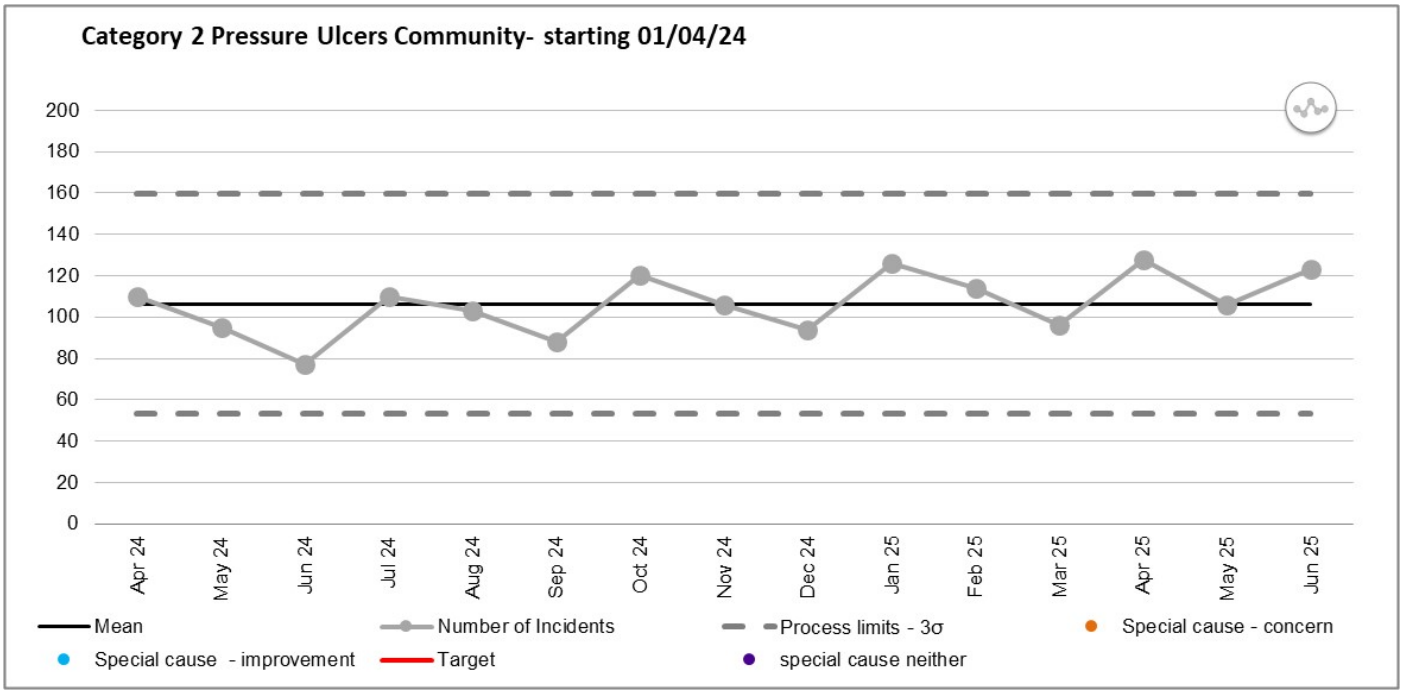
The SPC charts show normal variation to Cat 2 pressure ulcers developed in our care.

Category 2 pressure ulcers developed in our care – In-patients.



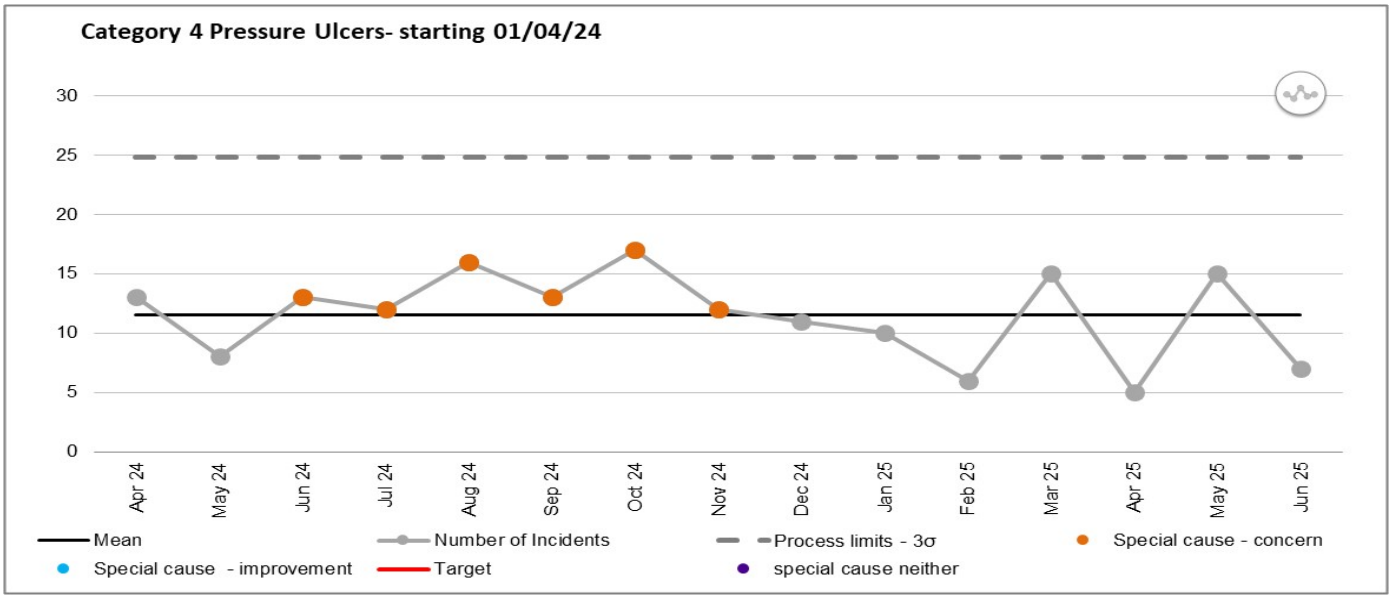
CHS Community Hospital pressure ulcer improvement work continues and there is a pressure ulcer validation meeting held weekly led by the senior nursing team.

Category 2 pressure ulcers developed in our care Community patients.



The chart above details the number of patients who have been affected by a Category 2 pressure ulcers that have been reported as developed in LPT community services. A review of these incidents by the community Hubs has identified that Charnwood, East North, East South, and North-West Leicestershire are the highest reporting hubs. Quality improvement interventions are in place linked to these hubs to support the teams and facilitate improvements in prevention and treatment.

Category 4 Pressure Ulcers developed or deteriorated in our care – Trust wide.



To note there have been no patients who have developed a category 4 pressure ulcer whilst in LPT in-patient care for 14 months since March 2024.

All patient incidents reported related to the development of category 4 pressure ulcers either developed, or deteriorated in CHS community nursing care and this continues to show normal variation, with no statistically significant improvement. It is too early to identify any themes/learning as patient care reviews for the May 2025 reported incidents are still being undertaken. High level themes are noted to relate to patients nearing the end of life. The full analysis will be reviewed at both the pressure ulcer group and the end-of-life steering group.

Patients affected by pressure ulcer harm is a 'nurse sensitive indicator' linked to safe staffing. There has been no evidence through the monthly safe staffing reviews that staffing was a contributory factor. The MDT care review process for Category 2 and Category 4 pressure ulcers has highlighted there are opportunities to improve, repositioning advice and the oversight of this when undertaken by care staff in patient's homes, escalation of concerns and senior nurse oversight particularly for complex patients. Challenges remain supporting patients with positioning difficulties, access to carers beyond packages of care in their own home and meeting patients care needs when they prefer to remain seated a chair for extended periods of time.

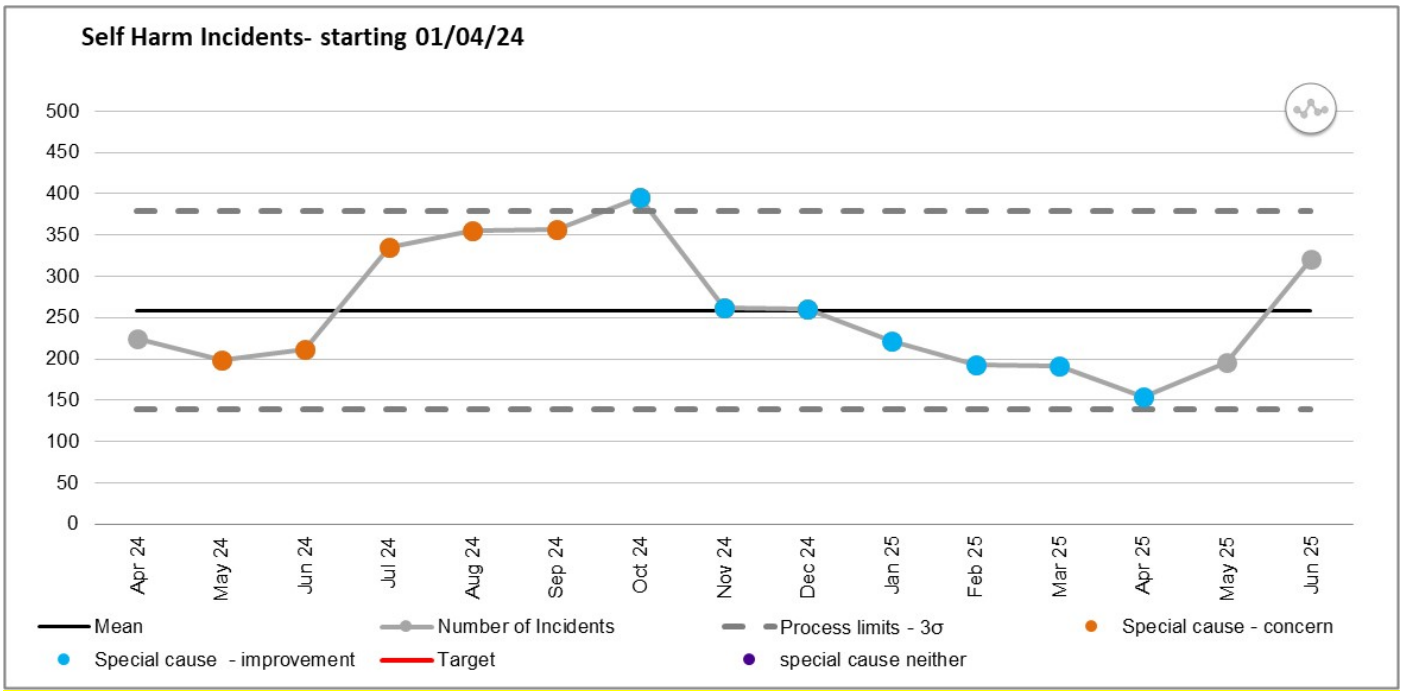
It is recognised that there is ongoing improvement work and staff education required in relation to consistency of categorising of patient's pressure ulcers; this is supported by the revised pressure ulcer prevention training level 3. Due to the introduction and embedding of the ILSA care application (a web-based App) including photography over time in community nursing there is an improved quality of wound photography, timeliness of being reviewed and as this is now added to the patient record this has resulted in closer scrutiny and oversight. The application will be rolled out across podiatry and community hospitals during quarter 3 and 4 2025/6.

The NHS Benchmarking Network's (NHSBN) 2024 for District Nursing which contains data from 1st April 2023 to 31st March 2024 highlights the Trust's position for a selection of key metrics, one of which is pressure ulcers (category 2,3,4) acquired whilst under the care of the service. (This is measured per 100 unique service users) During this collection period, the community nursing service was reported to remain close to the mean when measured against other providers. The next data collection is currently being undertaken.

The Quality Account Priorities for 2025/26 'Improving the Assessment and Prevention of Moisture Associated Skin Damage for patients in community hospitals' has been agreed. A Community of Practice with nursing, continence, allied health professional and tissue viability nurse experts has

been set up, led by the deputy head of nursing for community hospitals, with oversight by the Pressure Ulcer Prevention (PUP) Strategic Group.

2 Self-Harm



There were 517 patient self-harm incidents reported during May and June 2025, this equates to 14.2% of all reported patient safety incidents during this period.
During the previous reporting period there were 342 self-harm incidents reported across both inpatient and community settings, this shows an increase of 51.17% during the current reporting period.

The number of incidents has been analysed and over the reporting period and there are 3 areas with a significant number of self-harm incidents.

CAMHS Beacon Unit (currently on Thornton Ward)

104 incidents (20.1%) this is an increase from 38 incidents in the previous reporting period.

In May 2025 it has been noted that there has been a significant increase in all incidents.

Due to an issue with the water supply at the Beacon Unit the ward relocated on 16th April 2025 to Thornton Ward to allow for remedial works to be undertaken. Staff have reported that as a result of the different environment on Thornton Ward, echoey, not as spacious and lack of seclusion facilities, has led to protracted incidents which might have otherwise ended sooner; the increased in incident relates to 3 patients. The staff and patients returned to the ward on 17th July 2025.

Towards the latter part of the month there was also an increase in self-harm, via headbanging. Where there are multiple self-harm attempts the staff complete a shift report and report in one incident form so that each lower-level incident isn't reported to try and maximise staff time on supporting the patient opposed to completing multiple incident reports.

Watermead Ward - 57 incidents (11.0%) this is an increase from 3 incidents reported in the previous reporting period. This is an increase and varies according to increased acuity based on a changing patient cohort. Watermead is also a 'mixed gender' ward and will sometimes be mixed or single sex dependent on patients' need/demand resulting in variation month by month; the analysis of the incident figures is not therefore directly comparable.

Heather Ward – 43 incidents (8.3%), this is an increase of 330% from 10 incidents reported in the previous reporting period. Most of this increase is related to three patients, and despite higher levels of observation there are still situations where incidents occur which are predominantly no/low harm incidents. The ward has two QI projects running around reducing self-harm in recognition of this opportunity for learning and improving.

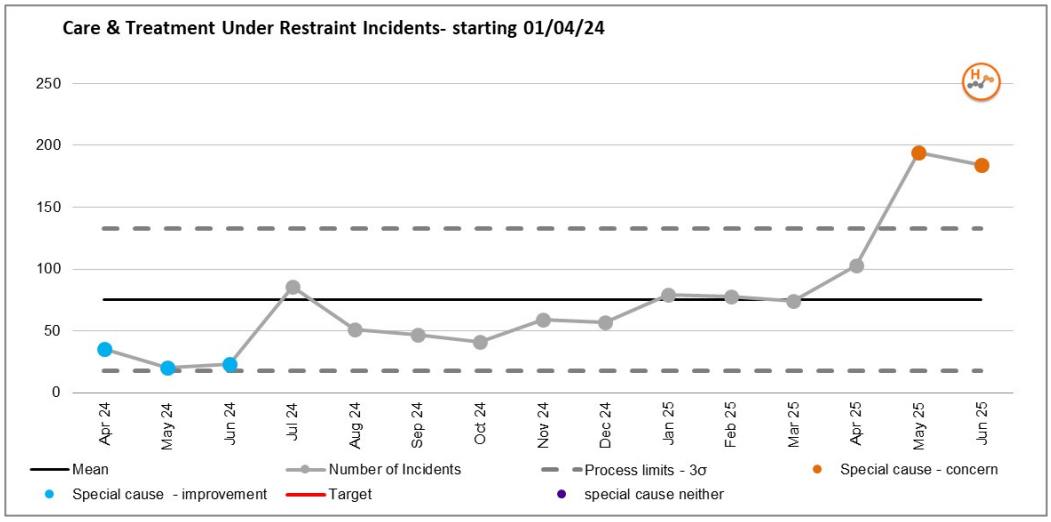
Harm Levels

Of the 104 incidents reported by CAMHS Beacon (on Thornton Ward), 1 (1%) was recorded as 'moderate harm', upon a further review by the Matron, the incident was regarded to minor/ low harm. 68 (65.4%) were recorded as 'minor/low' harm with the remaining 35 (33.7%) as 'no harm.

Of the 57 incidents reported by Watermead Ward 1 (1.8%) was recorded as 'moderate harm', 40 (70.2%) have been recorded as 'minor/low' harm with the remaining 16 (28.1%) being recorded as 'no harm'; and Heather Ward have recorded 33 (76.7%) as being 'minor/low harm', with the remaining 10 (23.3) being recorded as 'no harm'.

Overall, of the 517 total reported self-harm incidents, 310 (60%) have been reported as 'minor/low' harm, a further 196 (37.9%) have been recorded as 'no harm', 10 (1.9%) have been reported as 'moderate harm'. These incidents are being reviewed through the Directorate governance processes to ensure accurate reporting and identify themes and opportunities for learning.

2. Use of Restraint for Care and Treatment



There were 378 incidents where restraint was used during May and June 2025, representing 10.4% of all reported patient safety incidents during this period. During the previous reporting period, there were 175 incidents reported, where restraint was utilised, therefore this shows an increase of 116% during the current reporting period. The reporting of incidents using restraint currently fall into 2 categories, those related to the management of violence, aggression, and acute self-harm and those where restraint holds have been utilised to support care activities such as carrying out personal care – washing and changing incontinence wear. The Least Restrictive Practice Group is currently reviewing new training for 'clinical holding' for use to support these care activities and is reviewing the categories on the Ulysses system to allow the categories to be separately reported.

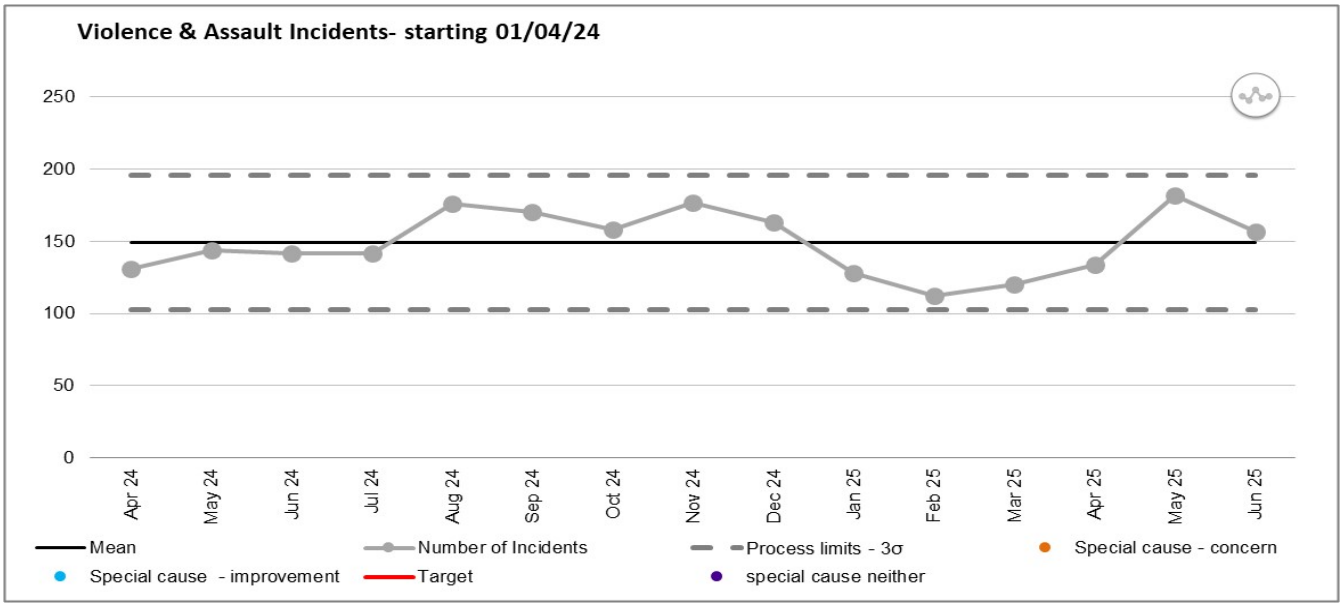
The analysis of incidents where restraint has been used over the reporting period there are 2 areas with a significant number of incidents reported relative to the total number (378) the CAMHS Beacon Unit (on Thornton Ward) with 236 (62.4%) incidents and Mill Lodge with 99 (26.2%) incidents.

CAMHS Beacon (on Thornton Ward): The increase reflects the interventions when patient are self-harming and the needs of patients who continue to require nasogastric tube feeds twice a day under restraint. Patients care and treatment is continually reviewed to minimise the need to restrain during nasogastric feeding.

Mill Lodge: The increased incidents are reflective of the complex needs of patients during personal care activities. The care team is being supported through regular reviews with the safety intervention training team, safeguarding and least restrictive practitioners.

Overall, of the 378 incidents reported where restraint was utilised, 276 (73.0%) were recorded as 'no harm', 101 (26.7%) were recorded as low harm and the remaining 1 (0.3%) incident was recorded as 'moderate harm'.

3. Violence/Assault



There were 339 incidents of violence and assault reported during May and June 2025. These incidents represent:

- Patient violence towards other patients, people not employed by the trust (temporary staff) and our staff.
- Incidents of disruptive behaviour towards others.

This represents 9.31% of all reported patient safety incidents. During the previous reporting period, there were 250 ‘violence and assault’ incidents reported, this shows an increase of 35.6% during the current reporting period.

The numbers of violence and assault incidents has been analysed and over the reporting period there is one area with a significant number of incidents reported relative to the total number (339) of violence and assault incidents, Gwendolen Ward with 45 (13.3%) incidents.

Of these 339 incidents, 165 (48.7%) were recorded as disruptive behaviour. Gwendolen Ward recorded 26 (15.8%) of these incidents, Coleman Ward recorded 16 (9.7%) this is due to the acuity of a few of patients and their advancing disease, and Mill Lodge recorded 15 (9.1%).

Of the 339 incidents reported as 'Violence and Assault', 226 (66.7%) were recorded as 'no harm', 110 (32.4%) were recorded as 'low harm', 2 (0.6%) were recorded as 'moderate harm' and 1 (0.3%) was initially recorded as 'severe harm' (the severe harm has now been downgraded to minor harm since the data was run)

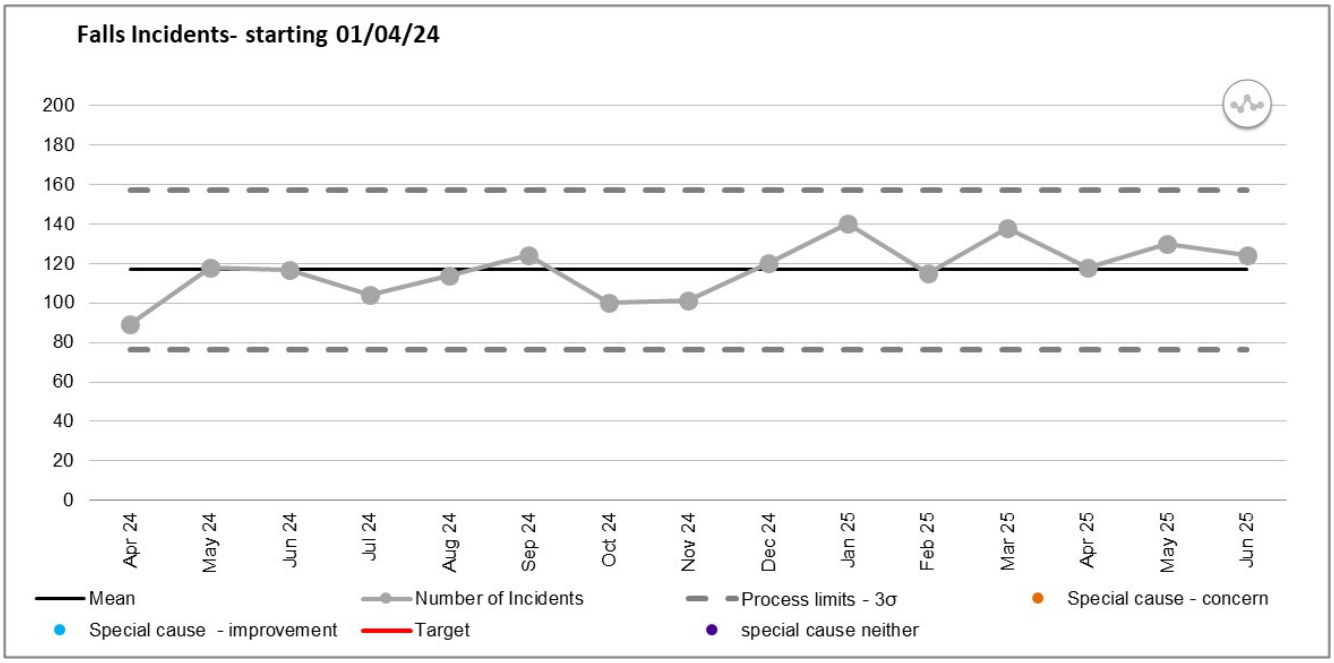
Additionally, in CAMHs Beacon Unit there has been an increase in physical aggression amongst the patients at the end of May 2025. This has been related to changing risks, self-harm interventions and behaviour aimed at property damage, requiring police support and uncertainty regarding discharge arrangements.

There were 3 incidents of violence and assault reviewed at Incident Review and Learning Meeting (IRLM) during this reporting period:

1. 381141 - Agnes Unit 'patient on staff' – There was sufficient learning identified so no further action (NFA) and is being reviewed against Health & Social Care Act 2014 Section 42 safeguarding thresholds for review.
2. 383344 – CAMHS Beacon (on Thornton) patient on staff, patient referred to a Psychiatric Intensive Care Unit (PICU), however, no beds were available -No opportunity for learning identified so NFA

382914 – CAMHS Beacon (on Thornton) disruptive behaviour assessed to be contributed to by the temporary environment which is described on the directorate risk register.

4. Patient Falls, Slips and Trips

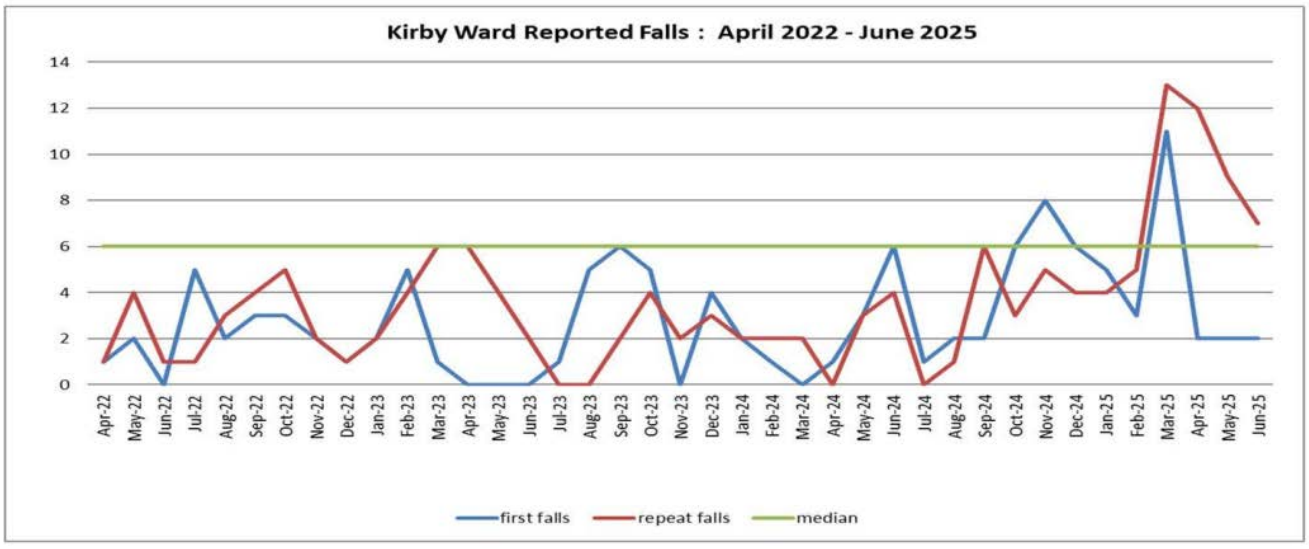


There were 254 falls during May and June 2025 representing 6.98% of all reported patient safety incidents. During the previous reporting period there were 255 Falls incidents reported, this shows a decrease of 0.39% during the current reporting period.

The following analyses the falls data per directorate.

Directorate of Mental Health (DMH)

The numbers of falls have been analysed and over the reporting period Gwendolen Ward at the Evington Centre reported 29 out of a total of 254 incidents, equating to 11.4%, Coleman Ward at the Evington Centre reported 25 incidents, equating to 9.8%, and Kirby Ward at the Bennion Centre reported 23 incidents, equating to 9.1%.



The increase incidents relating to inpatient falls on Kirby has seen a steady decline from 24 in March to 14 in May and 9 in June which included one patient who fell 5 times, care plans had been reviewed

and updated, and fortunately no injuries were sustained by our patients. The impact on patients should not be underestimated increasing their lack of confidence, fear of falling, potential delay in discharge and increase in staffing requirement to influence prevention of falls, the trust Fall Prevention Group are exploring further reduction approaches.

Gwendolen and Coleman Wards (mental health of the older persons) continue to report the higher numbers of falls in DMH (13 and 15 in May and 16 and 10 in June) due to the complexities and vulnerabilities of the patient cohort, who are generally mobile, however, with cognitive and behavioural presentations which increases their risk of falls.

Actions and support with staff knowledge in DMH to improve post falls management show improved compliance with the post falls process. Also, there has been the introduction of 'falls drills' to practise post falls management and the use of the flat lift equipment, particularly in areas with low numbers of falls where staff are less familiar with best practice.

Of the 254 reported Falls incidents, 142 (55.9%) were recorded as 'no harm', 106 (41.7%) were recorded as 'minor harm', 2 (0.8%) were recorded as 'moderate harm' and 4 (1.6%) were recorded as 'severe harm'. This data is also subject to review by local teams.

Community Health Services (CHS)

CHS shows a drop in falls in May and improved compliance with post falls huddles. Inpatient falls validation meetings continue weekly to ensure all actions are addressed and to provide shared learning across wards. Work to ensure appropriate levels of supervision continues and numbers of unwitnessed falls are monitored.

Medications and falls.

As previously shared, an audit on MHSOP and CHS wards demonstrated clear falls causal link with a high Anticholinergic Cognitive Burden score (ACB score). This is a numerical scale used to assess the potential for medications with anticholinergic effects to negatively impact a person's cognitive function. Higher scores indicate a greater potential for cognitive impairment and increase the risk of falls. Recommendations have been made to monitor ACB scores and an ongoing project with physiotherapy, pharmacy and the medical teams are working on developing an ACB tool to provide a screening and trigger tool for a medication review and consideration of reducing ACBs where possible.

Review of National guidance changes related to falls prevention.

Two national documents have been published recently and Falls Steering Group have reviewed to

identify improvement actions for 2025/26; the headlines are shared below.

Royal College of Physicians (RCP) National Audit for Inpatient Falls 2024

NAIF key recommendations	Falls Steering Group analysis
Recommend change in terminology from MFRA (Multi Factorial Falls Risk assessment) to a MASA (Multifactorial Assessment to optimise Safe Activity)	Sign up to MASA in principle but retain title MFRA to avoid initial confusion as questions are identical and MFRA terminology is still used in NICE
To have a focus on preventing Hospital Acquired Deconditioning (HAD) – linked with functional decline, increased readmissions, increased mortality	To develop programme across I/P wards to address deconditioning
KPI 1: High-quality multifactorial assessment to optimise safe activity (MASA) 6 factors that influence safe activity – potentially modifiable or require care plans to accommodate: • Vision • LSBP • Med's review • Delirium • Mobility • Continence	LPT Falls risk assessments cover these areas but recognise that there is room for improvement in the quality and focus of the assessment and the 'so what'
KPI 2: Check for injury before moving	Assured we have a clear process but need to strengthen audit process to monitor compliance.
KPI 3: Safe lifting equipment used to move the patient from the floor	Good evidence of consistent use of Flat lifting Equipment on al wards – monitored monthly
KPI 4: Medical assessment within 30 minutes of the fall	This is a challenge OOH on CHS wards

NICE 2025 – Falls: assessment and prevention in older people and in people 50 and over at higher risk (NG249)

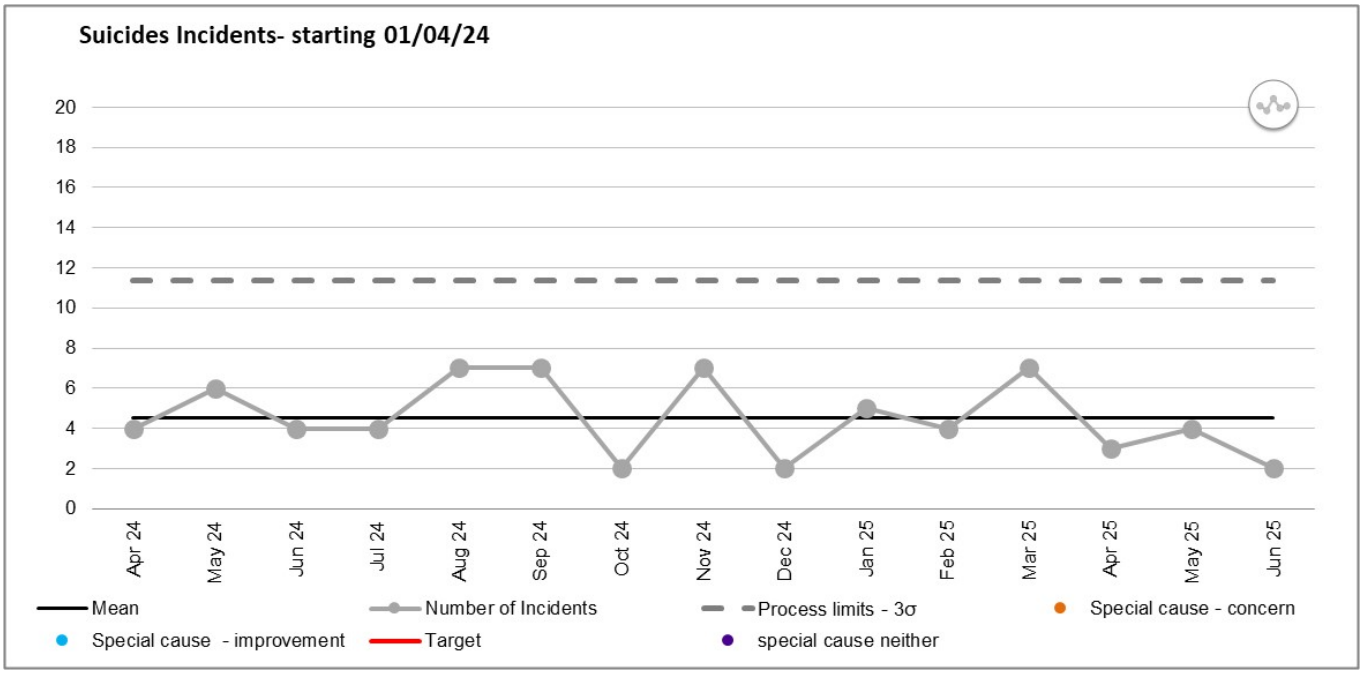
- No significant change for Inpatient processes
- MFRA questions unchanged and our risk assessments meet requirements recommended.

Changes

- Change in trigger questions to identify need for MFRA and now includes identification of frailty – need to agree consistent method for identifying and assess frailty.
- Addition of
    - Maximising ongoing participation in falls prevention interventions – Need to ensure evidence of personalisation of plan with patient involvement.
    - Information and education for people receiving falls assessment or interventions – Shared decision making in community and inpatients.

Suicide Prevention

While suicide does not feature in the top five reported incidents, we review every suicide for learning, themes, and trends. We also assess our services and actions against National Learning from National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)



It is important to consider suicide over time. The data above currently does not identify any statistically significant reduction.

Skills Training on Risk Management (STORM) continues as an ongoing area of development and embedding these skills. There are several Practice Development Nurses trained to be ‘train the trainers’ who continue to support the delivery of STORM training to staff across the services.

The Self Harm and Suicide Prevention Lead was in post for 12 months and in that time had progressed a series of interventions based on our self-assessment against NCISH recommendations and the national suicide prevention strategy. Permanent recruitment to this role has been on hold due to workforce controls currently in place and ongoing work to progress the Suicide Prevention Plan is being shared by other clinical leadership posts in different services however there is a risk that this will be significantly delayed without a dedicated lead.

The latest information from NCISH describes that self-harm is a major factor in those that die by suicide, across society and in all healthcare areas, not just those people who have been known to or in receipt of care in mental health services. Sadly, in May 2025 there were 4 suspected suicides

these will all be reviewed through a rapid review meeting and progress if required to the Trust Incident Review and Learning meeting (IRLM) to consider the opportunity for learning.

It is nationally recognised that lack of a robust assessment and consideration of all risks features in many of those that die by suicide. There is continued work to improve the completion of risk assessments within and across LPT regarding using a formative approach and summary.

Areas of improvement for staff to influence/support patients according to their risks and to learn from those who have taken their life by suicide include:

- Building on the current good practice of undertaking a rapid review of each person who may have taken their life by suicide, expanding the review by measuring/assessing the care and interventions (as appropriate) against NCISH standards.
- To improve the progress with self-harm training for our staff. This is a LPT wide piece of work to achieve best practice against the national suicide prevention strategy. This needs to be progressed and is currently on the risk register as a corporate risk.
- To increase postvention support and build on the areas of excellent support in the trust, to ensure that we are following the national strategy for supporting those affected/ bereaved by suicide.
- To gather pace on the LPT suicide prevention plan, which is trust wide on a variety of interventions.

LPT hosted the LLR suicide prevention conference on Wednesday 2nd July 2025, which was well attended, with guest speakers including Dr Mo Abbas, and Navpreet Kapur, Head of Research at the Centre for Suicide Prevention, University of Manchester

Learning from Deaths

The National Quality Board (NQB) Guidance on Learning from Deaths (LfD), published in March 2017, sets out the expectation for NHS Trusts to collect and publish specified information on deaths on a quarterly basis. The quarterly reports will be shared separately through the Quality and Safety Forums and on to Board for Q1 for assurance.

LeDeR

Monthly panel meetings continue as per the revised LeDeR processes and Governance arrangements. The panel have shared the following information:

- There were 3 notifications made by LPT staff to LeDeR related to patients with a known learning disability and who have died for May (1) 2025 and June (2) 2025.

- For city and countywide reviews there were 2 patient death notifications in May 2025 and 11 patient death notifications in June 2025.
- No patient deaths have undergone a focused review; 1 was out of scope, 5 currently allocated, currently 7 initial reviews, however this may change after allocation, 5 are focused, 2 due to ethnicity, 1 Autism only review and 2 meet the local priority area (2025/26) for all deaths from cancer.

During May the LeDeR team shared with the patient safety team a review they had undertaken as they felt some aspects of the care may meet the criteria for review as an 'incident' this was reviewed at IRLM and agreed to undertake a multi-agency review to consider any learning across services.

Outstanding patient safety reviews: As of end of June 2025.
This data was taken from the Accountability Assurance Framework 4th July 2025.

Table below shows total number of learning responses in progress with numbers and percentage of those that are overdue.

	CHS	**DMH**	**FYPC**	**Corporate**
Total Learning Responses in progress	12	(21 with CPST and 39 with DMH) 60	7	(21 are DMH) 27
Overdue PSII	0	0	0	5
Overdue SEIPs	2	26	2	3
Overdue AAR	0	0	0	0
Overdue Other Learning Response	0	0	1	0
Overdue StEIS	0	1	0	1
Grand Total Overdue	2	27	3	9
Percentage Overdue	**16.67%**	**69.23%**	**42.86%**	**33.33%**

Of these, 2 'Serious Incident Investigation (SI) from under the previous framework remains overdue. One has been delayed due to not being able to speak to the patient while a legal process was under

way. The other was undertaken by an external investigator and there has been a delay in agreeing the final report.

As previously reported, local directorate learning responses are allocated to staff who also have clinical/operational commitments and are trying to balance completion within time frame, applying different thinking and approach to undertaking reviews along with work priorities it is considered that this trend is likely to continue. Involving staff to support the identification of learning is a key objective of The Patient Safety Incident Response Framework (PSIRF).

Duty of Candour

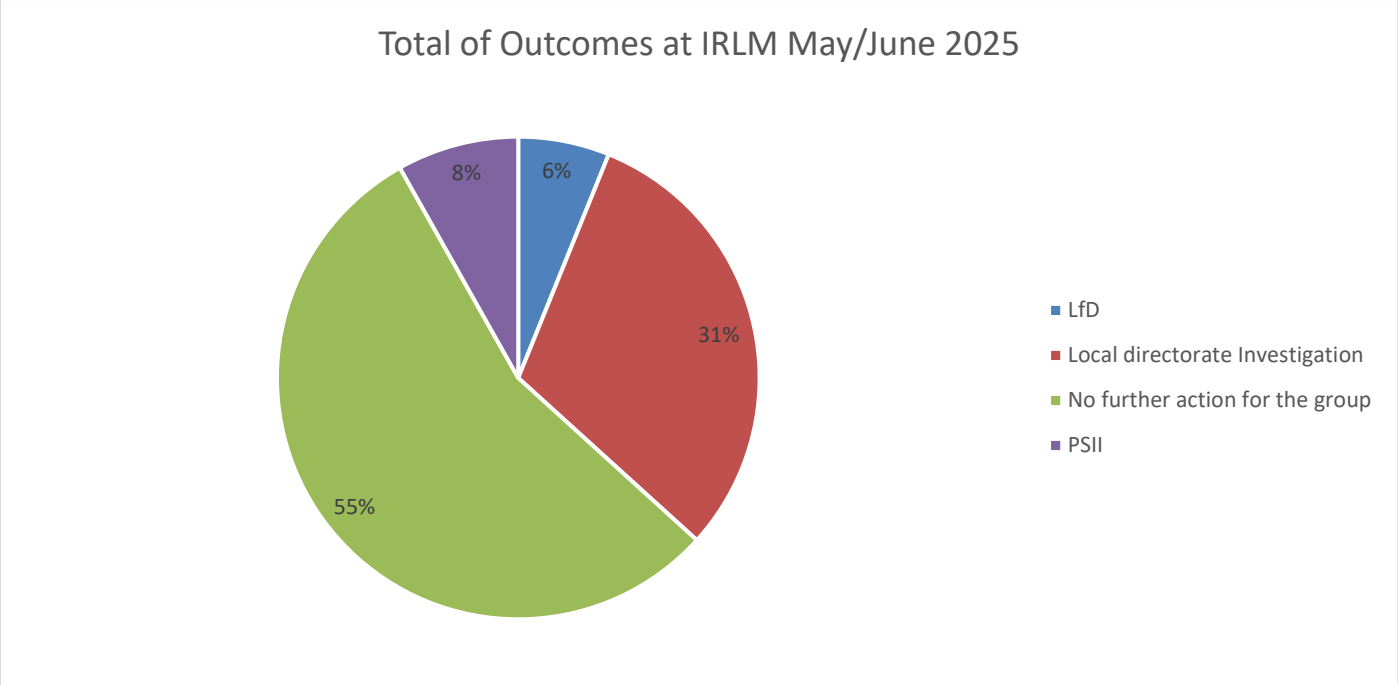
There was no statutory duty of candour breaches during this period we continue to follow 'being open' which is inbuilt in PSIRF principles of compassionate and positive engagement with patients/families.

Never Events

No Never Events were reported during this period. We continue to await NHSE outcome of the review of the 'Never Event' Framework.

Incident Review & Learning Meeting (IRLM)

49 cases were reviewed at IRLM during, May and June 2025. 4 (6%) Patient Safety Incident Investigations (PSIIs) were declared during this reporting period. 27 (55%) were identified as having already identified any learning and actions put in place. There were 15 (31%) Local Directorate reviews requested to explore appropriate actions, 3 (6 %) initial service managers reviews (ISMR's) were shared with Learning from Deaths (LfD) for theming.



Learning from patient safety events (LFPSE) – LPT is compliant.

The LFPSE service is a national NHS system for the recording and analysis of patient safety events that occur in healthcare. The service introduces a range of innovations to support the NHS to improve learning from the over 2.5 million patient safety events recorded each year, to help make care safer.

LFPSE is now in use across the NHS, and organisations have switched to recording patient safety events onto the new LFPSE service using LFPSE-compliant local systems, rather than the National Reporting and Learning System (NRLS), which was decommissioned on 30/06/2024. The Strategic Executive Information System (StEIS) is still in use while the next version of LFPSE is rolled out to replace it and we continue to report our PSIIs here. LFPSE initially provides two main services:

1. The ability to record a patient safety event – organisations, staff and patients will be able to record the details of patient safety events, contributing to a national NHS wide data source to support learning and improvement.
2. For organisations to be able to access data about recorded patient safety events – providers and commissioners can access data that has been submitted by their teams, to better understand their local recording practices and culture, and to support local safety improvement work. Find out more about LFPSE by watching this short video:

https://www.youtube.com/watch?v=mlRu-B-XbGM

As a result of the move to LFPSE, trust incidents can be accessed by NHSE, Care Quality Commission (CQC) and LLR Integrated Care Board Commissioner.

Further information is available via NHSE website NHS England » Learn from patient safety events (LFPSE) service and also on the CPST StaffNet page.

LFPSE publish a data link for all trusts to check their incidents. The number of incidents reported to LFPSE is 3641 matching the total number of patient safety incidents above. This assures us that we have our mapping correct.

NHSE describe that LFPSE data is not directly comparable to the previous National Reporting Learning System (NRLS) data, as the concepts and definitions within the taxonomy have changed, and care should be taken to avoid continuous comparison over time between one data set and the other. https://record.learn-from-patient-safety-events.nhs.uk/data-principles

Where LPT sits in comparison with other Trusts is only detailed for incident reporting and more sharing learning and incident discussions occur in the network forums.

In June 2025 we have further received requests from CQC related to LPT incidents that are automatically uploaded to LFPSE and is across the directorates, with a predominance in DMH. The main purpose of LFPSE is for learning and early identification of emerging risks in keeping with PSIRF, it has not been designed currently for benchmarking or for scrutiny into individual incidents This shift in purpose has been raised from various organisations at a national patient safety forum with NHSE.

Queries Raised by Commissioners / HM Coroner on reports submitted shared.

LLR ICB patient safety team continue to be members of the IRLM and continue to feedback how assured they find the conversations and appreciate the focus on system learning. Whilst there is no requirement under PSIRF to share completed reviews with the ICB, we continue to share as assurance of our learning and request that they use the National Learning and Response review tool which LPT CPST contributed to the testing and final development of the tool.

No queries have been raised by LLR ICB or HM Coroner during the reporting period.

Patient Safety Strategy

Training: Systems Engineering Initiative for Patient Safety (SEIPS) approach to investigation training.

During 2024, 120 members of staff from across all directorates undertook the SEIPS training provided by the CPST (this does not include refresher training and basic SEIPs for the governance teams who were asked to roll out the changing way of approaching incident reviews locally).

In May it was reported that 79 staff had been trained this year and since than an additional 45 staff have been trained bringing the total so far 124 members of staff. There are further dates available throughout2025/26.

The training is evaluating well with staff feeding back that it feels a supportive way to learn and undertake incident reviews:

Directorate	Numbers trained in SEIPS 2025	Numbers trained in SEIPS. 2024
DMH	72	71
CHS	26	27
FYPC/LDA	25	22
Enabling	1	0
TOTAL	**124**	**120**

National: Level one and level two National patient safety training.

This is national training delivered as E learning to support the patient safety strategy and the implementation of PSIRF. The training has been available for staff to access and is required as pre learning for the SEIPS training. The figures below are the staff who have attended so far and as part of our improvement work, we have agreed that all staff will access level 1 and have finalised the staff groups who will benefit from level 2 as band 7 and above.

Table below shows updated figures for whole trust:

Month Year	Patient Safety Level 1	Patient Safety Level 2	Grand Total
Jan-2025	37	26	63
Feb-2025	48	32	80
Mar-2025	34	25	59
Apr-2025	4817	35	4852
May-2025	1184	12	1196
Jun-2025	459	18	477

Patient, Family, and staff engagement as part of PSIRF

The offer of training via Ulearn continued from the CPST supporting one of the key principles of PSIRF ‘compassionate engagement and involvement of those affected by patient safety incidents. Going forward this will be included in the SEIPs training.

Feedback from staff has been sought to understand their experience of the new review process using SEIPS methodology. Twenty-five staff provided anonymous feedback online and reported a

positive experience from the review process and a shift to truly thinking about system improvements and away from individual blame. There was mixed feedback on the information provided, some staff felt it was too much and other felt they would like more. The CPST will review how the information is presented on the web site so that it can be easily found.
Many staff reported the investigation process was open, non-blaming; this was the most commented on by those who participated.

We know that blaming individuals in investigations can negatively impact on safety and performance by discouraging reporting of incidents, hindering learning, and damaging trust between colleagues and teams.

If there is a focus on finding fault can create a 'fear culture' where mistakes are hidden, and opportunities for improvement are missed. Instead, a 'no-blame' or 'just culture' approach, which promotes learning from errors and improving systems, is more effective for long-term safety and performance.

What was reported by our staff was the investigation process did not apportion blame and their voices were mostly heard.

Proposal

The Trust Board of Directors are asked to:

- Review and confirm that the content and presentation of the report provides assurance around the processes we have to identify levels of harm.
- Be assured on the quality of Patient Safety Incident reports, completion, and compliance with 'Being Open' and 'Duty of Candour'.

Decision Required

Briefing – no decision required	✓
Discussion – no decision required	
Decision required – detail below	

Governance Table

For Board and Board Committees:	Trust Board
Paper sponsored by:	Emma Wallis/ Michelle Churchard Smith, Deputy Executive Director of Nursing, AHP's & Quality
Paper authored by:	Corporate Patient Safety Team
Date submitted:	July 2025
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	N/A – in this format however learning is reported from governance groups
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	N/A
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Bi-Monthly
LPT strategic alignment:	T - Technology H – Healthy Communities R – Responsive x I – Including Everyone x V – Valuing our People E – Efficient & Effective
CRR/BAF considerations *(list risk number and title of risk):*	CRR 27 – processes for proportionate and timely review of incidents
Is the decision required consistent with LPT's risk appetite:	N/A
False and misleading information (FOMI) considerations:	
Positive confirmation that the content does not risk the safety of patients or the public	No risks.
Equality considerations:	

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Leicestershire Partnership NHS Trust

Emergency Preparedness, Resilience and Response (EPRR)

Annual Report

June 2025

Contents

Glossary

BCAW	Business Continuity Awareness Week
BCI	Business Continuity Institute
BCP	Business Continuity Plan
BIA	Business Impact Analysis
CBRNe	Chemical, Biological, Radiological, Nuclear and explosive
DOC	Director on Call
EPRR	Emergency Planning, Resilience and Response
EPRRSG	Emergency Planning, Resilience and Response Steering Group
ICB	Integrated Care Board
ICC	Incident Coordination Centre
ISO	International Standard Organisation
HCID	High Consequence Infectious Disease
HEPOG	Health Emergency Preparedness Officers Group
IPC	Infection Prevention and Control
KPI	Key Performance Indicator
LHRP	Local Health Resilience Partnership
LLR	Leicester, Leicestershire and Rutland
LRF	Local Resilience Forum
MOC	Manager On Call
NHSE	NHS England
PDP	Personal Development Portfolio
PPE	Personal Protective Equipment
SCG	Strategic Coordinating Group
TCG	Tactical Coordinating Group
UKHSA	United Kingdom Health Security Agency

1. Purpose of the Report

The purpose of this report is to provide an overview of the Emergency Preparedness, Resilience, and Response (EPRR) activities carried out by LPT over the past year. This report is intended to inform the relevant Committees about our current EPRR capabilities, key activities undertaken, achievements, and areas that require further improvement.

Key aspects of this report include:

- **Assessment of EPRR Resource and Activities**: To evaluate the effectiveness of the EPRR activities and initiatives implemented throughout the year.
- **Review of Incident Management**: To provide a detailed account of incidents managed, response actions taken, and recovery efforts.
- **Training and Development**: To outline the training programs delivered and their impact on enhancing staff preparedness and response capabilities.
- **Compliance/Audits/KPI's**: To report on compliance with relevant EPRR standards and regulations, including findings from internal and external audits.

2. Governance and Structure

LPT EPRR have the adequate resources to undertake the requirements as set out by the EPRR Framework 2022. This includes the required personnel which ensures adequate staffing cover to meet the annual needs of the EPRR work programme as set out by the NHS EPRR Framework and NHS EPRR Core Standards

LPT and NHFT: In 2024, the Northamptonshire Healthcare Foundation Trust (NHFT) EPRR Manager transitioned to the Head of EPRR for both NHFT and LPT. This shared EPRR leadership role across NHFT and LPT brings significant benefits in terms of consistency, efficiency, and strategic alignment. By sharing staffing resource and oversight, both trusts benefit from a unified approach to emergency preparedness and business continuity. This ensures that learning, best practice, and where appropriate, resilience capabilities can be effectively coordinated. This model supports the reduction of duplication, whilst strengthening collaboration across organisational boundaries. This supports a more agile response to system-level risks and incidents. It also enhances the ability to contribute meaningfully to ICS-wide planning and multi-agency engagement, while maintaining the flexibility to address the unique needs of each organisation.

2.1 EPRR Steering Group

The LPT EPRR Steering Group meets bi-monthly and reports into the Health and Safety Committee. The group is well represented and includes Assistant Directors and subject matter

experts, from Estates and IPC, to Cyber. Attendance at each group meeting has been consistently positive, which is indicative of the Trust's support and buy-in to EPRR needs.

The Accountable Emergency Officer or Shared Deputy Director of Safety and EPRR will chair and ensures that the group operates in accordance with these Terms of Reference. In addition to this the Head of EPRR will lead on all Business Continuity and EPRR matters to ensure that key responsibilities of the group continue to be aligned to the NHS EPRR Framework.

3. Incidents

3.1 Incident Response

The following are incidents that have been declared by LPT over the past 12 months. Please note that all actions/learning that come directly from an incident debrief are managed and monitored by the EPRR team and are escalated to the EPRR Steering Group as required.

Incident	**Type of Incident**	**Debrief Report**
13th September 2024 – Legionella – Melton Hospital	Business Continuity Incident	*Report available on request*
23rd September 2024 – Flooding – Prince Philip House	Business Continuity Incident	*Report available on request*
27th December 2024 – Loss of heating – St Lukes Hospital	Business Continuity Incident	*Report available on request*
10th January 2025 – Loss of heating and hot water – Feilding Palmer	Business Continuity Incident	*Report available on request*
5th February 2025 – Boiler Failure – Rutland Memorial Hospital	Business Continuity Incident	*Report available on request*
10th February 2025 – Loss of Telephony – Rutland Memorial Hospital	Business Continuity Incident	*Report available on request*
16th April 2025 – Legionella / Decant – Beacon Unit	Business Continuity Incident	*Report available on request*

The following are incidents that have been declared or put on standby by external partners over the last 12 months and have impacted NHFT, or NHFT have been directly involved in the response -

9th October 2024 - UHL Critical Incident resulting in flow support

26th November 2024 - Regional UEC Pressures resulting in escalation

6th January 2025 - LLR Major Flooding

20th June 2025 - UHL Nerve Centre downtime (planned work managed as BC incident)

3.2 Incident Response Evaluation

The following is extrapolated from incident response debriefs and summarised -

Prompt and Efficient Response

LPT has consistently responded to incidents with good speed and efficiency. The implementation of a robust incident management system has ensured that all incidents were addressed promptly and adequately. This quick response has minimised the need for escalation, whilst ensuring potential further disruption to patients and staff has been reduced, and ensuring high standards of care is maintained.

Comprehensive Training and Preparedness

LPT's dedication to continuous training and preparedness is evident. Exercises, workshops, and training sessions have equipped staff with the necessary skills to handle a wide variety of incidents effectively. This proactive approach has fostered a culture of readiness, ensuring that the Incident Management Team are always prepared to respond to emergencies confidently and competently.

Continuous Improvement and Learning

LPT has shown a strong commitment to continuous improvement and learning. Following each incident, thorough reviews and debriefs were conducted to identify lessons learned and areas for improvement, and the actions that result are monitored and managed via the EPRR Team and escalated when and if necessary. This commitment to learning and evolving ensures that the Trust remains at the forefront of best practice in incident response.

Patient/Staff-Centred Response

At the heart of the Trust's incident response is a strong emphasis on patient-centric care and the wellbeing of our staff. The Trust has consistently prioritized the well-being of patients, ensuring that their needs are met promptly and compassionately during incidents. This focus on patient care has not only improved outcomes but also reinforced trust and confidence in the NHS services.

Effective Communication and Coordination

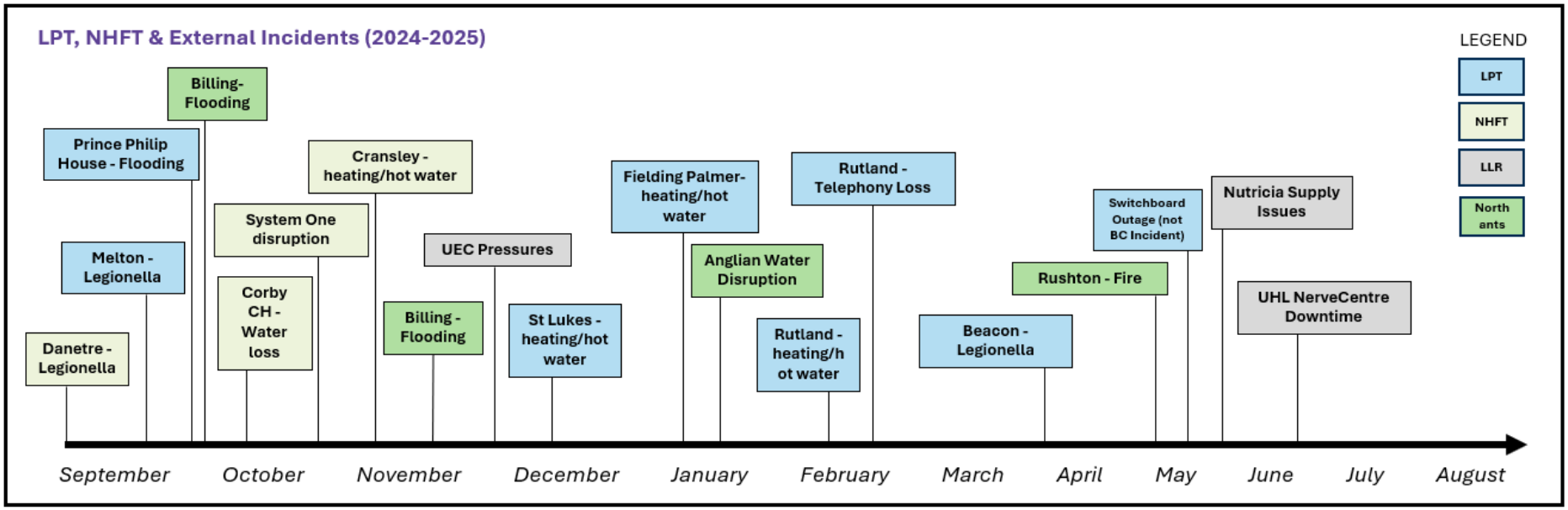
Communication and coordination during incidents have been exemplary. The Trust has established clear communication channels and protocols, ensuring seamless information flow between departments and external organisations within the County. This has facilitated coordinated efforts, timely interventions, and effective management of incidents, ultimately benefiting patient outcomes.

Conclusion

LPT has responded to a variety of incidents with professionalism, efficiency, and compassion. Through comprehensive training, effective communication, data-driven strategies, patient-centric care, innovation, collaboration, and a dedication to continuous improvement, the Trust has set a high standard for incident response. This positive performance not only enhances patient safety and care but also strengthens the overall resilience and reputation of the NHS Trust.

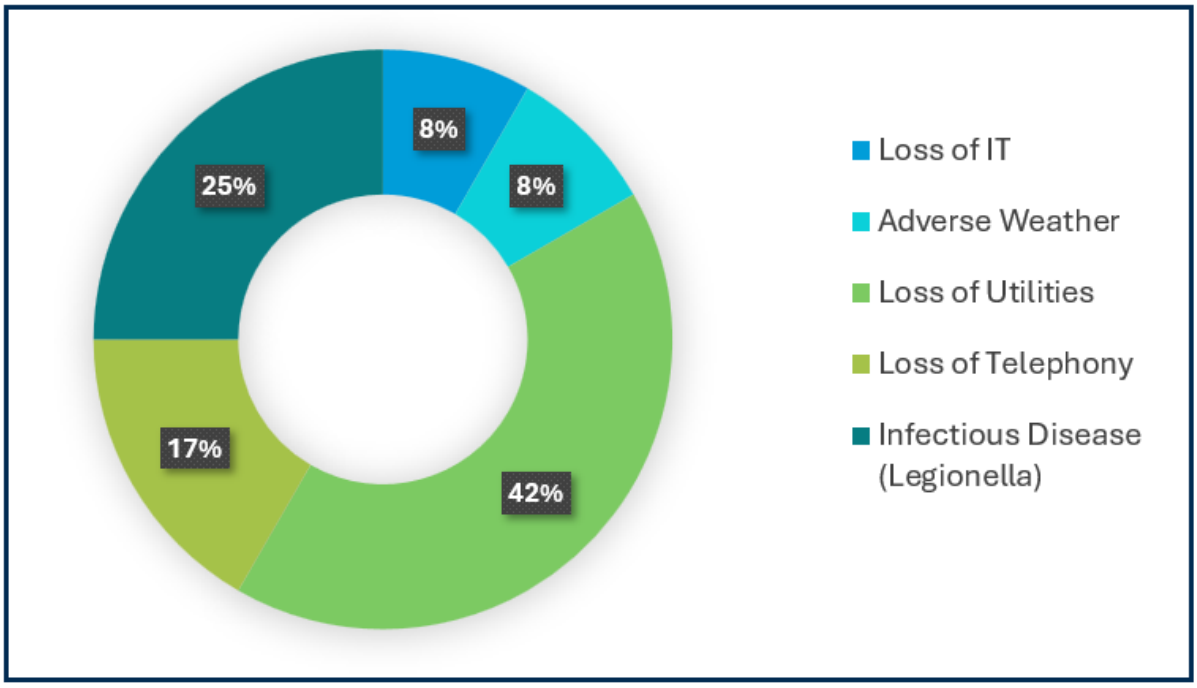
3.3 Incident Response Timeline

Due to the NHFT and LPT shared working model for EPRR, the following chart highlights the number of incidents the EPRR team have actively led or been involved in through September 2024 to June 2025.



3.4 Breakdown of Internal Incident Type

Please note, all incidents listed were declared as Business Continuity across both Trusts.



4. Risk Management

To ensure relevant risks are managed, EPRR maintain the EPRR Risk Register via the EPRR Steering Group. This register considers those risks aligned to the EPRR work programme. It utilises the Local Health Resilience Partnership (LHRP) Risk Register, ensuring the risks are aligned. As well as this alignment, EPRR also utilise the Leicester, Leicestershire and Rutland Risk Register to ensure local risks to LLR are considered. All risks are discussed, scored, agreed and updated on to ULearn.

5. Business Continuity

The following is an overview and analysis of the LPT Business Continuity Management System. It highlights progress, gaps and continued focus.

5.1 Overview

Business Continuity continues to be a focus for EPRR, and major work has been taking place to ensure a robust, updated business continuity management system is implemented across the trust. Embedding effective business continuity across LPT will ensure resilience at all levels of the Trust against disruptive events and ensure services can continue delivery of activities. Engagement is extremely positive, with directorates and services regularly engaging with, and understanding the importance of bespoke and up to date Business Continuity arrangements across the trust.

The primary focus has been those services deemed Critical and High Priority, as per the LPT service prioritisation lists. Following major progress within CHS, FYPCLDA and DMH, the team are now focusing on enabling services.

5.2 Business Impact Analysis (BIA)

BIA development was a previous gap in the LPT Business Continuity Management System. Significant progress has been made over the past year to ensure BIA development has been prioritised across all directorates and services.

5.3 Business Continuity Plans

EPRR maintain the overarching LPT Business Continuity Management Plan which contains the service prioritisation list, developed through Covid and Industrial Action, and updated annually.

The primary focus for EPRR is to ensure service level Business Continuity plans are in place, as the operational level of business continuity is the basis for any robust business continuity system. Significant progress has been made here, as evident in the key performance indicators for business continuity.

5.4 Tracking Business Continuity Progress

EPRR continue to monitor progression of all Business Continuity documentation utilising overview trackers. The outputs of these trackers directly feed into Business Continuity Key Performance Indicators (KPIs), which were agreed through the EPRR Steering Group. Managing business continuity in this way ensures any gaps or areas of concern can be identified and escalated where appropriate.

5.5 Key Performance Indicators (KPIs) – Business Continuity

The following tables show the overall compliance of each directorate against the Business Continuity KPI's who have existing business continuity arrangements in place. Please note the BIA percentages are low due to a previously identified gap in the system. Although low, the percentages indicate excellent buy in and progress through the year.

Overall figure of LPT services with business continuity arrangements in place

	Community Health Services	Mental Health Services	Families, Young People and Children and Learning Disability Services	Corporate / Enabling Services
Business Continuity Plans	92%	88%	94%	20%
Business Impact Analysis	76%	33%	43%	36%

Going forward, under the renewed Business Continuity system being put into place, there are three KPIs now reported through the EPRRSG on its progress, and these will now be reported to the Health and Safety Committee going forward. These are –

KPI 1 – All LPT services have a fully completed Business Impact Analysis and are updated annually.

KPI 2 – All LPT services, where necessary, have fully completed a Service Business Continuity Plan or have access to a Site Business Continuity Plan; ensuring these are updated annually.

KPI 3 – All LPT services exercise their Business Continuity arrangements on an annual basis.

KPIs are measured against the following:

- Below 54% fully (or partially) completed = Non compliant
- 55% - 69% fully completed = Partially compliant
- 70% to 85% fully completed = Substantially compliant
- 86% and above fully completed = Fully Compliant

5.6 Looking Ahead 2025/2026

The EPRR Team will focus on the development of corporate business continuity plans into next year and continue Business Impact Analysis development as a priority. To further enhance the BC system, EPRR will be pushing all services with a BCP to undertake at least one exercise from the Off-The-Shelf Exercise Programme annually to test their arrangements. This will be reportable through the EPRR Steering Group and included into the Business Continuity KPI's next year.

6. Emergency Plans

A number of EPRR owned plans are updated annually and monitored for effectiveness. These plans are up to date and aligned to the NHS EPRR Framework and NHS Core Standards for EPRR.

- Adverse Weather Plan
- Contaminated Self Presenters (CBRNe) Plan
- Cyber Incident Response Plan
- Evacuation and Shelter Plans
- Lockdown Plans
- Major Incident Plan
- New and Emerging Pandemic Plan

EPRR are also instrumental in the support, development or maintenance of other Trust plans and processes which may not be directly owned by EPRR. These include but not limited to:

- Cyber Incident Response Plan
- Communications Plan
- VIP Plan
- Infectious Disease and Outbreak Management processes

7. EPRR Training and Exercising

Training is a key area within EPRR that benefits a cross-trust approach and alignment. As such, both the Principles of Incident Response and Principles of Business Continuity are delivered to the same staff cohort in joint NHFT and LPT capacity. This reduces operational pressure on the team but also ensures consistency in approach across both Trusts

7.1 EPRR Training

As per the EPRR Policy and EPRR Training Needs Analysis, and aligned to the National Occupational Standards, EPRR conduct the following training:

7.1.1 Incoming Director On-Call (One-to-One)

The Director On-Call Introduction training centres around the roles and responsibilities of undertaking Director On-Call duties, including elements of incident response training and role expectation. All new Directors On-Call are required to undertake this training. EPRR also provide a refresher version of this training for any Director that requests it.

7.1.2 Principles of Incident Response

Historically incident response training at LPT has struggled to gain attendance and traction. To tackle this, the Head of EPRR has introduced Principles of Incident Response which has been running successfully at NHFT for two years. It has now been overhauled as a cross-trust training package, definitely to both trusts simultaneously and bi-monthly.

Principles of Incident Response is a training package designed by the EPRR team which is aligned to the National Occupational Standards for EPRR and was initially directed towards all NHFT Directors On-Call. This training was then successfully opened up to all NHFT Managers On-Call. The overarching cross-trust approach for key workstreams was opened up to LPT MOC's in May 2025. Going forward, from July 2025 this training is now being made available to all staff across LPT who may be involved in an incident response, and therefore all on-call groups, including LPT's DOCs. The training centres around (but not limited to) multi-agency working, command and control, legislation, information sharing, decision making, risk anticipation, assessment, and debriefing and there is a requirement to attend one session every year.

The below figures represent both current and forecast attendance for Operational Directorate Managers On-Call. The forecasted figures are based on MOC's who have signed up to the training via uLearn. Future reporting will include (separately) all on-call functions that have attended the training.

Principles of Incident Response - Operational Directorate Managers on Call (only) (116 MOC's total)				
Date	Current (June)	Jul-25	Sep-25	Nov-25
% Complete/Due	18%	40%	58%	60%

7.1.3 Management of Contaminated Casualties

This training is targeted to staff who are most likely to come in to first contact with CBRNe (Chemical, Biological, Radiological, Nuclear and explosive) and HCID (High Consequence Infectious Disease) contaminated self-presenters. It is going live with the first session/exercise in July 2025 for LPT but has been well established in NHFT for the past 18 months.

7.1.4 Principles of Business Continuity

This training is aimed at all staff involved in the BC development process. This training is for all those involved in the Business Continuity plan development process and provides an overview of what business continuity is and what the LPT Business Continuity Management System looks like.

7.1.5 Loggist Training

The Trust currently has thirteen trained loggists who can support the Strategic Commanders if a major incident occurs.

7.2 Key Performance Indicators – Training

The following KPI's are aligned to both the Trust KPI measures as well as the EPRR Framework. These are used to monitor the compliance of all LPT staff who undertake a role within incident response.

- All DoCs to be 100% compliant in all mandatory training
- All other staff (excluding DoCs) to be 85% and over complaint in all mandatory training
- Below 70% (Red) = Non compliant
- 70% to 85% (Amber) = Substantially compliant
- 85% and above (Green) = Compliant

The EPRR team regularly deliver training throughout the year, to ensure compliancy is consistently improving, and that LPT staff feel confident in the areas they are being trained within. EPRR produce a bi-monthly training report for the EPRR Steering Group which details and outlines compliancy figures in detail.

7.3 Training - Monitoring

To ensure all staff who undertake EPRR training are fully monitored, staff are required to maintain their own Personal Development Portfolio (PDP) which is aligned to the National Occupation Standards. Any training, or live incident that a colleague has been involved in will trigger the PDP to be updated to reflect. EPRR manage and maintain a full comprehensive list of all staff who have undertaken or due to undertake training. This way EPRR can ensure training is kept up to date and gaps in training can be addressed.

7.4 EPRR Internal Exercises

EPRR are required to conduct a number of exercises throughout the working year. These exercises provide a safe space to test and validate people, plans and processes and help identify potential improvements, furthering resilience to future disruptive events.

7.4.1 Exercise Grey Cloud – Tabletop – Business Continuity - Cyber Attack (March 25)

Exercise Grey Cloud is the first 'Off the Shelf' exercise designed to test the ability of LPT services to respond to and recover from a cyber-attack scenario, ensuring patient safety and service

continuity is maintained. This was piloted with a number of LPT services in March 2025 with the support of the EPRR team but is intended to be used by services independently in order to test their business continuity arrangements.

Post-Exercise Report Available on Request

7.4.2 Exercise Wave 25 - Communications – No Notice (10/04/25)

The aim of Exercise Wave 25 was to test the ability of those with an on-call responsibility, in the event of an incident occurring out of hours at LPT, to receive, confirm and appropriately escalate notification of an incident. The EPRR team carried out the exercise from 1800 hours on 10th April 2025. The exercise was two-fold: to test response times from notification of incident scenario to escalation call to ICB Director on Call; and to test the on-call capability of other services with on-call responsibility.

Post-Exercise Report Available on Request

7.4.3 Exercise *First Contact* - 'Live' Contaminated Casualties Exercise (July 2025)

As part of the management of contaminated casualties training delivered to front of house staff, who are most likely to come into contact with contaminated casualties. In this context, contaminated casualty refers to someone who is either contaminated with a Chemical, Biological, Radiological, Nuclear and explosive (CBRNe) substance or with a High Consequence Infectious Disease (HCID). This exercise, well established annually at NHFT, is now undertaken no less than annually at LPT.

7.4.4 Exercise Ripple 25 - Communications – Notice (15/07/25)

EPRR will be undertaking an in-hours 'notice' communications exercise in July to assess LPT's internal on-call communications processes in an emergency. This exercise will test the emergency mobile facility of inpatient services, to assess access to these emergency phones and response times.

7.5 External Exercises

LPT has been actively participating in a number of external exercises, including being instrumental in the design and delivery of one.

7.5.1 Exercise Tangra – Pandemic Tabletop – 08/04/25

A regional pandemic exercise designed to test the response to a new and emerging pandemic scenario

7.5.2 Exercise Mercury – Mass Casualty - Tabletop – 19/06/25

A multi-agency major incident exercise resulting in a mass casualty event from a major road traffic accident scenario.

7.5.3 Exercise Echo One – Northants/LLR Pan-ICS Cyber Exercise – 26th June

Designed and delivered by NHFT/LPT EPRR team alongside LLR and Northants ICBs, Exercise Echo One has been developed to support Strategic leaders across both the Northants and LLR ICS in rehearsing and testing their response to a significant ransomware cyber incident, challenging assumptions versus reality of a major cyber-attack scenario.

7.5.4 External Communications – Tabletop

LPT have actively participated in a number of external communications exercises. These include Exercise Busby (LLR ICB led) and Exercise Toucan (NHS National Communications exercise)

8. Compliance / Audits

8.1 NHS EPRR Core Standards

- The EPRR Core Standards is an annual piece of work with a legislative background where the Trust is required to evidence around 50+ subjects and a 'Deep Dive' topic within a submitted report. The gathered evidence for each standard is then presented to LLR ICB, who assess and forward on to NHS-Midlands for further review. A confirm and challenge process is undertaken, and additional evidence is submitted as requested, within set timeframes.

- The current process is underway for 2025 and EPRR are regularly reporting on progress to the Local Health Resilience Partnership.

- **LPT EPRR scored overall as fully compliant. Out of 58 standards, all 58 were scored as fully compliant**

- LPT EPRR are aiming to maintain Fully Compliant in 2025.

- Please see Appendix 1 below for previous final Core Standard Board Report

Appendix 1 – EPRR Core Standards 2023/2024 Report - Final

Core Standards Board Report – January 2025 - Final

NHSE Core Standards for Emergency Preparedness, Resilience and Response (EPRR), Self-Assessment Assurance Review Report 2024/25.

Purpose of the report

This report provides assurance that Leicestershire Partnership NHS Trust (LPT) is discharging its EPRR responsibilities, aligned to the LPT EPRR Policy and the Civil Contingencies Act (2004). Also, this report describes the work undertaken to drive up compliance against the 04 standards deemed to be partially compliant in year 2023/24.

Analysis of the issue

Compliance with the NHS Core Standards for EPRR

Self-assessment against the NHS core standards for EPRR utilises a four-tier system to rate compliance.

Overall EPRR assurance rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

In 2024/25 LPT are required to report against 58 standards that are grouped across 10 domains. This is supplemented with a Deep Dive section containing 11 Standards applicable to Cyber Security and Incident Response. The Deep Dive score has no bearing on the overall compliancy rating for the organisation but gives a strong indication how the trust is performing in that area.

In 2023/24 NHSE deemed LPT to be Substantially Compliant with an agreed overall compliancy rate of 93%, broken down into 54 Standards fully compliant and 04 Standards partially compliant. This was a change in the LPT compliancy rate from partially compliant (2022/23) to substantially compliant (2023/24).The 04 standards that were graded as partially compliant were relating to

business continuity, duty to maintain plans and CBRNE and a number of actions were undertaken to address the points raised by the NHSE confirm and challenge process.

EPRR Core Standards Score - 2024/2025 *(current)*

LPT has completed and finalised the self-assessment against the applicable NHS Core Standards for EPRR in England. Considering the positive work against the 04 partially rated standards and the work delivered against the EPRR Work Plan – the trust can evidence that it meets all standards and rates itself Fully Compliant. In order to achieve compliancy in 2024/25 the trust has undertaken some key collaborative work with all stakeholders including NHS England Regional EPRR Team, LLR ICB and the Local Resilience Forum (LRF).

Headline achievements in each domain 2024/25

	Domain	Headline Work Activity
01	Governance	• Review of the EPRR Policy, shared with NHSE for consultation, all feedback fed into the policy. • Clear governance structure for EPRR appended to the policy. • Introduced an improved process to capture learning from incidents and exercises and embed it into plans process and procedure. • **C**apture **A**ssess **A**ction **P**lan **E**mbed (CAAPE)
02	Duty to Risk Assess	All EPRR Risk Assessments on ULYSEES updated and reviewed against the LLR Community Risk Register
03	Duty To Maintain Plans	The following plans / Action Cards have been reviewed and shared with system partners for consultation. • Major Incident Plan • New and Emerging Pandemic Plan • Evacuation and Shelter Plan • Lockdown Plan • Contaminated Self Presenters Plan (CBRNE) • Adverse Weather Plan • EPRR Communications Plan • Incident Coordination Centre Standard Operating Procedure • Countermeasures Action Card (AC11) • High Consequence Infectious Disease (HCID) Action Card (AC12) • Protected Individuals (Response to a VIP in LPT Care) A new plan introduced in 2024 – LPT **C**yber **A**ttack **R**esponse **P**lan (CARP) – This is the product of Exercise Dark Day 24
04	Command and Control	On Call Training delivered to strategic and Tactical responders

05	Training and Exercise	The following Exercises and training have been delivered by the LPT EPRR Team. • Ex Bradgate Bounce – Mental Health inpatient Evacuation exercise. • Ex Crystal Clear – LPT Communications Team EPRR Training • Ex Prepared Communications – Out of Hours communications test / exercise of the LPT Emergency Contacts List. • Ex Dark Day 24 – Cyber Attack Response exercise • Ex Full House – Winter Preparedness exercise 2024 • Ex Contaminated Response – CBRNE exercise. • Director on Call continuation training

Confirm and Challenge Dispute

Please be aware that although LPT has rated itself as fully compliant against the applicable standards for EPRR, the review of the trust self-assessment is also undertaken by the Head of Emergency Planning for the LLR ICB and the Regional EPRR Team.

Following the confirm and challenge with both organisations, the regional EPRR team did not feel one standard was fully compliant. This standard (03 Board Reports) was centred around how EPRR progress is reported to Trust Board. Within LPT, EPRR is fully aligned to the our internal governance structure and therefore disputed the Regional view and rejected any suggestion to lower the score of this standard. Our self-assessment against the standards was discussed and agreed within the Local Resilience Forum. The regional team have subsequently stated they are now reviewing that standard to ascertain if more flexibility is required going forward.

A number of observations were noted by ICB/NHSE. These items have been incorporated into LPT's EPRR's annual work programme for 2024/2025. The work programme is reportable to the bi-monthly EPRR Business Continuity and Emergency Planning Steering Group to monitor progress.

Decision Required

The committee are asked to receive this report for information, assurance and agree with the trust position.

Governance Table

For Board and Board Committees: Paper sponsored by:	Health and Safety Committee, Quality and Safety Committee, Trust Board Ian Cromarty / Jean Knight	
Paper authored by: Date submitted:	Dan Adamson 24.06.2025	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	n/a	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	n/a	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	One off (annual)	
LPT strategic alignment:	**T** - **T**echnology	✓
	H – **H**ealthy Communities	✓
	R - **R**esponsive	✓
	I – **I**ncluding Everyone	✓
	V – **V**aluing our People	✓
	E – **E**fficient & Effective	✓
CRR/BAF considerations *(list risk number and title of risk):*	n/a	
Is the decision required consistent with LPT's risk appetite:	n/a	
False and misleading information (FOMI) considerations:	n/a	
Positive confirmation that the content does not risk the safety of patients or the public	✓	
Equality considerations:	✓	

N

Leicestershire Partnership NHS Trust

Leicestershire Partnership NHS Trust Board (Public)

29 July 2025

Freedom to Speak Up Annual Report 2024 – 2025

Purpose of the Report

This report provides an annual review of speaking up activity, to Leicestershire Partnership NHS Trust (LPT) Board of Directors, to ensure the Board is aware of the themes raised through the Freedom to Speak Up (FTSU) Guardians and the actions being taken.

It seeks to provide assurance that matters raised are effectively managed in line with current best practices. It also seeks to provide assurance in both of these areas by assessing the effectiveness of the FTSU guardian's efforts in supporting staff members who speak up and in fostering a culture of open communication.

Finally, it aims to demonstrate that speaking up is valued and that the Trust is committed to addressing matters and acting on concerns in a timely and appropriate manner, identifying areas for improvement and sharing learning.

Although, the report intends to provide commentary on speaking up activity during the period 2024 – 2025 in LPT it will also highlight how this information and data will inform future work in the FTSU service aligning this with our (Leicestershire Partnership and Northampton Healthcare Associate University Group) shared vision, “Together we thrive; building compassionate care and wellbeing for all” and the mission “Making a Difference Together”, which was published in April 2025. The corresponding strategy is titled THRIVE and includes six strategic priorities:-

T - Technology
H - Healthy communities
R - Responsive
I - Including everyone
V - Valuing our people

T H R I V E

E - Efficient and effective

The key priorities that will underpin and continue to embed a healthy speaking up culture are, including everyone, when we can demonstrate we have a culture of inclusivity where everyone's voice is heard and matters, and valuing our people, when people at all levels of the organisation, feel valued, having their voice heard and being recognised for their efforts and achievements.

Analysis of the issue

Following the Francis Inquiry 2013 and 2015, the NHS launched 'Freedom to Speak Up' (FTSU). The aim of this initiative was to foster an open and responsive environment and culture throughout the NHS.

When things go wrong, we need to make sure that lessons are learnt, and things are improved. If we think something might go wrong, it's important that we all feel able to speak up to stop potential harm. Even when things are good, but could be even better, we should feel able to say something and be confident that our suggestion will be used as an opportunity for improvement. Making Speaking Up Business as Usual (National Guardians Office (NGO), 2020).

LPT is committed to underpinning their speaking up culture with open and transparent routes by which colleagues feel safe to speak up, confidence in their voices being heard and concerns/suggestions acknowledged and acted upon and evidenced through a robust system of reporting and learning.

The Freedom to Speak Up: Speak Up, Listen Up, Follow Up policy provides detailed information about the structure and processes of the Speaking Up service. It aligns with current guidance from NHS England.

360 Assurance were commissioned to provide and independent assurance opinion of the arrangements that are in place to meet the FTSU requirements. They considered elements of governance, risk management, control and culture in compliance with Public Sector Internal Audit Standards and their findings were categorised in accordance with this. The audit opinion gave significant assurance (October 2023)

The policy identifies a variety of ways or different routes in which staff can speak up within the Trust in addition to the manager, senior leadership team or FTSU Guardian, for example, the Chaplaincy 'Listening Ear' service, AMICA counselling services, Occupational Health service, Human Resources, Patient Safety Team and Staff-side services. In addition, the policy also identifies the non-executive director with responsibility for FTSU, and other external mechanisms such as Care Quality Commission, professional bodies and the National Whistleblowing helpline.

Freedom to Speak Up Accountability Arrangements

The Trust is committed to providing outstanding care to service users and staff to achieve the highest standards of conduct, openness, and accountability. The Chief Executive Officer (CEO) is the named Executive Lead for FTSU and is accountable for ensuring that FTSU arrangements meet the needs of the staff across the Trust. The Non-Executive Director (NED) responsible for FTSU is available to the Guardians to seek second opinions and support as required. The Guardians have direct access to the CEO, NED, and Chair, with regular meetings scheduled to discuss all elements of FTSU activity. The Deputy Chief Executive (DCEO) is responsible for the supervision and support to the Guardians.

The Guardians are responsible for presenting FTSU reports to the People and Culture Committee, the Audit Committee and Trust Board.

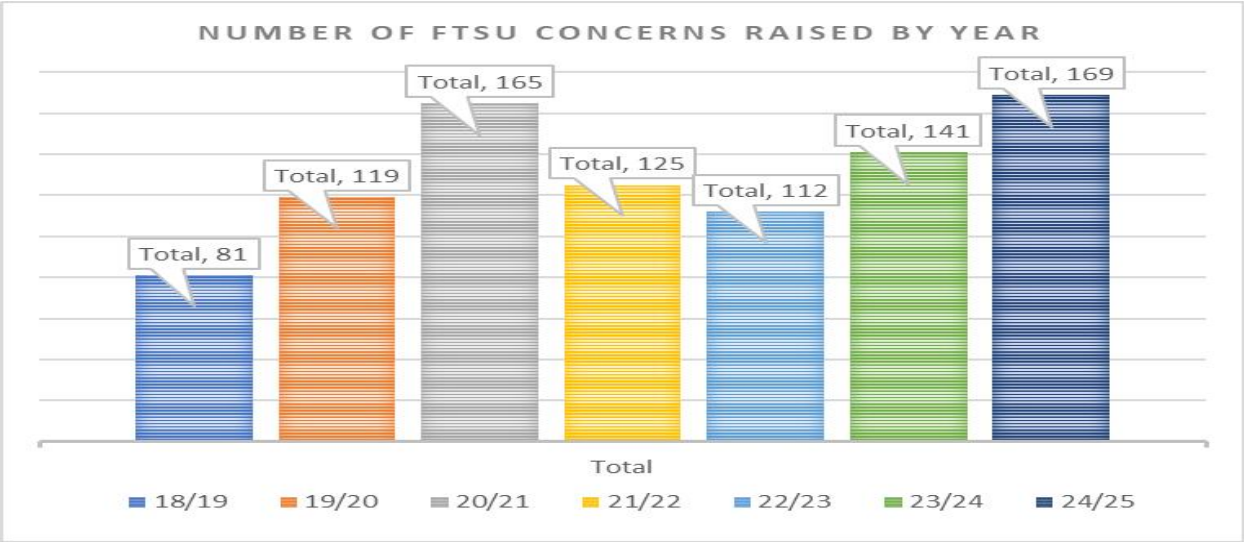
Freedom to Speak Up Data

The Trust promotes speaking up through whatever route feels right for the individual and through whatever means i.e., openly, confidentially, or anonymously. Data from anonymous reporting includes contact through internal anonymous reporting mechanisms to the FTSU Guardians (telephone messages, encrypted emails and the FTSU form on StaffNet) or through external mechanisms direct to Care Quality Commission (CQC). During the year 2024 – 2025 there were seven internal anonymous reports and four anonymous reports to CQC understood to be from LPT workers. This data is used to provide an, albeit limited, indication of colleague's confidence in the speaking up culture.

The table below illustrates the number of contacts to the FTSU Guardians since 2018 to the year end for 2024 - 2025. While the number of speak-up contacts has shown a fluctuating pattern over the years, the number of contacts this year has shown a gradual increase to its

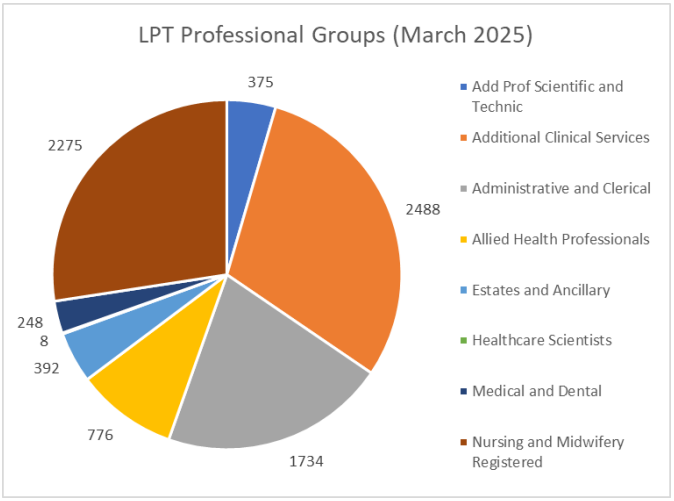
highest number. This is a positive representation of the growing confidence in the speaking up culture.

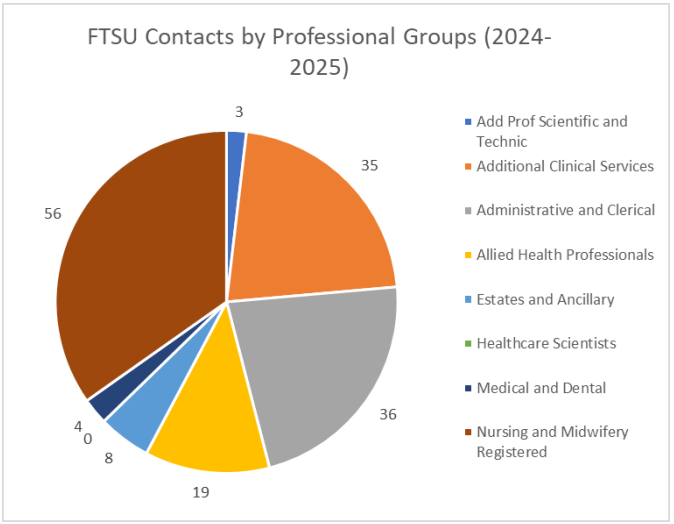
Table 1 - Comparative Summary of recorded contacts per year 2018/19 – 2024/25



There were 169 cases raised with the FTSU Guardians in 2024 – 2025. Where agreed, all matters raised were escalated in line with the employees wishes and speaking up process, therefore the issues have been shared with or signposted to relevant senior leaders within the organisation. Where there has been a request for no further action from the FTSUG, advice has been given and signposting to appropriate services including Human Resources, Staffside and professional bodies, Occupational Health or other Health and Wellbeing support mechanisms including AMICA and Chaplaincy services. Where requested these matters have been appropriately highlighted to the senior leadership team for intelligence only which provides further information and relevant data for triangulation with other culture work programmes supported through Patient Safety, Organisational Development, Staff Engagement, Health and Wellbeing, Human Resources and Equality, Diversity and Inclusion projects.

Chart 1 and 2 – Comparison showing Professional Groups in LPT (Mar 2025) and FTSU Contacts (2024/2025)

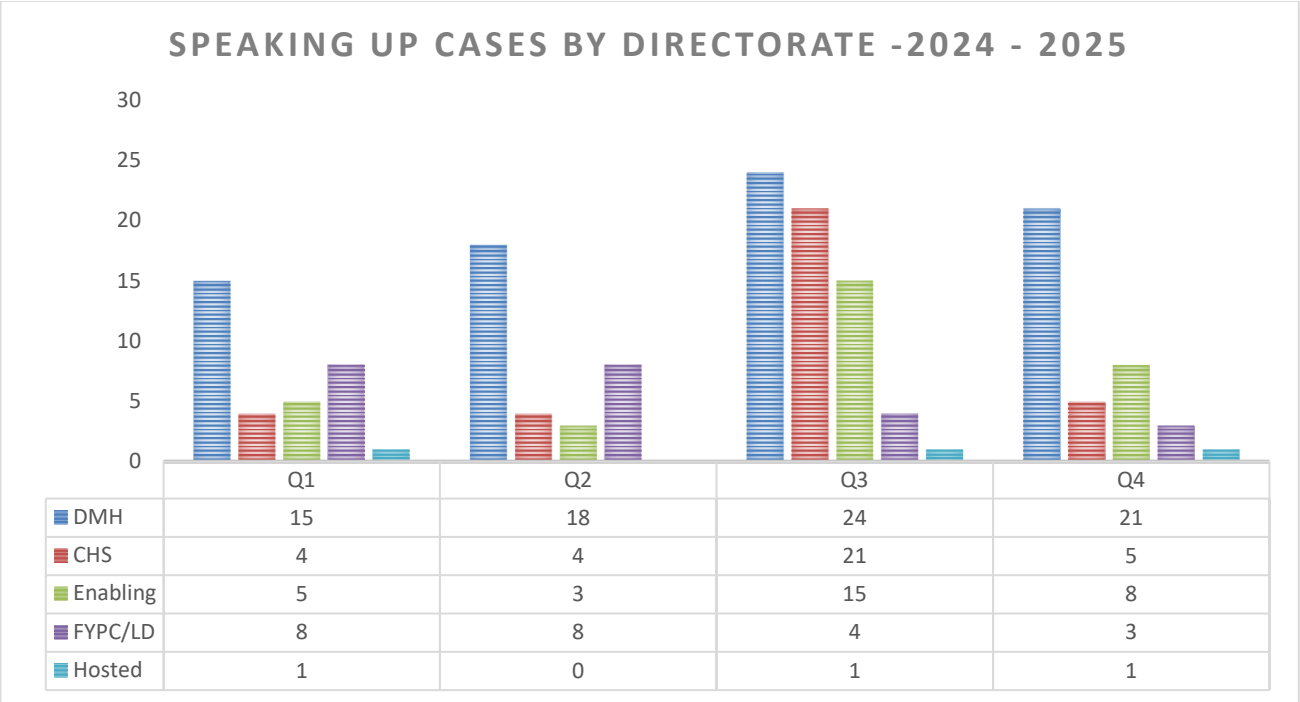




Charts 1 and 2 seek to show the breakdown of staff professional groups to compare whether the numbers of people that are speaking up correspond to the staff make-up for LPT as a whole.

The categories of Additional Clinical Services, Allied Health Professionals and Registered Nursing and Midwifery are proportionally higher in the speaking up chart to the total staff ratio and the categories for Additional Clinical Services, Medical and Dental and Additional Professional, Scientific and Technical professions are proportionally lower. We will be doing more research into the data here and look at focussing on raising awareness across all the professional groups over the coming year.

Table 2. Comparative Summary of Speaking up Cases per Directorate 2024 - 2025



	Q1	Q2	Q3	Q4
DMH	15	18	24	21
CHS	4	4	21	5
Enabling	5	3	15	8
FYPC/LD	8	8	4	3
Hosted	1	0	1	1

The data in table 2 shows comparatively higher numbers of contacts from Directorate for Mental Health (DMH) which has been a very typical pattern over the previous years. There appears to be a marked increase in contacts during Q3 across all Directorates, which again is a typical pattern and may be related to the higher level of communications and visibility during October which is, both nationally and locally, promoted as Speak Up month.

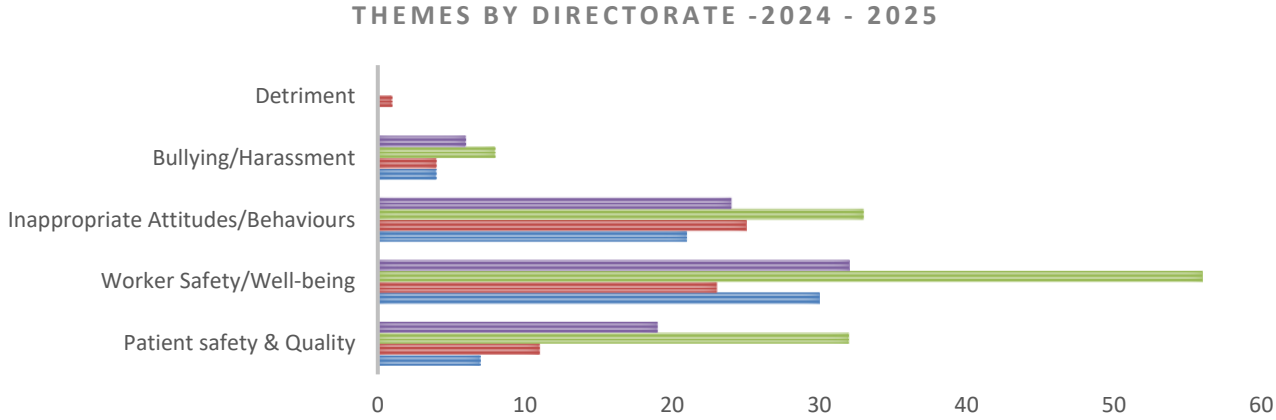
Key themes identified from speaking up 2024 – 2025.

To comply with the National Guardian Office guidance on recording cases and reporting data themes are collated using the following categories;

- Patient Safety & Quality
- Bullying & Harassment,
- Worker Safety or Well-being,
- Element of other inappropriate attitudes or behaviours,
- Disadvantageous and/or demeaning treatment (Detriment) because of speaking up

Reports are recorded on the best fit according to the workers' descriptions with reference to the NGO data descriptors.

Table 3. Comparative Summary of Speaking up Themes by Directorate 2024 - 2025



	Patient safety & Quality	Worker Safety/Well-being	Inappropriate Attitudes/Behaviours	Bullying/Harassment	Detriment
Q4	19	32	24	6	0
Q3	32	56	33	8	0
Q2	11	23	25	4	1
Q1	7	30	21	4	0

** Speak-up cases often contain multiple themes; therefore, data sets do not always equate together. Reports are recorded under the workers' description and in line with National Guardian Office Guidance.*

Patient Safety and Quality:

Colleagues will often highlight an indirect risk to patient safety in addition to their primary concern of leadership behaviours explaining how their wellbeing, experience or team culture could impact on patient care (as discussed later in this report). Where there has been patient safety and quality concern raised these are immediately reported through to the appropriate Director for information and their delegation to relevant leader or manager for action.

Specific issues have included concerns from nursing colleagues working in the same area but speaking up about different matters such as staffing numbers (safer staffing), dignity and respect around personal care (eating and drinking), care planning and risk assessments (behaviours), leadership and management.

Additional issues have been raised specifically by Allied Health Professional colleagues in relation to impact of multi-disciplinary assessment and holistic care planning, safe discharge (policy and protocols), patient placements, staffing numbers and understanding roles and responsibilities of professional groups.

These speaking up contacts provided intelligence to the senior leadership team and opportunity for review and/or fact find in relation to the specific concerns. Where appropriate

immediate actions were taken and longer-term plans, for learning, created focusing on review of establishment with reference to specific needs of individual patients and level of acuity, individual learning and team development, supporting training needs and highlighting roles and responsibilities across a multi-disciplinary team.

Worker Safety and Wellbeing:

Worker safety or well-being and inappropriate attitudes or behaviours show as the highest reported themes across the year. These are generally reported using the sub-headings of compassionate leadership, (often matters relating to perceived management style, implementation of policy and processes, psychological safety and/or health and wellbeing) or leadership behaviours, (attitudes or behaviours that do not appear to comply with the Trust values or agreed organisational leadership behaviours), or a combination of both.

It is important to note high levels of worker safety and well-being issues and inappropriate attitudes or behaviours can significantly contribute to staff burnout, low morale, and ultimately, staff leaving the Trust.

In addition, while incidents of reports under the heading patient safety and quality can be a direct measure, the indirect impact of a distressed workforce on patient outcomes cannot be overstated. Staff who are experiencing burnout, stress, or bullying may be more prone to making errors, less able to focus on patient needs, and less compassionate in their interactions.

With this in mind, speak up matters have been consistently managed, in line with the agreed FTSU process, across all directorates (and individually escalated as requested and appropriate) and have been actively addressed directly when required and/or through Trust-wide events and leadership development initiatives. These efforts include a series of Trust-wide development sessions for members of the workforce with management responsibilities, directly introduced by the Senior Leadership team focusing on compassionate and inclusive leadership. In addition, there have been intensive bespoke development sessions for identified teams to build and sustain a positive workplace culture.

Furthermore, the Organisational Development team have refreshed their offer, and regularly communicate reminders of supportive training packages for all workers (First Steps into

Leadership, Leading Great Teams, Team Development Tools, CUBE feedback model, Compassionate and Inclusive Leadership, Leadership Conversations).

Finally, the Trust prioritised 'psychological safety' as one of the key features of the 'Our Future, Our Way' culture programme. The Freedom to Speak Up Team have been active stakeholders in this programme working collaboratively with Patient Safety teams, Equality, Diversity and Inclusion service, Health and Wellbeing team, Organisational Development service, Human Resources and wider staff support networks to develop a local definition, create accessible resources and embed key messages across the organisation. An agreed definition, infographic and resource pack have been developed and shared across the Trust.

The core issues, as previously stated, primarily revolve around Worker safety or Well-being and Inappropriate attitudes and behaviours, with Patient Safety & Quality as an underlying concern.

In addition, it is widely evidenced that working conditions are major drivers for staff retention. Replacing staff is costly, involving recruitment, onboarding processes, and training time. Meaning that high staff turnover can lead to a loss of experienced staff. Meanwhile poor well-being directly correlates with increased sick leave significantly impacting on existing staffing levels. However, as a Trust our staff turnover remains within the target.

While the provided data does not explicitly breakdown incidents by protected characteristics (e.g., race, gender, disability), the themes of bullying and harassment, inherently, raise some equality concerns. LPT focus on equality, diversity and inclusivity for all and our shared commitment to the Together Against Racism project directly supports our ambition to create a truly inclusive Trust for our colleagues, patients and service users.

Numerous studies in healthcare and organisational psychology demonstrate the direct link between positive workplace culture, psychological safety, staff well-being, and improved patient outcomes, staff retention, and financial performance.

The feedback and learning from colleagues speaking about their work experience, through the existing speak up mechanisms have, in part, provided the foundations for the aspiration of the THRIVE strategy. The strategic objectives: Including everyone and Valuing people are fundamental to addressing any speaking up matter as they aim to improve psychological safety

and professional conduct for all staff encouraging a culture where everyone's voice is heard and considered, and all workers feel safe to contribute, challenge, and innovate ensuring everyone feels valued as a leader and are inspired to continuously learn and improve in the future.

Effectiveness of Existing Policies and Interventions:

There have been an increasing number of issues raised relating to policy, procedure and guidance and the staff experience in all aspects of these. Given there will always be various perspectives in these matters it is important to try to understand where there may be anomalies or inconsistency in application negatively impacting on individuals (for example, equal opportunity to personal and professional development, reasonable adjustments, dispute resolution in the workplace and disciplinary matters). Where matters are reported through FTSU Guardians the information is either shared openly (when requested) or provided as intelligence to the Director of Human Resources (HR) and the HR advisory service to highlight staff experience in relation to a specific policy/event. In turn, this provides subjective information of staff experience, for future consideration and consultation when reviewing existing policies and procedures.

What Does the National Staff Survey (NSS) Tell Us About Speaking Up?

National Context - National Guardians Office (NGO)

According to the NGO, the NHS Staff Survey 2024 reveals a concerning stagnation in Freedom to Speak Up (FTSU) culture across the NHS, with the sub-score remaining virtually unchanged at 6.45, signalling a potential slide towards disengagement and silence (Speaking Up in healthcare: has progress plateaued – and what must be done? March 2024).

The NGO emphasises that simply encouraging staff to speak up is insufficient; leaders must demonstrate tangible action in response to concerns. Without a renewed focus on listening and acting, the risk of a decline in speaking-up culture and subsequent harm to patient safety is significant. The need for a consistent, structured, and accountable approach across the NHS is paramount.

National Staff Survey Results at LPT

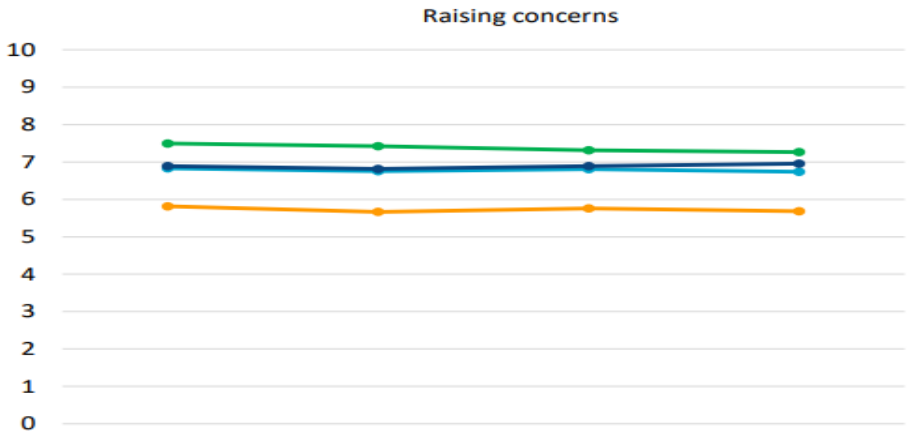
Information referenced from LPT – NHS Staff Survey Benchmark Report 2024. The results are presented in the context of best, average, and worst outcomes for similar organisations. Data is weighted to enable fair comparisons between organisations.

There are 4 questions within the annual NHS Staff Survey which relate to Speaking Up. The survey aligns with the People Promise element – We each have a voice that counts and included below are results for element 3 sub-score Raising Concerns and the individual questions that make up that sub-score (Q20a, Q20b, Q25e and Q25f).

2024 NHS Staff Survey responses to statements relating to raising concerns.

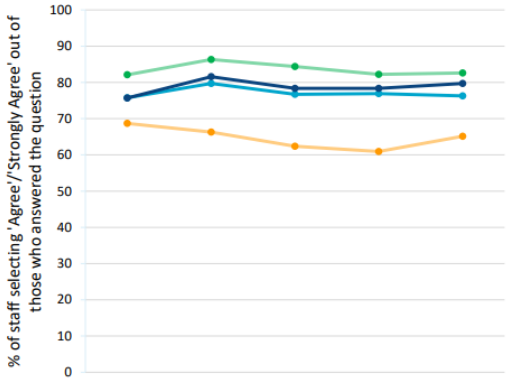
People Promise element 3: We each have a voice that counts

We each have a voice that counts



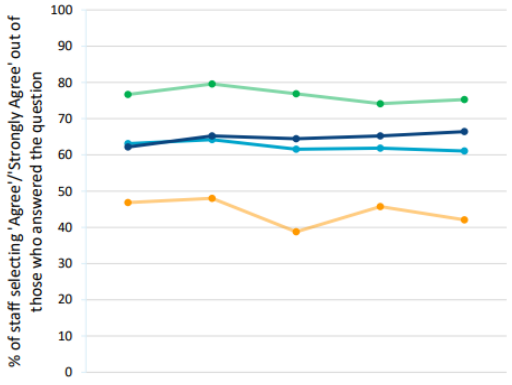
	2021	2022	2023	2024
Your org	6.89	6.81	6.89	6.95
Best result	7.49	7.42	7.31	7.26
Average result	6.83	6.76	6.81	6.74
Worst result	5.81	5.66	5.76	5.68
Responses	2843	2910	3313	3927

Q20a I would feel secure raising concerns about unsafe clinical practice.



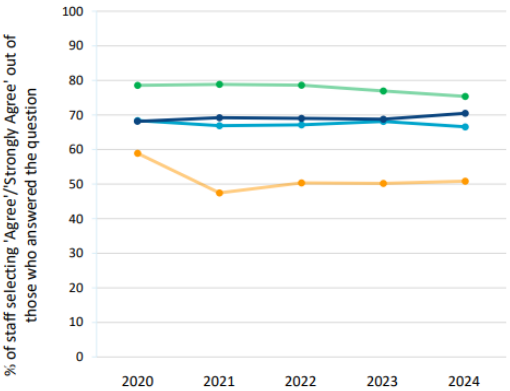
	2020	2021	2022	2023	2024
Your org	75.69%	81.57%	78.38%	78.36%	79.71%
Best result	82.10%	86.32%	84.40%	82.22%	82.61%
Average result	75.76%	79.72%	76.72%	76.90%	76.27%
Worst result	68.68%	66.30%	62.38%	60.93%	65.14%
Responses	2763	2847	2913	3319	3941

Q20b I am confident that my organisation would address my concern.



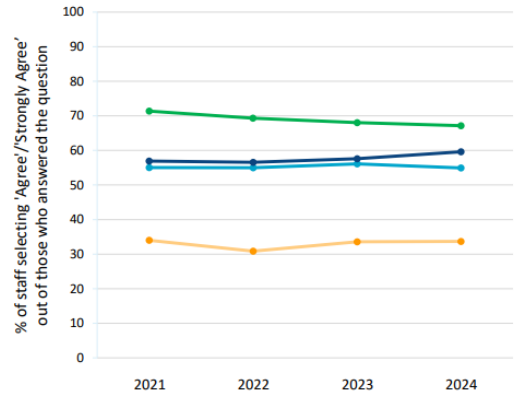
	2020	2021	2022	2023	2024
Your org	62.18%	65.22%	64.45%	65.21%	66.41%
Best result	76.65%	79.56%	76.86%	74.13%	75.27%
Average result	63.13%	64.21%	61.55%	61.84%	61.06%
Worst result	46.86%	48.01%	38.77%	45.73%	42.06%
Responses	2760	2838	2911	3308	3932

Q25e I feel safe to speak up about anything that concerns me in this organisation.



	2020	2021	2022	2023	2024
Your org	68.14%	69.22%	69.03%	68.76%	70.49%
Best result	78.55%	78.85%	78.61%	76.93%	75.37%
Average result	68.38%	66.88%	67.13%	68.13%	66.58%
Worst result	58.92%	47.46%	50.35%	50.21%	50.87%
Responses	2755	2844	2914	3328	3933

Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022	2023	2024
Your org	56.90%	56.56%	57.63%	59.60%
Best result	71.37%	69.31%	68.05%	67.15%
Average result	55.04%	55.00%	56.11%	54.93%
Worst result	34.00%	30.87%	33.60%	33.65%
Responses	2844	2914	3326	3931

Each graph shows an increased percentage in the number of staff selecting agree/strongly agree, (out of those who answered the question) on the previous 2 years responses. All five data sets show LPT scores were above the national average.

In summary, the LPT National Staff Survey results related to speaking up are encouraging and appear to indicate a positive impact of the combined efforts across the organisation to create a supportive speaking up culture. The FTSU Guardians are committed to fostering an inclusive culture where staff feel empowered to speak up and contribute to positive change, encouraging

staff to speak up voice their concerns or ideas and contribute to a safer, more transparent healthcare environment.

Reporting Culture:

The NGO report Fear and Futility: What does the Staff Survey tell us about speaking up in the NHS (June 2023) and Dr Jayne Chidgey-Clark's (National Gurdian for the NHS) associated comments suggested that responses to the speaking up questions show "that there is a growing feeling that speaking up in the NHS is futile – that nothing changes as a result". Furthermore, from the data analysis at that time she said "It is not acceptable that two in five workers responding to the NHS staff survey do not feel able to speak up about anything which gets in the way of them doing their job" suggesting a fall in how safe people feel to raise a clinical concern.

While the Trust data give some indication of various issues or concerns, the Board may want to consider the reporting culture within the Trust, particularly the previously reported themes of fear and futility as potential barriers to speaking up. Are staff comfortable reporting concerns without fear of reprisal? Will their concern or issue be listened to and acted upon?

Ther FTSU Guardians have supported events and activities, in response to local (team level) staff survey results, including targeted listening events working alongside leaders and managers, the Organisational Development Team and the Staff Engagement Lead. This action has enabled the FTSU Guardians to raise the profile of speaking up with the intention of building confidence in the process and enabling colleagues to speak thereby reducing the potential effects of fear and futility.

It is understood that low reporting figures in certain areas may indicate few issues or other matters that impact negatively on the speak up culture. Conversely, high reporting figures could indicate both a prevalent issue and a healthy reporting culture. The NSS results are being used to invite direct engagement with teams that may show areas for development and improvement in the People Promise element 3: We each have a voice that counts. In addition, FTSU Guardians are using results to inform future engagement sessions with teams that show a low return rate to try to understand the current data and suggest how speaking up culture and therefore level of engagement in all speaking up mechanisms can be improved.

Raising Awareness of FTSU 2024 - 2025

The Freedom to Speak Up Guardians continue to assist the Trust in developing a restorative and forward-thinking approach to addressing staff concerns based on reflective learning. They aspire to weave a strong speaking up culture across the organisation and truly make 'speaking up business as usual'. In this regard, the service is well aligned with the Trust's vision, "Together we thrive; building compassionate care and wellbeing for all".

The FTSU team is tasked with raising awareness about speaking up and supporting the development of an open and transparent culture. The role of the FTSU Guardian continues to be widely promoted through internal communication routes including the Trust's weekly eNews, monthly Team Brief and social media, Trust-wide emails, posters across Trust sites, computer screen savers, face to face meetings and team presentations. The Trust's commitment to 'making speaking up business as usual' is also highlighted at all induction presentations for new staff, including corporate induction specifically for qualified and non-qualified staff, bank staff and volunteers. Bespoke presentations are delivered to medical trainees and students, nursing associates, apprentices, preceptors, international recruits and other Allied Health Professionals. The Guardians actively promote inclusive FTSU approaches, targeting seldom heard groups within the workforce, as identified by research; these include but are not limited to, those with protected characteristics, night workers, students, medical trainees and offsite workers.

FTSU Champions

The Trust currently has 24 volunteer Freedom to Speak Up Champions (providing varying degrees of activity and engagement) who play an important role in positively promoting the key messages about speaking up and widening the reach of the FTSU agenda. Champions offer support and signpost colleagues to appropriate services as required. There has been a recent recruitment drive and specific invitations to existing ambassador and champions networks including change leaders, health and wellbeing champions and cultural ambassadors. All Cultural Ambassadors within directorates are requested to complete the FTSU Champion training as part of their role. FTSU Champions are offered support and supervision at monthly drop-in sessions, more formal forum meetings and one to one sessions when requested. We are currently piloting the provision of peer support sessions in collaboration with the Health and Wellbeing Champions.

Given the national acknowledgment of additional barriers for speaking up amongst certain groups of staff, great care has been taken to ensure the Champions network is representative

of the workforce in terms of equality, diversity and inclusion and professional groups. The Trust FTSU Champions network has representatives from staff support networks and from a variety of services and disciplines including physical health and mental health teams (both registered and unregistered clinicians), volunteers, Allied Health Professionals and administrative roles across the breadth of the workforce.

October – National Speak Up Month

Throughout Speak Up month in October 2024 the Guardians, along with the non-executive director and CEO undertook a series of events to promote the importance of speaking up and offering further opportunities for staff to speak up. In addition, a webinar was held with partners across the system and group with the National Guardian which was subsequently shared via appropriate media platforms. A leadership conference was held in October for colleagues across the Trust, where the importance of speaking up and listening up was also emphasised. Each non-executive and executive director shared their FTSU pledges to reiterate to colleagues the commitment.

Speak Up, Listen Up, Follow Up training compliance.

Throughout 2024 – 2025 all healthcare workers were encouraged through various local communications, to complete the Speak Up training, produced in collaboration by Health Education England and the NGO; 100 delegates completed the Speak Up module through our local learning platform uLearn.

Since April 2025, the speak up training module has been integrated into workers role essential training suite and at the end of June 2025 the overall Trust data shows 82% compliance.

Key Actions for 2025-2026

Whilst there has been a considerable amount of work undertaken in 2024/2025, work needs to continue to embed the FTSU programme across the Trust. This will continue to be reviewed as we work through the implications and expectations of wider guidance and recommendations of the NHS Ten Year Plan and Dr Penny Dash's review of patient safety across the health care landscape.

Our commitment for the next 12 months is to:

- Maintain high levels of visibility to support a positive speaking up culture aligning with group strategic objectives.

- Work collaboratively across the group to host a conference, embed key FTSU messages aligned to the THRIVE strategy, for October Speak Up month 2025.
- Work collaboratively with other teams and services as required to support improvements and learning from NSS.
- Undertake second survey of FTSU service and use this to inform future actions regarding raising awareness and education/training.
- Monitor uptake for Speak Up training as now role essential and include content to allow speak up pledges to be available on local platform.
- Continue collaborating with the staff networks and FTSU Champions to develop action plans for addressing staff barriers to speaking up.
- Use the NGO-Overseas-trained-workers-report_May-2025.pdf as the basis for a gap analysis looking at:
    - how anonymous speaking up cases are managed and/or investigated.
    - ensuring FTSU Champion network reflects LPT workforce diversity.
- Collect evidence and provide additional information to enable the Board to refresh the Freedom to Speak Up Reflection and Planning Tool.

Board Assurance:

Despite the challenges, the Board can draw assurance from the THRIVE strategic objectives and additional culture projects that directly address identified key issues, particularly around enhancing psychological safety to support speaking up and prioritising workforce well-being. This shows a clear intent to provide a positive environment where staff feel safe to speak up about anything that gets in the way of them doing their job.

The current approach to supporting a positive speaking up culture aligns directly with the Trust's strategic objectives and in doing so is most likely to deliver sustainable, positive change across the Trust, however, it must be acknowledged that culture change is a long-term journey requiring sustained effort across multiple fronts.

Decision required - The Board is asked to:

1. Confirm assurance that issues of concern are being raised and dealt with in line with the Freedom to Speak Up: Speak Up, Listen Up, Follow Up policy and that the Board is aware of themes and trends emerging in the organisation.

2. Confirm assurance that the work of the FTSUG's is supporting LPT to develop an open and transparent culture where staff are actively encouraged and enabled to speak up.
3. Confirm they are assured that the Trust has a policy and process in place for staff to safely raise concerns and as a consequence ensure action is taken on any themes emerging or areas of concern with feedback provided to those raising concerns.
4. Promote the demonstration of learning through open communication, addressing detriments, and fostering collaboration within the organisation on all matters related to speaking up.

Governance table

For Board and Board Committees: Paper sponsored by:	Trust Board Angela Hillery, CEO	
Paper authored by: Date submitted:	Pauline Lewitt & Chris Moyo: FTSU Guardians 29/07/2025	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	N/A	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	N/A	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Annual	
LPT strategic alignment:	**T** - **T**echnology	
	H – **H**ealthy Communities	
	R - **R**esponsive	
	I – **I**ncluding Everyone	X
	V – **V**aluing our People	X
	E – **E**fficient & Effective	
CRR/BAF considerations *(list risk number and title of risk):*	N/A	
Is the decision required consistent with LPT's risk appetite:	N/A	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed	
Equality considerations:	None	

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Leicestershire Partnership NHS Trust

3As Highlight Report
Meeting Name: Finance and Performance Committee
Meeting Chair & Report Author: Melanie Hall / Val Glenton
Date: 19 June 2025 Quorate: Yes

Agenda Item:	Minute Reference:	Lead:	Description:	BAF Ref:
ALERT:				
There were no items to advise the Board of.				
ADVISE:				
Business Pipeline	FPC/25/066	Director of Strategy and Partnerships	The award of the School Aged Immunisation Service contract had been delayed. There would be some financial risk as a result of the delay and the Strategy and Partnerships Team was working very closely with the service to ensure staff wellbeing was being maintained.	BAF 6.4
Accountability Framework Meeting	FPC/25/067	Deputy CEO	The upward trend of over 52 week waiters remained largely unaltered across a number of services. Both adults and children were experiencing very long waits, mainly for assessment under ADHD. The level one committees would be holding a joint workshop to deep dive into the topic of the most challenging waits in September.	BAF 3.2
Board Performance Report M2 2025/26	FPC/25/069	Director of Finance	FPC noted that 24 exception report areas were consistently failing targets which was significantly more than reported previously. Discussion took place on how the committee received assurance that the right areas were being addressed. More in-depth discussion would be held at future meetings.	BAF 3.2
ASSURE:				
Finance Report M2 2025/26	FPC/25/063	Director of Finance	FPC received assurance that the month 2 financial position had been delivered as planned. A combination of CIP under delivery and operational overspends meant that central reserves had been used to balance the position. CIP EQIA approval progress was discussed and how they were monitored in year, including whether the Quality and Safety Committee had a role.	BAF 6.3 BAF 6.4

Agenda Item:	Minute Reference:	Lead:	Description:	BAF Ref:
Board Performance Report M2 2025/26	FPC/25/069	Director of Finance	FPC received assurance that the majority of performance metrics reported were consistent with previous performance reporting. All DMH KPIs had improved in month. They were still below target but it was a promising start to the year.	BAF 3.2
Data Security and Protection Toolkit Annual Submission 2024/25	FPC/25/070	Head of Data Privacy	The audit of the Trust submission by 360 Assurance had given the 12 out of 47 audited outcomes a substantial assurance rating with a small number of low-level recommendations. Confidence in the Trust's self-assessment against the DSPT had been noted as high overall.	N/A
Caldicott Guardian Annual Report	FPC/25/071	Caldicott Guardian / Medical Director	FPC received assurance on the work being carried out by the Data Privacy Team who supported the Caldicott Guardian to fulfil his duties. This included information sharing, incidents that were logged with the Information Commissioner's Office and on the development of a Data Security and Awareness Strategic Plan to support compliance with the principles of the Data Protection Act 18 and UK-GDPR.	N/A
Cyber Security Annual Report	FPC/25/072	Cyber Security Manager	FPC received assurance on the work being carried out by the LHIS Cyber Security Team. LHIS had deployed a number of additional counter measures and controls throughout the year and had also recently been onboarded to the NHS England Cybersecurity Operations Centre Active Service which would provide an out of hours capability in responding to cyber security attacks.	N/A
LHIS Annual Report 2024/25	FPC/25/073	Group Chief Digital Information Officer	Assurance was received on the achievements of LHIS during 2024/25 but FPC noted clarity was needed on the SLA for 2025/26, discussions were taking place.	BAF 1.2
Estates & Facilities Performance Report	FPC/25/078	Associate Director of Estates and Facilities	FPC received assurance on the performance of the Estates and Facilities Team; • The majority of KPIs were RAG rated green - the red areas related mainly to cleaning services which had been affected by sickness during the period. • C£18k worth of funding had been granted to install a photovoltaic panels system at Hinckley and Bosworth Community Hospital which would start in this financial year and was expected to generate savings in future years.	BAF 6.1
Annual Review of Committee Effectiveness	FPC/25/081	Deputy Director of Governance and Risk	A review of FPC effectiveness had been undertaken and concluded that the committee had been effective during the year as it had fulfilled its terms of reference.	N/A
CELEBRATING OUTSTANDING:				

Agenda Item:	Minute Reference:	Lead:	Description:	BAF Ref:
Director of Finance Verbal Update	FPC/25/062	Director of Finance	FPC acknowledged the phenomenal performance of all teams across the Trust to achieve a balanced financial position at the end of 2024/25. LPT's external auditors had undertaken the annual value of money assessment and were satisfied there were no significant weaknesses which was a very positive outcome for the Trust.	BAF 6.3 BAF 6.4
Accountability Framework Meeting	FPC/25/067	Deputy CEO	The committee noted two specific areas of celebrating outstanding; • A significant amount of work had been undertaken around productivity in FYPCLDA and the Special Educational Needs Change Programme Partnership conference had been a huge success. • The excellent management and joint working across teams of the recent Legionella outbreak at the Beacon Unit which had been declared a critical incident.	N/A
Transformation and Quality Improvement Delivery Group	FPC/25/068	Deputy CEO	The excellent initiatives that clinicians were reporting on that were making a difference to the lives of patients were highlighted as celebrating outstanding. FPC acknowledged the links being set up between directorates and transformation leads to share best practice, especially around digital innovation.	BAF 3.1 BAF 3.3
DSPT Annual Submission 2024/25	FPC/25/070	Head of Data Privacy	FPC noted the huge amount of work that had gone into achieving a 'standards met' Data Security and Protection Toolkit submission by the deadline of 30th June, congratulations were extended to the Data Privacy Team.	N/A

Leicestershire Partnership NHS
NHS Trust

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Trust Finance Report
for the period ended
30 June 2025

For presentation at the
TRUST BOARD MEETING
29 July 2025

Contents

Executive dashboard - overall performance against targets

Statutory targets	Year to date	Year end f'cast	Comments	Further detail
1. Income and Expenditure break-even.	A	G	The Trust is reporting a YTD deficit of £1.4m at the end of June (in line with plan). The forecast year end position is currently a surplus of £0.3m, also in line with plan.	APPENDIX A
2. Remain within Capital Resource Limit (CRL).	G	G	The YTD capital spend for June is £2.01m, which is within funding limits.	APPENDIX E
3. Capital Cost Absorption Duty (Return on Capital).	G	G	The capital cost absorption duty of 3.5% net assets has been achieved	N/A
Secondary targets	**Year to date**	**Year end f'cast**	**Comments**	**Further detail**
4. Deliver I&E performance in line with plan.	G	A	The reported YTD I&E deficit for June is in line with plan, as is the forecast year end surplus (but with significant risks)	SUMMARY REPORT
5. Achieve Efficiency Savings targets.	G	A	Savings at 30th June are £4.5m, on plan. The £28.4m target for the year is expected to be delivered, although this includes a significant number of high risk schemes	APPENDIX B
6. Manage agency staff spend in line with plan	G	G	YTD agency spend at the end of June is £3.3m, which is lower (£119k) than planned YTD spend. Forecast year end spend is £10.5m, £0.6m lower than plan.	APPENDIX C
7. Comply with Better Payment Practice Code (BPPC).	A	A	Cumulatively the Tust achieved 2 of the 4 BPPC targets, and in month, the Trust achieved all of the BPPC targets.	APPENDIX D
Internal targets	**Year to date**	**Year end f'cast**	**Comments**	**Further detail**
8. Achieve retained cash balances in line with plan	G	G	The cash balance is £15.2m at the end of June. This is £0.8m below planned cash levels. The planned cash forecast for the year is £13.2m.	APPENDIX F
9. Maintain cash levels to cover at least 11 days of operating expenditure	G	G	The trust has set an internal target of having cash availability to cover at least 11 days of operating expenditure, or £13m. June's cash level of £15.2m was 13 days.	APPENDIX F
10. Deliver capital investment in line with plan	G	G	YTD capital expenditure is £2.01m - compared with planned levels of £1.75m, this is £0.26m (15%) above plan. See 'Capital Section' in summary report.	APPENDIX E

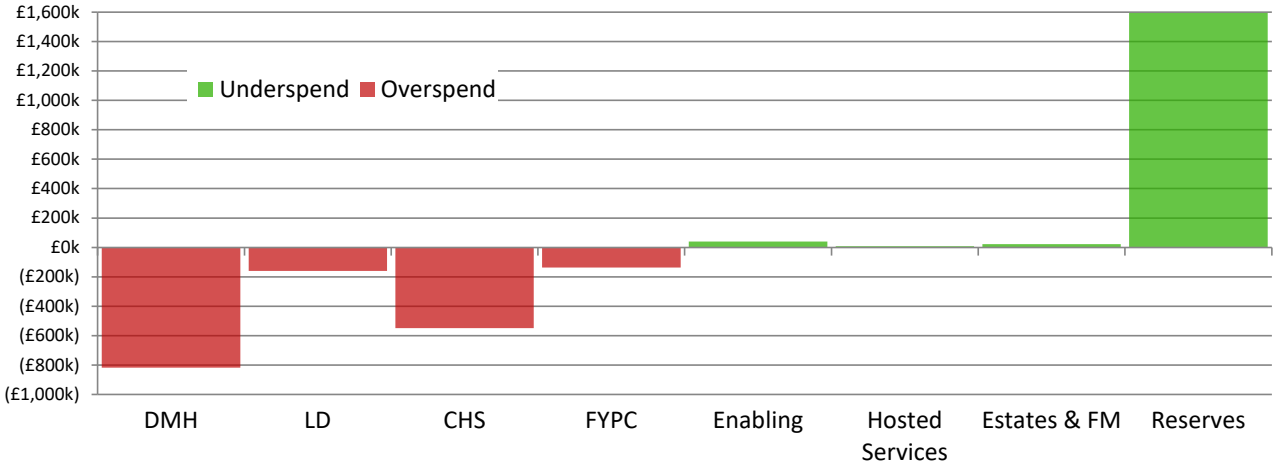
Summary report – financial position as at 30 June 2025

OVERVIEW AND KEY ISSUES

- The year-to-date income and expenditure plan (being a planned deficit of £1,443k for June) has been achieved.

- Initial operational overspends within all clinical services are currently being offset by non-recurrent underspends in central reserves – see table below:

YEAR TO DATE INCOME AND EXPENDITURE VARIANCES TO BUDGET, BY DIRECTORATE:



DIRECTORATE POSITION SUMMARY

- **The Mental Health Directorate** is overspent by £816k as at Month 3. CIP underperformance is £647k and so makes up the majority of the overspend – this includes a £253k under-delivery against the out of area placements reduction scheme for the first 3 months of the year. Medical locum usage remains high, contributing a further pressure to the position. The high cost of observations and overall acuity of patients makes up the remainder of the overspend.

- **The Community Health Service** is reporting an overspend of (£549k) for the first 3 months of the year, representing an adverse movement of (£121k) from the previous month. The overspend relates to the impact 24/25 non-recurrent CIPs carried forward which creates a pressure increasing at a rate of £183k per month. Other pressures are generally being absorbed or mitigated, including the impact of additional supernumerary staff which are mitigated through further reductions in bank and agency use. Non pay is currently reporting a slight overspend resulting from monthly cost fluctuation within continence products and drugs budgets.

  The CHS CIP target for 2025/26 has been identified but does include £1.85m of non-recurrent cost reduction.

- **FYPC budgets** are £136k overspent and **LDA** £160k overspent. The LDA year to date overspend has further increased since month 2, the FYPC position has improved. Overall, pay budgets are overspent by c. £700k mainly linked to negative budgets which are allocated against pay. Non-pay budgets are underspent at month 3 however this continues to include pressures within medical equipment budgets and room hire (related to accommodation for the Audiology service). Income budgets show an over recovery mainly as a result of the occupancy on Welford ward, albeit at the end of June occupancy had fallen.

- **Enabling budgets** show a minor underspend of £39k. This is mainly due to vacancies. Within this position there are still areas of cost pressure, including the International Recruitment Team which is overspending by £28k. The Occupational Health contract is also resulting in an overspend of £20k over the first 3 months of the year.

- **Hosted and Estates budgets** are generally breaking even at M3. Within the Estates position, medical equipment maintenance budgets are £33k overspent, catering budgets £18k overspent and cleaning budgets £26k overspent. These overspends are offset by pay budget vacancy underspends.

- **The Central Reserves position** is underspent by £1.6m. This is mainly due to the up-front release of balance sheet flexibility as per planning assumptions.

FORECAST INCOME AND EXPENDITURE POSITION

- The forecast for the end of the year is currently in-line with plan, which is a surplus of £311k. This forecast is very much a best case risk-adjusted scenario – a range of risk adjusted scenarios is included in **appendix G**.

- The monthly surplus / deficit planned positions are shown in the table below. The YTD £1,443k planned deficit can be seen in M3. Subsequent monthly positions are expected to improve each month across the year in order to deliver the £311k surplus by the end of the year. A monthly run-rate improvement of £1,057k (from M3 to M12) is required to achieve the plan for the year.

	M1 £'000	M2 £'000	M3 £'000	M4 £'000	M5 £'000	M6 £'000	M7 £'000	M8 £'000	M9 £'000	M10 £'000	M11 £'000	M12 £'000	Year Ending £'000
Monthly surplus / (deficit)	(601)	(469)	(373)	(233)	(141)	(26)	91	158	251	414	556	684	**311**
Cuml. YTD surplus / (deficit)	(601)	(1,070)	(1,443)	(1,676)	(1,817)	(1,843)	(1,752)	(1,594)	(1,343)	(929)	(373)	311	**311**

Finance Report for the period ended **30 June 2025**

APPENDICES

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 30 June 2025	YTD Actual M3 £000	YTD Budget M3 £000	YTD Var. M3 £000
Revenue			
Total income	108,120	107,730	391
Operating expenses	(108,542)	(108,152)	(390)
Operating surplus (deficit)	**(422)**	**(422)**	**0**
Investment revenue	239	239	0
Other gains and (losses)	0	0	0
Finance costs	(456)	(456)	0
Surplus/(deficit) for the period	**(639)**	**(639)**	**0**
Public dividend capital dividends payable	(804)	(804)	0
I&E surplus/(deficit) for the period (before tech. adjs)	**(1,443)**	**(1,443)**	**0**
NHS Control Total performance adjustments			
IFRIC 12 adjustment (PFI interest adj - excl. from Con.Total)	0	0	0
NHS I&E control total performance	**(1,443)**	**(1,443)**	**0**
Other comprehensive income (Exc. Technical Adjs)			
Impairments and reversals	0	0	0
Gains on revaluations	0	0	0
Total comprehensive income for the period:	**(1,443)**	**(1,443)**	**0**
Trust EBITDA £000	**2,848**	**2,848**	**0**
Trust EBITDA margin %	**2.6%**	**2.6%**	**0.0%**

APPENDIX B – Efficiency savings performance

At the end of month 3, CIP performance is reported in line with plan which is delivery of £4.5m total savings. Some initial year-to-date shortfalls have been identified against directorate targets. These are being offset by Estates and Corporate schemes over-delivery. The Estates over-delivery is caused by schemes in the original plan being phased towards the end of the year whereas actual savings are being achieved in equal monthly amounts. Whilst this results in additional gains in the early part of the year, later months will suffer. Corporate savings include various non-recurrent gains (such as balance sheet movements). Again, these will not continue at the same rate as in the early months of the year, thus putting further pressure on future months.

CIP year-to-date performance by directorate

	CIP YTD PERFORMANCE			CIP FORECAST YEAR END		
Directorate	**YTD plan**	**YTD actual**	**YTD variance**	**YTD plan**	**YTD actual**	**YTD variance**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
DMH	1,345	698	(647)	6,210	5,733	(477)
CHS	1,263	1,263	0	5,404	5,404	0
FYPCLDA	934	738	(196)	4,730	4,551	(179)
Estates	190	600	409	2,399	2,196	(203)
Enabling	476	471	(5)	1,779	1,779	(0)
Corporate*	317	756	439	7,836	8,695	859
Unallocated						
Grand total CIPs	**4,525**	**4,525**	**0**	**28,358**	**28,358**	**0**

*Corporate schemes = final plan gap-closing mitigations. Will likely require some re-allocation to specific directorates (e.g corporate / admin staff national re-alignment)

The total planned CIP delivery for the year is £28.4m (6.6% of total Trust operating costs). In the forecast position, the plan target is expected to be delivered in full. However, there is a £0.9m shortfall on directorate schemes, which is currently offset by additional non-recurrent Corporate gains in reserves.

APPENDIX C – Agency spend

2025/26 Agency Expenditure	24/25 Outturn £000s Actual	24/25 Avg mth £000s Actual	25/26 M1 £000s Actual	25/26 M2 £000s Actual	25/26 M3 £000s Actual	25/26 M4 £000s F'cast	25/26 M5 £000s F'cast	25/26 M6 £000s F'cast	25/26 M7 £000s F'cast	25/26 M8 £000s F'cast	25/26 M9 £000s F'cast	25/26 M10 £000s F'cast	25/26 M11 £000s F'cast	25/26 M12 £000s F'cast	25/26 YTD £000s Actual	25/26 Year End £000s F'cast
Consultant Costs	-5,175	-431	-436	-455	-411	-390	-375	-360	-355	-350	-349	-345	-345	-345	-1,302	-4,516
Nursing - Qualified	-3,192	-266	-167	-123	-118	-106	-102	-98	-90	-80	-83	-80	-80	-80	-408	-1,207
Nursing - Unqualified	-144		-2	0	-4	0	0	0	0	0	-2	0	0	0	-5	-7
Other clinical staff costs	-145	-12	-11	-9	-15	-8	-7	-7	-7	-7	-7	-7	-7	-7	-34	-98
Non clinical staff costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-total - DMH	**-8,655**	**-709**	**-616**	**-586**	**-548**	**-504**	**-484**	**-465**	**-452**	**-437**	**-441**	**-432**	**-432**	**-432**	**-1,750**	**-5,829**
Consultant Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nursing - Qualified	-647	-54	-9	-16	-17	-15	-15	-15	-15	-15	-5	-5	-5	-5	-42	-137
Nursing - Unqualified	-36		0	0	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-10
Other clinical staff costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non clinical staff costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-total - LD	**-684**	**-54**	**-9**	**-16**	**-18**	**-16**	**-16**	**-16**	**-16**	**-16**	**-6**	**-6**	**-6**	**-6**	**-43**	**-147**
Consultant Costs	-370	-31	-30	-16	-23	-23	-23	-20	-20	-20	-16	-16	-16	-16	-69	-239
Nursing - Qualified	-7,723	-644	-358	-329	-264	-250	-250	-250	-250	-225	-250	-225	-220	-220	-951	-3,091
Nursing - Unqualified	-1,129		-31	-12	-7	-15	-15	-15	-15	-15	-15	-15	-15	-15	-50	-185
Other clinical staff costs	-326	-27	-27	3	-6	-15	-15	-15	-15	-10	-10	-7	-7	-5	-31	-130
Non clinical staff costs	0	0	0	0	0	-5	-5	-5	-5	0	0	0	0	0	0	-20
Sub-total - CHS	**-9,548**	**-702**	**-447**	**-354**	**-301**	**-308**	**-308**	**-305**	**-305**	**-270**	**-291**	**-263**	**-258**	**-256**	**-1,102**	**-3,666**
Consultant Costs	-438	-37	-22	-22	-22	-22	-22	0	0	0	0	0	0	0	-66	-110
Nursing - Qualified	-1,406	-117	-94	-70	-76	-60	-60	-40	-22	-22	-22	-22	-22	-22	-240	-532
Nursing - Unqualified	-40		0	-1	-4	-2	-2	-2	-2	-2	-2	-2	-2	-2	-5	-23
Other clinical staff costs	-23	-2	-9	-14	-10	-14	-14	-14	0	0	0	0	0	0	-33	-75
Non clinical staff costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-total - FYPC	**-1,907**	**-156**	**-125**	**-108**	**-111**	**-98**	**-98**	**-56**	**-24**	**-24**	**-24**	**-24**	**-24**	**-24**	**-344**	**-740**
Consultant Costs	0			0	0	0	0	0	0	0	0	0	0	0	0	0
Nursing - Qualified	101	8		-1	1	0	0	0	0	0	0	0	0	0	0	0
Nursing - Unqualified	0			0	0	0	0	0	0	0	0	0	0	0	0	0
Other clinical staff costs	-5	0		0	0	0	0	0	0	0	0	0	0	0	0	0
Non clinical staff costs	-297	-25	-6	-4	-7	-6	-6	-6	-6	-6	-6	-6	-6	-6	-17	-71
Sub-total - Enab/Host	**-202**	**-17**	**-6**	**-5**	**-6**	**-6**	**-6**	**-6**	**-6**	**-6**	**-6**	**-6**	**-6**	**-6**	**-17**	**-71**
Consultant Costs	-5,983	-499	-488	-493	-456	-435	-420	-380	-375	-370	-365	-361	-361	-361	-1,437	-4,865
Nursing - Qualified	-12,868	-1,072	-628	-539	-475	-431	-427	-403	-377	-342	-360	-332	-327	-327	-1,642	-4,968
Nursing - Unqualified	-1,349	-112	-33	-13	-16	-18	-18	-18	-18	-18	-20	-18	-18	-18	-62	-226
Other clinical staff costs	-499	-42	-47	-20	-31	-37	-36	-36	-22	-17	-17	-14	-14	-12	-98	-303
Non clinical staff costs	-297	-25	-6	-4	-7	-11	-11	-11	-11	-6	-6	-6	-6	-6	-17	-91
Total	**-20,996**	**-1,750**	**-1,203**	**-1,069**	**-985**	**-932**	**-912**	**-848**	**-803**	**-753**	**-768**	**-731**	**-726**	**-724**	**-3,256**	**-10,453**

Agency spend for June (month 3) is £0.99m.

YTD spend is £3.3m; this is slightly lower (by £119k) than the planned YTD spend. Current monthly spend is significantly lower than the average monthly cost during 2024/25 and reflects the continued downward trend in costs.

Agency spend for the year is forecast to be £10.5m, which is lower than plan (£11.1m).

APPENDIX D – BPPC performance

The specific BPPC target is to pay 95% of invoices within 30 days. The Trust is achieving 2 of the 4 cumulative targets– both successful targets relate to the value of invoices paid within the 30 day period. The non-compliant targets relate to the number of NHS and Non-NHS invoices paid late. All four targets were met for June's in-month performance.

Better Payment Practice Code	June (Cumulative)		May (Cumulative)	
	Number	£000's	Number	£000's
Total Non-NHS trade invoices paid in the year	8,875	24,992	5,332	10,957
Total Non-NHS trade invoices paid within target	7,879	24,032	4,487	10,530
% of Non-NHS trade invoices paid within target	**88.8%**	**96.2%**	**84.2%**	**96.1%**
Total NHS trade invoices paid in the year	194	18,762	123	11,920
Total NHS trade invoices paid within target	176	18,329	107	11,580
% of NHS trade invoices paid within target	**90.7%**	**97.7%**	**87.0%**	**97.1%**
Grand total trade invoices paid in the year	9,069	43,754	5,455	22,877
Grand total trade invoices paid within target	8,055	42,361	4,594	22,110
% of total trade invoices paid within target	**88.8%**	**96.8%**	**84.2%**	**96.6%**

Non-compliant target – Number of Non-NHS invoices:

The cumulative performance for the number of Non-NHS invoices for the first quarter of the year is 88.8%, however the position is improving - the in-month performance for June was 95.74%.

- 92% of Non NHS invoices not paid within the target period are in the estates & facilities directorate, 915 of the 996 late invoices relate to catering and estates invoices not being approved and paid on time, with the majority relating to catering invoices. The Estates & Facilities position did improve in Month 3: 98 invoices were paid late in June, compared to 603 in May and 214 in April.

- DMH is also contributing to the non-compliant performance. 53 invoices were paid late in the first quarter of the financial year, with 45 of these being paid late in June. These invoices relate to patient transport and Out of Area placements.

Non-compliant target – Number of NHS invoices:

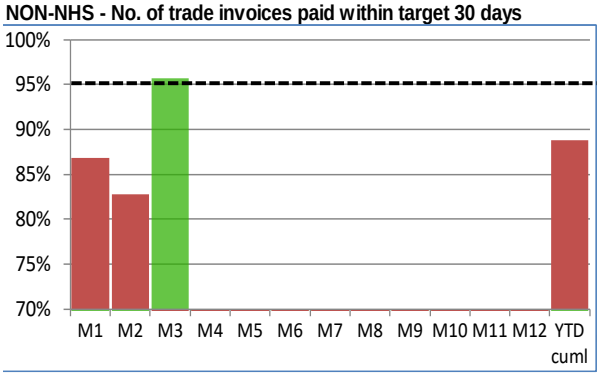
The cumulative performance for the number of NHS invoices for the first quarter of the year is 90.7%. Similar to the Non NHS performance, the position is improving - the in-month performance for June was 97.18%.

Due to the relatively low volume of NHS invoices paid during the year, only a small number of late invoices will make the performance non-compliant. So far this year, 194 NHS invoices have been paid in total, with 18 invoices being paid outside of the target period of 30 days.

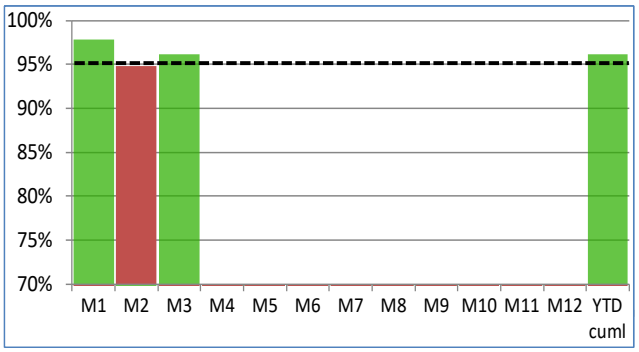
The majority of the non-compliant invoices relate to the various Enabling functions.

Trust performance – run-rate by all months and cumulative year-to-date

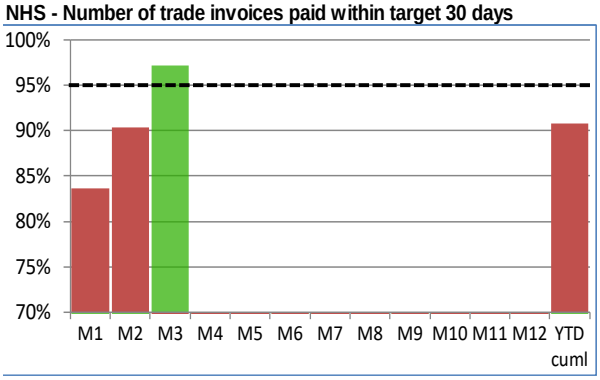
NON-NHS - No. of trade invoices paid within target 30 days



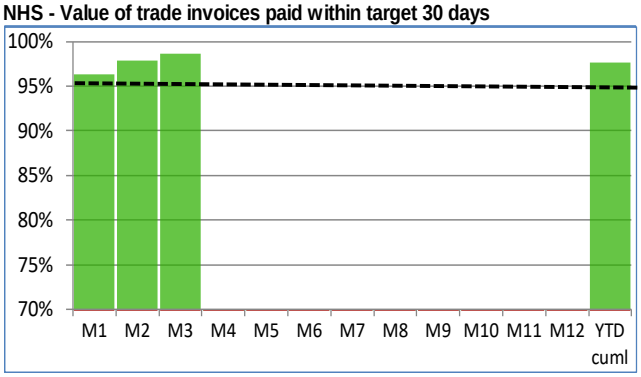
NON-NHS - Value of trade invoices paid within target 30 days



NHS - Number of trade invoices paid within target 30 days



NHS - Value of trade invoices paid within target 30 days



APPENDIX E - Capital Programme 2025/26 update

Trust Board approved an internal capital plan of £13.5m at the start of the year, comprising of £11.5m operational capital and £2m property lease investment. In addition, the Trust secured £5m PDC funding to support a number of national schemes as detailed in the table below. PFI capital lifecycle costs of £0.2m are also included within the programme. Overall this equates to arevised plan of £18.7m.

Capital expenditure for the first quarter of the year totals £2.011m, which is £260k (14.85%) above planned levels for June 2025.

	Annual Revised Plan	June Actual	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation	13,066	3,267	13,066	0
Cash reserves	2,840	(144)	3,135	295
Capital borrowings repayments	(4,447)	(1,112)	(4,447)	0
Total System operational capital	**11,459**	**2,011**	**11,754**	**295**
IFRS-16 new leases	**2,000**	**0**	**2,000**	**0**
MH OAPS - Acacia Ward Refurb	1,200	0	1,200	0
MH OAPS - Thornton Ward refurb	1,300	0	1,300	0
MH OAPS - Acute wards bathroom refurb	270	0	270	0
GB Energy	118	0	118	0
Estates Critical Infrastructure Risk (CIR)	2,129	0	2,129	0
National Programmes (PDC)	**5,017**	**0**	**5,017**	**0**
PFI capital lifecycle costs	**202**	**0**	**202**	**0**
Total Capital funds	**18,678**	**2,011**	**18,973**	**295**
Application of Funds				
Estates	**£'000**	**£'000**	**£'000**	**£'000**
Strategic schemes	(1,497)	0	(1,057)	440
Capital staffing	(567)	(111)	(567)	0
Estates backlog programme	(3,470)	(45)	(3,623)	(153)
Estates rolling programme	(2,107)	0	(2,480)	(373)
Medical devices	(170)	0	(170)	0
Directorate investment	(7,430)	(1,565)	(7,573)	(143)
PFI Agnes Unit capital lifecycle costs	(202)	0	(202)	0
	(15,443)	**(1,721)**	**(15,672)**	**(229)**
IM&T investment	**(1,235)**	**(290)**	**(1,301)**	**(66)**
Operational Capital	**(16,678)**	**(2,011)**	**(16,973)**	**(295)**
IFRS16 - Right of Use Leases	**(2,000)**	**0**	**(2,000)**	**0**
Total Capital Expenditure	**(18,678)**	**(2,011)**	**(18,973)**	**(295)**
(Over)/underspend	**0**	**(0)**	**0**	**0**

Capital changes since plan:

The total capital envelope has increased by £295k this month, following the distribution of the System's fair share allocation (which was previously held in contingency). This has been allocated to the Trust's backlog maintenance fund.

Further changes have been made to the capital programme this month. These mainly relate to the PDC funded schemes due to an estimated 6-month delay on scheme commencement, and the utilisation of associated scheme slippage on emerging capital pressures. This will impact on next year's capital programme - c£2.6m of next year's allocation will need to be ringfenced to support these deferrals. More details are shown in the following table:

2025/26 Changes

		Opening Plan	Changes	Revised Plan		Comments
		£'000	£'000	£'000		
	M03 Position	**(18,678)**	**(295)**	**(18,973)**		Additional non-cash allocation from LLR ICB
	Changes to Plan over £100k					
P22100	Acacia Full Refurbishment - The Willows	(1,770)	885	(885)		Scheme already 3m delay, expect 6m delay - phased into 26/27
P25006	Thornton Ward Refurbishment	(1,300)	800	(500)		Scheme already 3m delay, expect 6m delay - phased into 26/27
P22112	Bradgate receipt and distribution redesign	(500)	470	(30)		Scheme moved to 26/27
P24042	DeMontfort and Langton repurpose	(1,040)	440	(600)		Scheme already 3m delay, expect 6m delay - phased into 26/27
P23050	Lift replacement	(200)	200	0		Scheme not required
	Contingency (Backlog)	(1,211)	158	(1,053)		Reallocated funds
P24052	Glenfield Gas Main	(250)	130	(120)		Scheme value revised
			3,083			
P24091	Charnwood Mill Moves	0	(900)	(900)		Estimated costs for moves - TD to confirm
P24031	Wakerley Ward options	0	(450)	(450)		Funded as part of CIR - reallocated from Contingency Backlog
P23085	Backlog Maintenance (Holding Fund)	(1,150)	(450)	(1,600)		Backlog schemes funded from CIR - reallocation from Contingency
P24034	Belvoir Unit 25/26 - due delay to works commencing	(487)	(354)	(841)		Increased costs
P22040	H&S - Fire	(165)	(273)	(438)		Funded as part of CIR - reallocated from Contingency Backlog
P23044	BMS Strategy	0	(200)	(200)		BMS replacements not factored into plan
P21100	Hinckley Hub (incs £600k conversion costs)	(564)	(100)	(664)		Revised costs
P24003	Soundproofing Audiology	(200)	(100)	(300)		Completion of Beaumont pod, and Hynca Lodge b/f
			(2,827)			
	Changes less than £100k					
P25003	Renal Doors & Windows (Loughborough)	0	(80)	(80)		
P24002	Junior Doctors On-call room	0	(70)	(70)		
	Revenue to capital (IT)	0	(66)	(66)		Services IT purchases - not in Plan
P22108	Replacement Boilers	0	(53)	(53)		Funded as part of CIR - reallocated from Contingency Backlog
P23027	Environment audits & actions (inc CQC, IPC etc)	(100)	(50)	(150)		
P23079	Tarmac	(50)	(50)	(100)		
P24041	Site Electrical Supply	(109)	(41)	(150)		
P23002	Winstanley Drive - Reception and structural works	0	(40)	(40)		Costs to ensure building safety
P24048	Beacon Decant	0	(39)	(39)		Work was critical and already completed
P25004	Cold Water Storage - RMH	0	(30)	(30)		Funded as part of CIR - reallocated from Contingency Backlog
P24026	Ward Handheld Devices (VAT adjustment)	0	(26)	(26)		VAT reclaim reversed on invoices paid in 24/25
P24024	Wellsky S1 integration	0	(23)	(23)		c/f scheme not included in plan - final invoices
P25001	Hinckley & Bosworth Hospital Solar Panels	(118)	(23)	(141)		VAT not included in bid
P25002	Belvoir Ward AHU replacement	0	(10)	(10)		
P22086	Backlog - ORC Lift Pit Tanking	(20)	20	0		
P23057	Gas scavenging system	(50)	30	(20)		
			(551)			
	Other Schemes - unchanged	(9,394)	0	(9,394)		
	TOTAL	**(18,678)**	**(295)**	**(18,973)**		

APPENDIX F - SoFP, cash and working capital

PERIOD: June 2025	2024/25 31/03/25 Audited £'000's	2025/26 30/06/25 June £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	132,331	132,252
Intangible assets	4,422	4,066
IFRS16 - Right of use (ROU) assets	18,538	18,001
Trade and other receivables	920	920
Total Non Current Assets	**156,211**	**155,239**
CURRENT ASSETS		
Inventories	436	460
Trade and other receivables	8,747	15,687
Short term investments	0	0
Cash and Cash Equivalents	19,547	15,205
Total Current Assets	**28,730**	**31,352**
Non current assets held for sale	**0**	**0**
TOTAL ASSETS	**184,942**	**186,591**
CURRENT LIABILITIES		
Trade and other payables	(28,128)	(34,076)
Borrowings	(4,481)	(4,399)
Provisions	(3,298)	(3,228)
Other liabilities	(6,755)	(4,752)
Total Current Liabilities	**(42,662)**	**(46,455)**
NET CURRENT ASSETS (LIABILITIES)	**(13,932)**	**(15,103)**
NON CURRENT LIABILITIES		
Borrowings	(39,939)	(39,237)
Provisions	(899)	(899)
Total Non Current Liabilities	**(40,838)**	**(40,136)**
TOTAL ASSETS EMPLOYED	**101,442**	**100,000**
TAXPAYERS' EQUITY		
Public Dividend Capital	108,228	108,228
Retained Earnings	(24,744)	(26,186)
Revaluation reserve	17,958	17,958
Other reserves	0	0
TOTAL TAXPAYERS EQUITY	**101,442**	**100,000**

Non-current assets

Property, plant, and equipment (PPE) amounts to £132.3m, and includes capital additions of £2.01m, offset by depreciation charges.

Right of Use (ROU) leased assets account for £18m of total non-current assets.

Current assets

Current assets of £31.4m mainly includes cash of £15.2m, and receivables of £15.7m.

Current Liabilities

Current liabilities amount to £46.5m with trade and other payables making up £34.1m of this balance.

Other liabilities of £4.8m relate to deferred income, of which the majority relates to Provider Collaborative income and Secure Digital Environment (SDE) funding, carried forward from 2024/25 to support future service delivery.

Net current assets / (liabilities) show net liabilities of £15.1m.

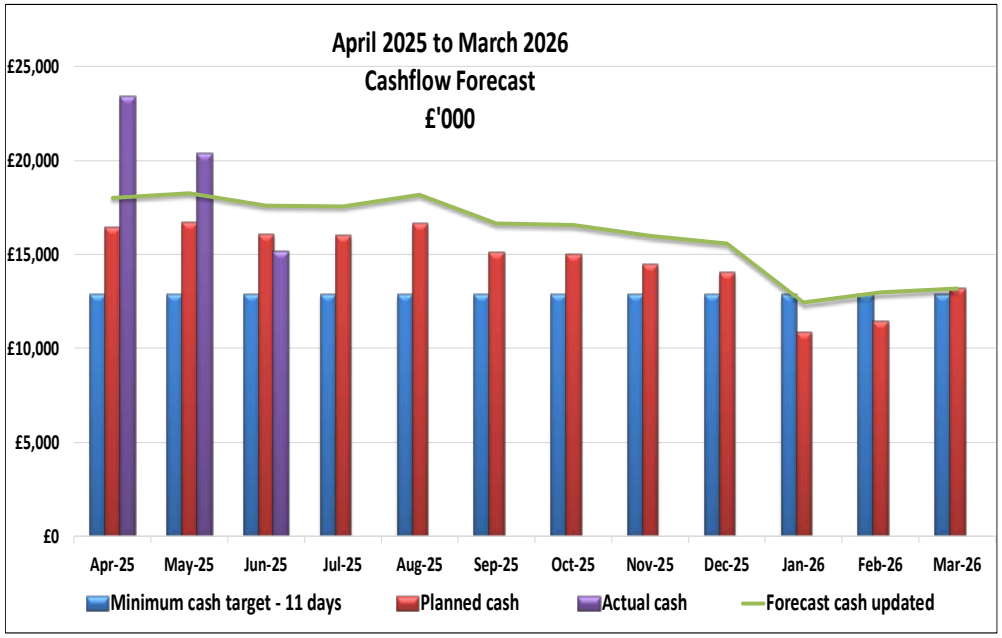
Taxpayers' Equity

June's deficit of £1.4m is reflected within retained earnings.

Public dividend capital balance is £108.2m at the end of June. This will increase once we receive additional capital investment funding for a number of capital projects.

Cash

The closing cash balance at the end of June was £15.2m, a decrease of £4.3m since the start of the financial year. This delivers 13 operating days cash. This is below the plan level for June of 14 days cash.



The forecast closing cash balance as at the 31st of March 2026 is £13.2m. This is a £6.3m reduction compared with the previous year's closing cash balance of £19.5m. The in-year reduction is due to:

- Previous years' cash reserves to support our in-year capital investment - £3m
- Movements in working capital e.g., utilisation of deferred income & provisions - £3.3m

From this financial year, the Trust has set an internal cash target, to work to a minimum of 11 operating cash days (or £13m). This target was established by Monitor several years ago and is a good threshold to mitigate against not having sufficient working capital to meet operational cash requirements.

The cashflow forecast will be monitored closely against the income and expenditure forecast, to ensure any deviations from plan are factored into the cash position.

Cashflow Forecast - by value and days:

£000	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Minimum cash target - 11 days	12,872	12,872	12,872	12,872	12,872	12,872	12,872	12,872	12,872	12,872	12,872	12,872
Planned cash	16,442	16,697	16,052	16,005	16,612	15,118	15,032	14,459	14,046	10,883	11,443	13,172
Forecast cash updated	17,989	18,244	17,599	17,552	18,159	16,665	16,579	16,006	15,593	12,430	12,990	13,172
Actual cash	23,383	20,358	15,205	-	-	-	-	-	-	-	-	-

Days	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Minimum cash target - 11 days	11	11	11	11	11	11	11	11	11	11	11	11
Planned cash days	14	14	14	14	14	13	13	12	12	9	10	11
Forecast cash days	15	16	15	15	16	14	14	14	13	11	11	11
Actual cash days	20	17	13	-	-	-	-	-	-	-	-	-

Receivables

Current receivables (debtors) total £15.7m, an increase of £6.9m since the start of the year. £5.2m of this increase relates to outstanding Leicester City Council and Leicestershire County Council monthly contract recharges. Payment is expected in July. These delayed payments contribute to the Trust's reduced cash balance at month 3.

Receivables	Current Month June 2025					
	NHS £'000	Non NHS £'000	Emp's £'000	Total £'000	% Total	% Sales Ledger
Sales Ledger						
30 days or less	1,009	5,589	9	**6,607**	**39.78%**	**85.5%**
31 - 60 days	38	70	9	**117**	**0.70%**	**1.5%**
61 - 90 days	252	142	3	**397**	**2.39%**	**5.1%**
Over 90 days	37	366	203	**606**	**3.65%**	**7.8%**
	1,336	6,167	224	**7,727**	**46.53%**	**100.0%**
Non sales ledger	4,469	3,491	0	**7,960**	**47.93%**	
Total receivables current	**5,805**	**9,658**	**224**	**15,687**	**94.46%**	
Total receivables non current		920		920	**5.54%**	
Total	**5,805**	**10,578**	**224**	**16,607**	**100.00%**	**0.0%**

Debt greater than 90 days stands at £0.61m; this is a decrease of £14k since the previous month. Receivables over 90 days should not account for more than 5% of the overall total receivables balance. The proportion at Month 3 is 3.65% (last month: 4.92%).

The bad debt provision is £0.4m and covers all Non-NHS debt greater than 12 months old. Ex-employee debts of £2k were written off in the month, and £8k has been written off since the start of the year.

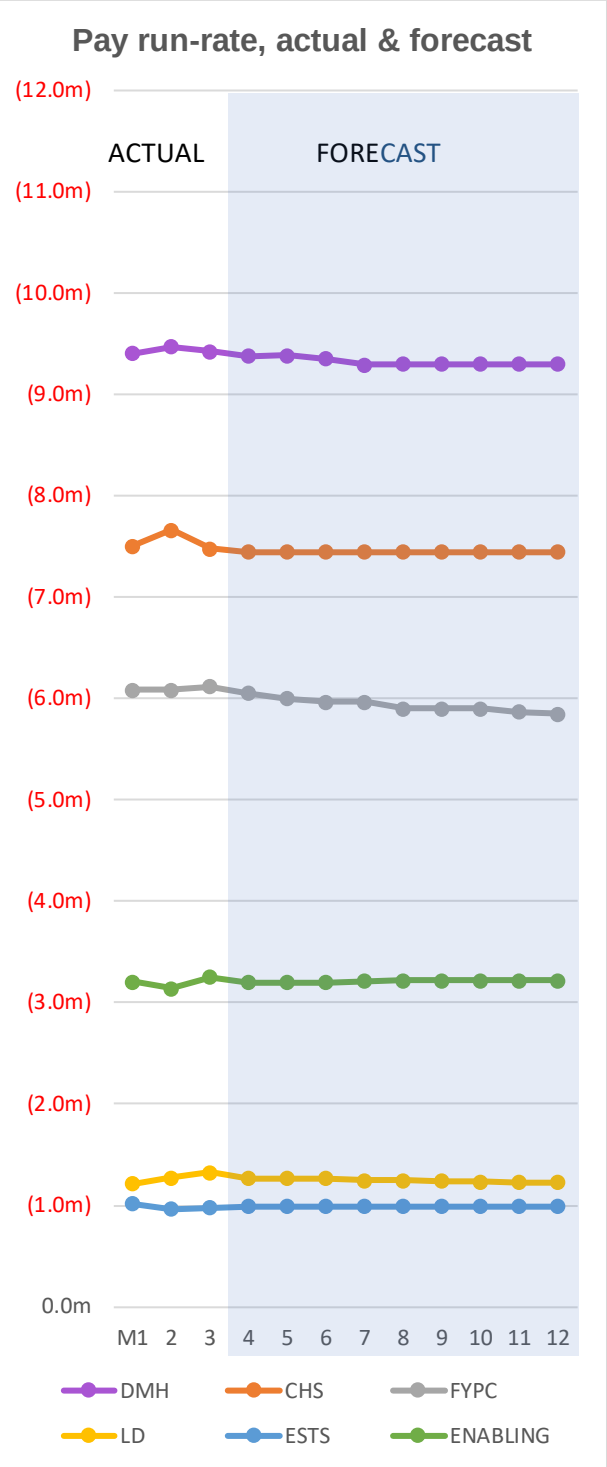
Payables

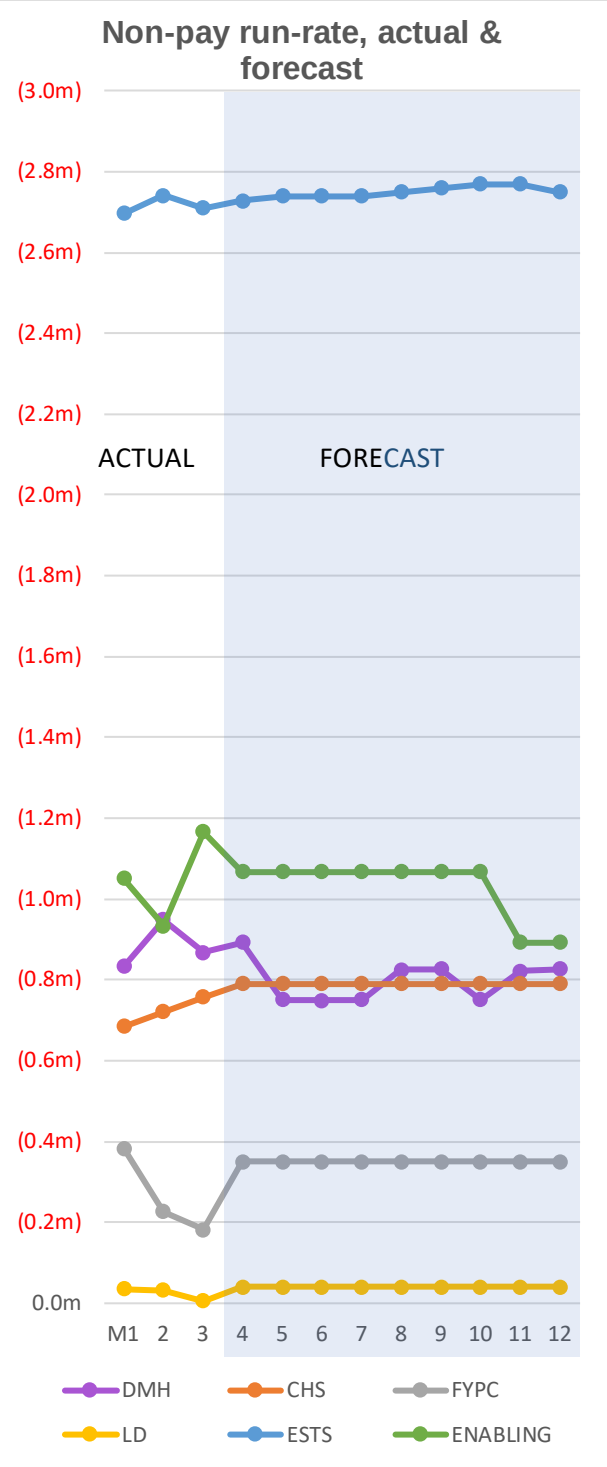
The current payables position in Month 3 is £34.1m – an increase of £5.9m since the start of the year. Other liabilities of £4.8m relate to deferred income. It mainly relates to income carried forward from previous years, for provider collaborative and Secure Digital Environment initiatives.

Borrowings

Current and non-current borrowings total £43.6m. PFI, property leases and the capital investment loan make up this balance, which reduces each month when corresponding payments are made or increases when new lease liabilities arise.

APPENDIX G – Directorate expenditure run-rates, forecast & actual





APPENDIX H – Risk adjusted best/likely/worst case forecasts

I&E BEST / LIKELY / WORST CASE FORECAST OUTTURN AS AT MONTH 3

	BEST CASE	LIKELY STRETCH	LIKELY FOT	WORST CASE
	£000	£000	£000	£000
INITIAL TOTAL DIRECTORATE FOT POSITIONS	**(1,635)**	**(2,750)**	**(4,155)**	**(6,700)**
CORPORATE				
Corporate services realignment - variance against £1.5m target	0	(750)	(1,000)	(1,500)
Difficult decisions / further NR savings - var. against £1m target	0	(750)	(977)	(977)
Non-rec income target - var. against £1.5m target	500	0	(478)	(978)
Slippage on internal investments	300	200	126	48
Interest receivable gain over new 25/26 budget	300	150	0	(200)
Pay award and NI funding shortfall	0	(616)	(2,149)	(2,649)
Other recovery actions	535	0	0	0
TOTAL RANGE OF RISK ADJUSTED FORECASTS:	**0**	**(4,516)**	**(8,633)**	**(12,956)**

Leicestershire Partnership NHS Trust

Trust Board

Month 3 Trust finance report

Purpose of the Report

- To provide an update on the Trust financial position.

Proposal

- The Board is recommended to review the summary financial position and accept the reported year to date financial performance.

Decision required: N/A

Governance table

For Board and Board Committees: Paper sponsored by:	Trust Board 29/07/2025 Sharon Murphy, Director of Finance & Performance	
Paper authored by: Date submitted: State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s): If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured: State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Chris Poyser - Head of Corporate Finance; Jackie Moore – Financial Controller 22/07/2025 Regular report issued to Accountability Framework Meeting, Finance & Performance Committee and Trust Board meeting. Monthly update report	
LPT strategic alignment:	**T** - **T**echnology	
	H – **H**ealthy Communities	
	R - **R**esponsive	
	I – **I**ncluding Everyone	
	V – **V**aluing our People	
	E – **E**fficient & Effective	X
CRR/BAF considerations: **Is the decision required consistent with LPT's risk appetite:** **False and misleading information (FOMI) considerations:**	**6.4** Inadequate control, reporting and management of the Trust's 2025/26 financial position could mean we are unable to deliver our financial plan, resulting in a breach of LPT's statutory duties and financial strategy (including LLR strategy) N/A	

Positive confirmation that the content does not risk the safety of patients or the public	It does not
Equality considerations:	

Q

Leicestershire Partnership NHS Trust

Trust Board – 29.07.25

Board Performance Report - June 2025 (Month 3)

Purpose of the report

To provide the Trust Board with an overview of Trust performance against an agreed set of KPI's for June 2025 (M3 of 2025/26).

Analysis of the issue

This report will be presented to the Accountability Framework Meeting ahead of Trust Board.

Proposal

The following should be noted by the Trust Board when reviewing the report and looking ahead to the next reporting period:

The following indicators have been removed from the national published Mental Health Core Data Pack for 2025/26: -

- MHSDS - Data Quality Consistency
- MHSDS - Data Quality Coverage
- MHSDS - Data Quality Outcomes

The target and performance for mental health average length of stay have been adjusted due to an error in reporting for April and May. Data for previous months has been corrected in this report.

Summary performance across the Trust's agreed indicators can be found in the Exception Reports Summary / Summary Matrix and Summary Dashboard sections of the Board Performance Report.

New special cause concerns, as reflected in the Exception Reports Summary Matrix, are as follows:

- Dynamic Psychotherapy - treatment waits / no. of waiters – SPC trend has changed to special cause concern.

- No. of episodes of prone (supported) restraint – SPC trend has changed to special cause concern.

All other special cause concerns remain unchanged from last month.

Other movements of note on the Exceptions Matrix this month are:

- Learning Disability 52 week treatment waits has moved to a special cause variation of an improving nature, with zero over 52 weeks waiters in June.

All exceptions in the Exception Report Summary have detailed exception reports within the board performance pack which include analytical and operational commentary covering performance and improvement actions.

NHSE has published an updated NHS Oversight Framework which will pull together a range of indicators using existing published data. This will be used to 'segment' NHS Trusts based on performance which will in turn determine the level of oversight afforded to each organisation. At the time of submission LPT's segmentation score has not been published. As part of wider work to maintain the BPR, the indicators included in the newly published Oversight Framework will be reviewed to identify any changes required to internal reporting to ensure a strong focus on these measures to support ongoing internal visibility and action where concerns may be indicated.

Decision required

The Trust Board is asked to:

- Approve the Performance Report.

Governance table

For Board and Board Committees:	Trust Board	
Paper sponsored by:	Sharon Murphy, Director of Finance and Performance	
Paper authored by:	Pardeep Dhami, Information Analyst Nasir Shaikh, Business Information Manager Anne Senior, Associate Director	
Date submitted:	17.07.25	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	None – due to meeting timings this BPR is presented in advance of the July Accountability Framework Meeting.	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	None	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Standard month end report	
LPT strategic alignment:	**T** - **T**echnology	
	H - **H**ealthy Communities	x
	R - **R**esponsive	x
	I - **I**ncluding Everyone	x
	V - **V**aluing our People	x
	E - **E**fficient & Effective	x
CRR/BAF considerations:	List risk number and title of risk	**BAF3.2** - Without **timely access** to services, we cannot provide high quality safe care for our patients which will impact on clinical outcomes.
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	None identified	

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NHS Trust

EXCEPTION REPORTS SUMMARY

EXCEPTION REPORTS - Consistently Failing Target

Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	SPC Assurance	SPC Trend
Adult CMHT Access (6 weeks routine) - Incomplete pathway	>=95%	May-25	45.9%	56.4%	F	
Memory Clinic (18 week Local RTT) - Incomplete pathway	>=92%	May-25	61.5%	61.9%	F	L
ADHD (18 week local RTT) - Incomplete pathway	>=92%	May-25	9.6%	9.5%	F	H
CINSS (6 weeks) - Incomplete Pathway	>=95%	May-25	36.6%	39.9%	F	L
Community Paediatrics (18 weeks) - Incomplete pathway	>=92%	May-25	13.2%	13.6%	F	L
Childrens Audiology (6 week wait for diagnostic procedures) - Incomplete pathway	>=99%	May-25	29.2%	29.0%	F	
Adult General Psychiatry - Community Mental Health Teams and Outpatients – Treatment waits - No of Waiters	0	Jun-25	55	55	F	L
Cognitive Behavioural Therapy - Treatment waits - No of waiters	0	Jun-25	54	53	F	H
Dynamic Psychotherapy - Treatment waits - No of waiters	0	Jun-25	14	11	F	H
Therapy Service for People with Personality Disorder - Treatment waits - No of waiters	0	Jun-25	307	355	F	L
Medical/Neuropsychology - Treatment waits - No of Waiters	0	Jun-25	84	93	F	H
ADHD (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	May-25	5190	5014	F	H

Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	SPC Assurance	SPC Trend
MHSOP Memory Clinics (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	May-25	8	11	F	L
Community Paediatrics - assessment waits over 52 weeks - No of waiters	0	May-25	5723	5509	F	H
Community Paediatrics Treatment (excl ND) - No of waiters	0	Jun-25	34	35	F	L
All Neurodevelopment (inc CAMHS, SALT, PAEDS) - Treatment waits - No of waiters	0	Jun-25	1378	0	F	H
CAMHS - Treatment waits (excl ND) - No of waiters	0	Jun-25	68	73	F	
All LD - Treatment waits - No of waiters	0	Jun-25	0	1	F	L
Children's SALT Communication & Dysphagia - No of waiters	0	Jun-25	1794	1734	F	H
Children's Physiotherapy - No of waiters	0	Jun-25	15	13	F	
Adult Eating Disorders Community - Treatment waits - No of waiters	0	Jun-25	19	10	F	
Vacancy Rate	<=10%	Jun-25	10.7%	10.5%	F	L
Sickness Absence	<=5.0%	May-25	4.9%	5.2%	?	
Agency Costs	<=£922,333	Jun-25	£984,921	£1,068,736	F	L

EXCEPTION REPORTS - Consistently Achieving Target						
Indicator	**Monthly Target**	**Data As At**	**Current Reporting**	**Previous Reporting**	**SPC Assurance**	**SPC Trend**
MRSA Infection Rate	**0**	**Jun-25**	**0**	**0**		
Clostridium difficile infection rate	**<=12**	**Jun-25**	**1**	**2**		
Occupancy Rate - Mental Health Beds (excluding leave)	<=85%	**Jun-25**	**85.4%**	**85.2%**		
Normalised Workforce Turnover (Rolling previous 12 months)	**<=10%**	**Jun-25**	**7.3%**	**7.3%**		
Core Mandatory Training Compliance for substantive staff	**>=85%**	**Jun-25**	**97.3%**	**97.2%**		
Staff with a Completed Annual Appraisal	**>=80%**	**Jun-25**	**93.9%**	**93.2%**		
% of staff from a BME background	**>=22.5%**	**Jun-25**	**32.5%**	**32.3%**		
% of staff from a BME background	**>=85%**	**Jun-25**	**Jun-25**	**94.2%**		

EXCEPTION REPORTS MATRIX SUMMARY

Variation/Trend		Assurance		
		Achieving Target 	**Inconsistently Achieving Target** 	**Not Achieving Target** 
	Special Cause - Improvement 	MRSA Infection Rate / Clostridium difficile infection rate Normalised Workforce Turnover / Core Mandatory Training Compliance for substantive staff / % of staff from a BME background / % staff clinical supervision		*Waiting Times* : CMHT 52 Wks / TSPPD 52 wks / MHSOP Memory Clinic 52 Wks / ADHD / Community Paediatrics Treatment 52 Wks / LD 52 Wks Agency Cost / Vacancy Rate
	Common Cause 	Occupancy Rate - Mental Health Beds (excluding leave) Staff with a Completed Annual Appraisal	Sickness Absence	*Waiting Times:* Adult CMHT / Children's Audiology / CAMHS - Treatment waits / Children's Physiotherapy / Adult ED Community 52 wks
	Special Cause - Concern 			*Waiting Times:* Stroke & Neuro / Memory Clinic / Community Paediatrics / CBT 52 weeks / DPS 52 wks / Medical_Neuro 52 wks / ADHD 52 weeks / Community Paediatrics 52 wks assessment / All Neurodevelopment 52 Wks / Children's SALT Communication & Dysphagia 52 Wks

SUMMARY

WORKFORCE						
Indicator	**Monthly Target**	**Data As At**	**Current Reporting Period**	**Previous Reporting Period**	**SPC Assurance**	**SPC Trend**
Normalised Workforce Turnover (Rolling previous 12 months)	**<=10%**	**Jun-25**	**7.3%**	**7.3%**		
Vacancy Rate	**<=10%**	**Jun-25**	**10.7%**	**10.5%**		
Sickness Absence (in arrears)	**<=5.0%**	**May-25**	**4.9%**	**5.2%**		
Agency Costs	**<=£922,333**	**Jun-25**	**£984,921**	**£1,068,736**		

QUALITY & SAFETY						
Indicator	**Monthly Target**	**Data As At**	**Current Reporting Period**	**Previous Reporting Period**	**SPC Assurance**	**SPC Trend**
Safe staffing - No. of wards not meeting >80% fill rate for RNs - Day	**0**	**Jun-25**	**3**	**0**		
Safe staffing - No. of wards not meeting >80% fill rate for RNs - Night	**0**	**Jun-25**	**3**	**1**		

FINANCE (Metrics TBC)

Board Performance Report
Summary Dashboard

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Quality Account	TRUST	Monthly	The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period	>=95%	Jun-25	97.8%	100.0%		?		
	TRUST	Yearly	The Trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period		24/25	6.6	6.3				
	TRUST	Monthly	The percentage of inpatients discharged with a subsequent inpatient admission within 30 days - 0-15 years		Jun-25	0.0%	0.0%				
	TRUST	Monthly	The percentage of inpatients discharged with a subsequent inpatient admission within 30 days - 16+ years		Jun-25	5.4%	7.1%				
	TRUST	Monthly	The number of patient safety incidents reported within the Trust during the reporting period		Jun-25	2021	1884			H	
	TRUST	Monthly	The rate of patient safety incidents reported within the Trust during the reporting period		Jun-25	70.8%	67.8%				
	TRUST	Monthly	The number of such patient safety incidents that resulted in severe harm or death		Jun-25	20	12				
	TRUST	Monthly	The percentage of such patient safety incidents that resulted in severe harm or death		Jun-25	1.0%	0.6%				
	MHSDS	Monthly (a quarter in arrears)	72 hour Follow Up after discharge (Aligned with national published data)	>=80%	Apr-25	90.0%	87.0%				
NHS Oversight	TRUST	Monthly	2-hour urgent response activity	>=70%	Jun-25	84.7%	85.9%				
	TRUST	Monthly	Daily discharges as % of patients who no longer meet the criteria to reside in hospital		Jun-25	22.9%	27.7%				
	TRUST	Monthly	Out of Area Placement - Inappropriate Bed Days	0	Jun-25	244	301				
	ICB	Monthly	Reliance on specialist inpatient care for adults with a learning disability and/or autism		Jun-25	30	31				
	ICB	Monthly	Reliance on specialist inpatient care for children with a learning disability and/or autism		Jun-25	2	1				
		Monthly	Overall CQC rating (provision of high quality care)		2021/22	2					
		Monthly	CQC Well Led Rating		2021/22	2					
		Quarterly	NHS SOF Segmentation Score		Q4	2	2				
	MHRA	Monthly	National Patient Safety Alerts not completed by deadline		Jun-25	1	1				

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
	TRUST	Monthly	MRSA Infection Rate	0	Jun-25	0	0		P		
	TRUST	Monthly	Clostridium difficile infection rate	<=12	Jun-25	1	2		P		
	UHL	Monthly (In Arrears)	E.coli bloodstream infections		May-25	2	0				
	GOV	Monthly (YTD)	Percentage of people aged 65 and over who received a flu vaccination								
			VTE Risk Assessment								
Operational Planning	TRUST	Monthly (3 month rolling)	Average Length of Stay in Adult Acute MH Beds	<=56.0	Jun-25	58.8	66.3				
	TRUST	Monthly	Average Length of stay - Community Hospitals	<=23.5	Jun-25	23.3	25.9				
	TRUST	Monthly	Community Care Contacts - CHS	Plan=75504	Jun-25	85473	85437				
	TRUST	Monthly	Community Care Contacts - FYPC	Plan=11112	Jun-25	11082	10798				
	TRUST	Monthly	Community Services Waiting List over 52 weeks	Target =0 Plan=5835	Jun-25	5858	5723				
Access Waiting Times - DMH	TRUST	Monthly (In Arrears)	Adult CMHT Access (6 weeks routine) - Incomplete pathway	>=95%	May-25	45.9%	56.4%		F		
	TRUST	Monthly (In Arrears)	Memory Clinic (18 week Local RTT) - Incomplete pathway	>=92%	May-25	61.5%	61.9%		F	L	
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - Incomplete pathway	>=92%	May-25	9.6%	9.5%		F	H	
	TRUST	Monthly (In Arrears)	Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral - complete pathway	>=60%	May-25	90.9%	62.5%		?		
Access Waiting Times - CHS	TRUST	Monthly (In Arrears)	CINSS (6 weeks) - Incomplete Pathway	>=95%	May-25	36.6%	39.9%		F	L	
	TRUST	Monthly (In Arrears)	Speech Therapy - Voice, Respiratory and Dysfluency - Routine (6 weeks) - Incomplete Pathway	>=95%	May-25	19.7%	22.6%				
Access Waiting Times - FYPCLDA	TRUST	Monthly (In Arrears)	CAMHS Eating Disorder (one week) - Complete pathway	>=95%	May-25	100.0%	45.5%		?		
	TRUST	Monthly (In Arrears)	CAMHS Eating Disorder (four weeks) - Complete pathway	>=95%	May-25	43.5%	18.2%		?	L	
	TRUST	Monthly (In Arrears)	Community Paediatrics (18 weeks) - Incomplete pathway	>=92%	May-25	13.2%	13.6%		F	L	
	TRUST	Monthly (In Arrears)	Childrens Audiology (6 week wait for diagnostic procedures) - Incomplete pathway	>=99%	May-25	29.2%	29.0%		F		

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Looked After Children	TRUST	Monthly	Percent of IHA plans sent to LA in month by 19th working day of being taken into care (City/County/Rutland)		Jun-25	16.2%	12.5%				
	TRUST	Monthly	(5-18yrs) Percent of RHAs sent to LA in month within 12 months of previous assessment (City/County/Rutland)		Jun-25	95.8%	100.0%				
	TRUST	Monthly	(0-4yrs) Percent of RHAs sent to LA in month within 6 months of previous assessment (City/County/Rutland)		Jun-25	100.0%	100.0%				
52 Week Waits - DMH	TRUST	Monthly	Adult General Psychiatry - Community Mental Health Teams and Outpatients – Treatment waits - No of Waiters	0	Jun-25	55	55				
	TRUST	Monthly	Adult General Psychiatry - Community Mental Health Teams and Outpatients – Treatment waits - Longest Waiter		Jun-25	188	184				
	TRUST	Monthly	Cognitive Behavioural Therapy - Treatment waits - No of waiters	0	Jun-25	54	53				
	TRUST	Monthly	Cognitive Behavioural Therapy- Treatment waits - Longest waiter (weeks)		Jun-25	84	89				
	TRUST	Monthly	Dynamic Psychotherapy - Treatment waits - No of waiters	0	Jun-25	14	11				
	TRUST	Monthly	Dynamic Psychotherapy - Treatment waits - Longest waiter (weeks)		Jun-25	77	72				
	TRUST	Monthly	Therapy Service for People with Personality Disorder - Treatment waits - No of waiters	0	Jun-25	307	355				
	TRUST	Monthly	Therapy Service for People with Personality Disorder - Treatment waits - Longest waiter (weeks)		Jun-25	186	182				
	TRUST	Monthly	Medical/Neuropsychology - Treatment waits - No of Waiters	0	Jun-25	84	93				
	TRUST	Monthly	Medical/Neuropsychology- Treatment waits - Longest Waiter		Jun-25	154	150				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	May-25	5190	5014				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - assessment waits over 52 weeks - Longest waiter (weeks)		May-25	379	374				
	TRUST	Monthly (In Arrears)	MHSOP Memory Clinics (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	May-25	8	11				
	TRUST	Monthly (In Arrears)	MHSOP Memory Clinics (18 week local RTT) - assessment waits over 52 weeks -Longest waiter (weeks)		May-25	94	143				

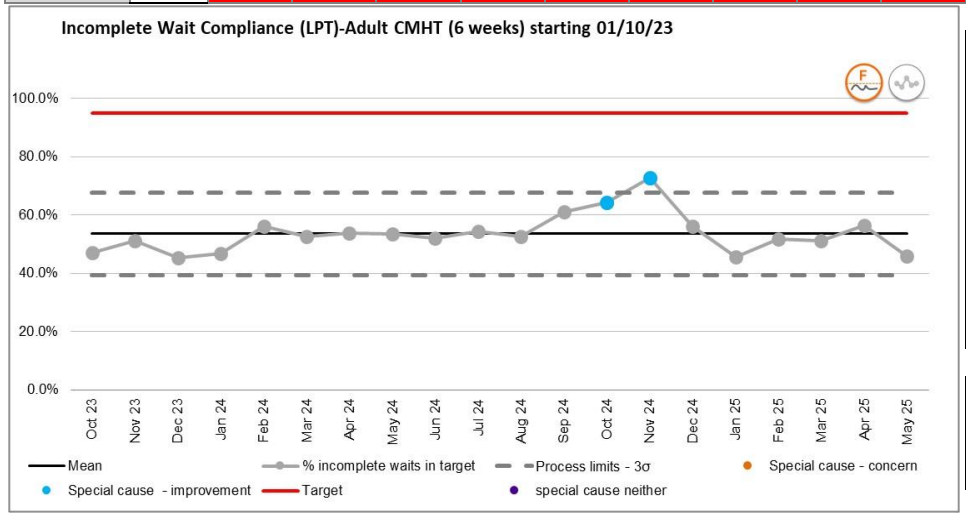
Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
52 Week Waits - FYPCLDA	TRUST	Monthly (In Arrears)	Community Paediatrics - assessment waits over 52 weeks - No of waiters	0	May-25	5723	5509		F	H	
	TRUST	Monthly (In Arrears)	Community Paediatrics - assessment waits over 52 weeks - Longest waiter (weeks)		May-25	187	188				
	TRUST	Monthly	Community Paediatrics Treatment (excl ND) - No of waiters	0	Jun-25	34	35		F	L	
	TRUST	Monthly	Community Paediatrics Treatment (excl ND) - Longest waiter		Jun-25	141	137				
	TRUST	Monthly	All Neurodevelopment (inc CAMHS, SALT, PAEDS) - Treatment waits - No of waiters	0	Jun-25	1378	1294		F	H	
	TRUST	Monthly	All Neurodevelopment (inc CAMHS, SALT, PAEDS) - Treatment waits - Longest waiter (weeks)		Jun-25	245	241				
	TRUST	Monthly	CAMHS - Treatment waits (excl ND) - No of waiters	0	Jun-25	68	73		F		
	TRUST	Monthly	CAMHS - Treatment waits (excl ND) - Longest waiter (weeks)		Jun-25	79	75				
	TRUST	Monthly	All LD - Treatment waits - No of waiters	0	Jun-25	0	1		F	L	
	TRUST	Monthly	All LD - Treatment waits - Longest waiter (weeks)		Jun-25	51	54				
	TRUST	Monthly	Children's SALT Communication & Dysphagia - No of waiters	0	Jun-25	1794	1734		F	H	
	TRUST	Monthly	Children's SALT Communication & Dysphagia - Longest waiter		Jun-25	112	110				
	TRUST	Monthly	Children's Physiotherapy - No of waiters	0	Jun-25	15	13		F		
	TRUST	Monthly	Children's Physiotherapy - Longest waiter		Jun-25	110	106				
	TRUST	Monthly	Children's Continence - No of waiters	0	Jun-25	0	0		?	L	
	TRUST	Monthly	Children's Continence - Longest waiter		Jun-25	20	20				
	TRUST	Monthly	Audiology - No of waiters	0	Jun-25	0	0		?		
	TRUST	Monthly	Audiology - Longest waiter		Jun-25	44	40				
	TRUST	Monthly	Adult Eating Disorders Community - Treatment waits - No of waiters	0	Jun-25	19	10		F		
	TRUST	Monthly	Adult Eating Disorders Community - Treatment waits - Longest waiter (weeks)		Jun-25	81	77				

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Patient Flow	TRUST	Monthly	Occupancy Rate - Mental Health Beds (excluding leave)	<=85%	Jun-25	85.4%	85.2%				
	TRUST	Monthly	Occupancy Rate - Community Beds (excluding leave)	>=93%	Jun-25	92.0%	90.2%				
	TRUST	Monthly	Delayed Transfers of Care	<=3.5%	Jun-25	5.1%	6.6%				
	TRUST	Monthly	Gatekeeping	>=95%	Jun-25	97.8%	100.0%				
	TRUST	Monthly	Admissions to adult facilities of patients under 18 years old	0	Jun-25	0	0				
Quality & Safety	TRUST	Monthly	No. of Complaints		Jun-25	23	21				
	TRUST	Monthly	No. of Concerns		Jun-25	47	44				
	TRUST	Monthly	No. of Compliments		Jun-25	212	214				
	TRUST	Monthly	Safe staffing - No. of wards not meeting >80% fill rate for RNs - Day	0	Jun-25	3	0				
	TRUST	Monthly	Safe staffing - No. of wards not meeting >80% fill rate for RNs - Night	0	Jun-25	3	1				
	TRUST	Monthly	Care Hours per patient day		Jun-25	12.1	11.9				
	TRUST	Monthly	No. of Long term Segregations		Jun-25	1	1				
	TRUST	Monthly	No. of episodes of seclusions >2hrs		Jun-25	2	6				
	TRUST	Monthly	No. of episodes of prone (Supported) restraint		Jun-25	4	0				
	TRUST	Monthly	No. of episodes of prone (Unsupported) restraint		Jun-25	0	0				
	TRUST	Monthly	Total number of Restrictive Practices		Jun-25	341	305				
	TRUST	Monthly (In Arrears)	No. of Category 2 pressure ulcers developed or deteriorated in LPT care		May-25	120	143				
	TRUST	Monthly (In Arrears)	No. of Category 3 pressure ulcers developed or deteriorated in LPT care		May-25	22	14				
	TRUST	Monthly (In Arrears)	No. of Category 4 pressure ulcers developed or deteriorated in LPT care		May-25	16	4				
	TRUST	Monthly (In Arrears)	No. of repeat falls		May-25	51	43				

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
	TRUST	Monthly	No. of Medication Errors		Jun-25	90	80				
	TRUST	Monthly	LD Annual Health Checks completed - YTD		Jun-25	12.2%	6.5%				
	TRUST	Monthly	LeDeR Reviews completed within timeframe - Allocated		Jun-25	8	8				
	TRUST	Monthly	LeDeR Reviews completed within timeframe - Awaiting Allocation		Jun-25	7	5				
	TRUST	Monthly	LeDeR Reviews completed within timeframe - On Hold		Jun-25	6	6				
HR Workforce	TRUST	Monthly	Normalised Workforce Turnover (Rolling previous 12 months)	<=10%	Jun-25	7.3%	7.3%				
	TRUST	Monthly	Vacancy Rate	<=10%	Jun-25	10.7%	10.5%				
	TRUST	Monthly (In Arrears)	Sickness Absence	<=5.0%	May-25	4.9%	5.2%				
	TRUST	Monthly (In Arrears)	Sickness Absence Costs		May-25	£1,009,670	£1,026,537				
	TRUST	Monthly (In Arrears)	Sickness Absence - YTD	<=5.0%	May-25	5.0%	5.1%				
	TRUST	Monthly	Agency Costs	<=£922,333	Jun-25	£984,921	£1,068,736				
	TRUST	Monthly	Core Mandatory Training Compliance for substantive staff	>=85%	Jun-25	97.3%	97.2%				
	TRUST	Monthly	Staff with a Completed Annual Appraisal	>=80%	Jun-25	93.9%	93.2%				
	TRUST	Monthly	% of staff from a BME background	>=22.5%	Jun-25	32.5%	32.3%				
	TRUST	Monthly	Staff flu vaccination rate (frontline healthcare workers)	>=80%							
	TRUST	Monthly	% of staff who have undertaken clinical supervision within the last 3 months	>=85%	Jun-25	94.1%	94.2%				

EXCEPTION REPORT - Adult CMHT Access (Six weeks routine) - Incomplete pathway *(Month in arrears)*

	Target	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
DMH	>=95%	52.0%	54.3%	52.6%	61.2%	64.4%	72.8%	56.1%	45.6%	51.7%	51.1%	56.4%	45.9%



Analytical Commentary

The metric is showing a common cause variation with no significant change. The metric will consistently fail to meet the target as demonstrated by the target line falling above the process limits.

Mean	Lower Process Limit	Upper Process Limit
53.5%	39.0%	68.0%

Operational Commentary (e.g. referring to risk, finance, workforce)

Daily huddles in place in the majority of the Neighbourhood teams. Hub and spoke consulter MDT in place with Community specialist teams connecting with all Neighbourhood teams. Expected outcome is that patients have access to the most appropriate service to meet their needs whilst improving service efficiency. – ongoing

Weekend clinics planned to commence 19/07/25 to support actioning the back log of routine referrals in CAP. Once cleared the routine referrals will be sent directly into the teams for MDT front door as BAU.

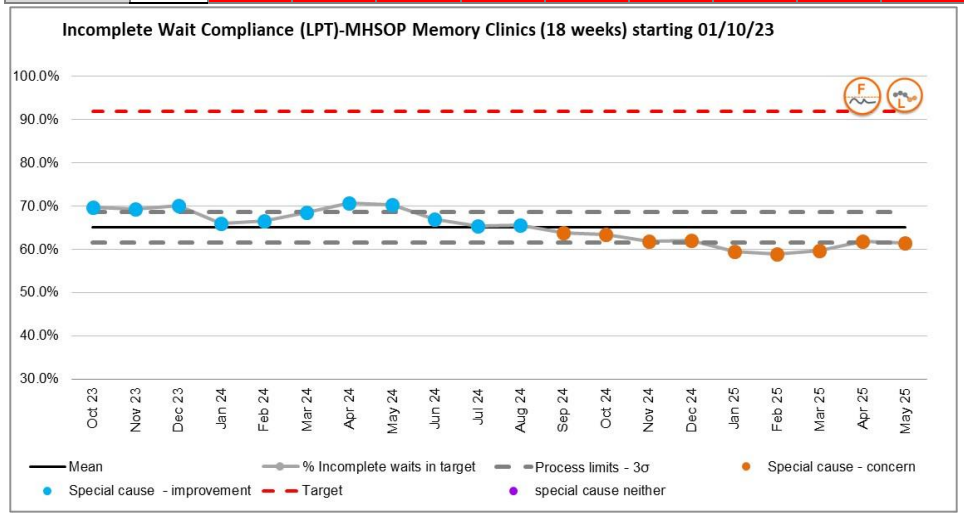
Work continues to progress the caseloads review programme in 2025/26. A Medical workforce transformation action plan has been developed with programmes of work identified to review caseload and patient cohorts in outpatient clinics. Expected outcomes are reduced consultant caseloads to bring these within agreed thresholds which will support increased retention of medical staff and improve patient flow. This is a long term target with a completion date of April 2026. – Positive results In Melton AMH with a 47% discharge rate of those cases reviewed. Meeting arranged for 28/07 to commence this in City East AMH. Both teams have started this work from the longest overdue recall pt.

Further work is underway to ensure that there is appropriate clinical pathways for those patients identified in the OPD caseloads who are on Clozapine or require a depot to ensure they have timely access to their treatment. This is being led by the Head of Nursing and should be completed by the end of July 2025.

Continued recruitment to Consultant posts with the aim to increase capacity.

EXCEPTION REPORT - MHSOP - Memory Clinics (18 weeks local RTT) - Incomplete pathway *(Month in arrears)*

	Target	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
DMH	>=92%	66.9%	65.4%	65.5%	63.9%	63.4%	61.9%	62.1%	59.4%	58.9%	59.7%	61.9%	61.5%



Analytical Commentary

The metric is showing a special cause variation of a concerning nature due to lower values. The metric will consistently fail to meet the target as demonstrated by the target line falling above the process limits.

Mean	Lower Process Limit	Upper Process Limit
65.1%	61.0%	69.0%

Operational Commentary (e.g. referring to risk, finance, workforce)

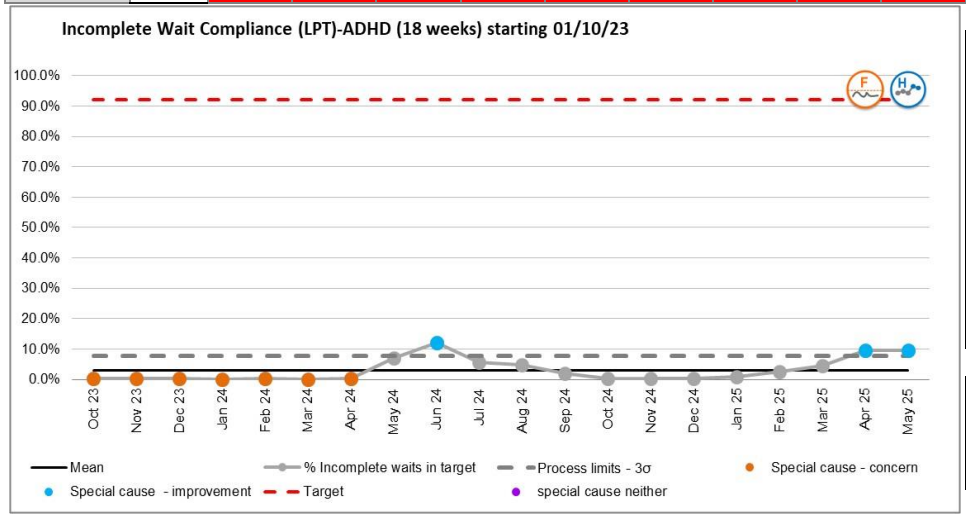
Plan to implement rapid access clinics between now and June 25 is going well, noted improvement in numbers waiting and length of wait where patients diagnosed in fast access clinics.

Meeting arranged with business team to work on capacity and demand in rapid access clinics in context of no opportunity to provide any weekend assessment slots in 2025/26. Team Lead/Manager feedback that clinical team are fully engaged, morale is high, and this has increased productivity and flow.

Work underway to triage waiting list and identify those for advanced dementia pathway which will enable a shortened assessment and more timely diagnosis. Proposal presented to FPP and approved at DMT 09/07/25. Community Manager and Matron to action by 01/09/25.

EXCEPTION REPORT - ADHD (18 weeks local RTT) - Incomplete pathway *(Month in arrears)*

	Target	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
DMH	>=92%	12.0%	5.6%	4.9%	2.0%	0.2%	0.4%	0.3%	0.9%	2.5%	4.5%	9.5%	9.6%



Analytical Commentary

The metric is showing special cause variation of an improving nature due to higher values. The metric will consistently fail to meet the target as demonstrated by the target line falling above the process limits.

Mean	Lower Process Limit	Upper Process Limit
3.0%	-2.0%	8.0%

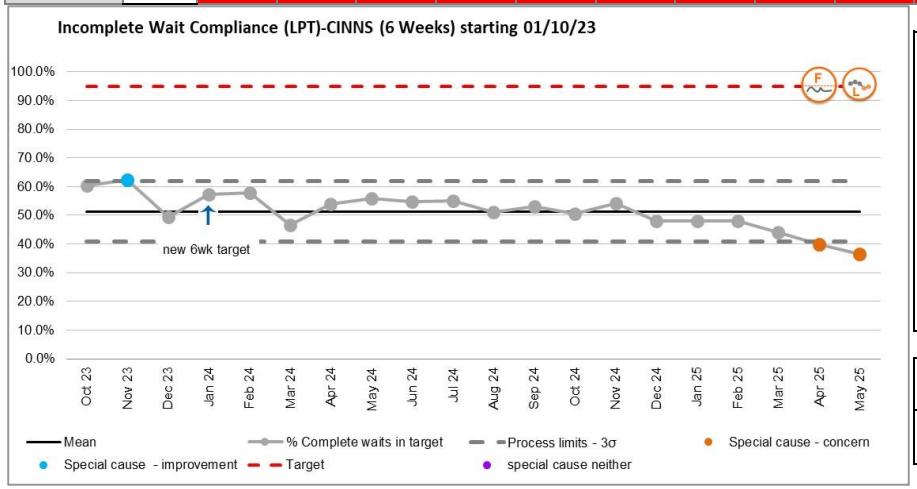
Operational Commentary (e.g. referring to risk, finance, workforce)

An options appraisal has been presented to EMB, further work continues on feasibility of the long term options. Expected outcomes are to develop a more efficient pathway with shorter waits for assessment and treatment, ensuring patients are sign posted to the most appropriate service to meet their needs. Long term action. A new group has been established following System Exec sign off co-chaired by DMH Exec Director and ICB Associate Director to oversee workstreams to take forward transformation of the Adult ADHD pathway which includes increasing productivity (reviewing other service models), development and implementation of Right to Choose framework for LPT, devise a training package for GPs and LPT staff, become an accredited provider of ADHD training in the East Midlands, procurement of replacement service for ADHD Solutions and Communications.

Continue to monitor ADHD medication supply issues and impact on waiting times / capacity. Expected outcomes are to understand the impact on treatment waits within the service. Some medications are now coming back into stock although some shortages are likely to continue until October 2025. Ongoing monitoring of the medication supply in place, seems to be improving.

EXCEPTION REPORT - CINSS (6 weeks) - Incomplete pathway *(Month in arrears)*

	Target	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
CHS	>=95%	54.8%	55.0%	51.1%	53.1%	50.5%	54.1%	48.0%	48.1%	47.9%	44.0%	39.9%	36.6%



Analytical Commentary

The metric is showing a special cause variation of a concerning nature due to lower values. The metric will consistently fail to meet the target as demonstrated by the target line falling above the process limits.

Mean	Lower Process Limit	Upper Process Limit
51.4%	41.0%	62.0%

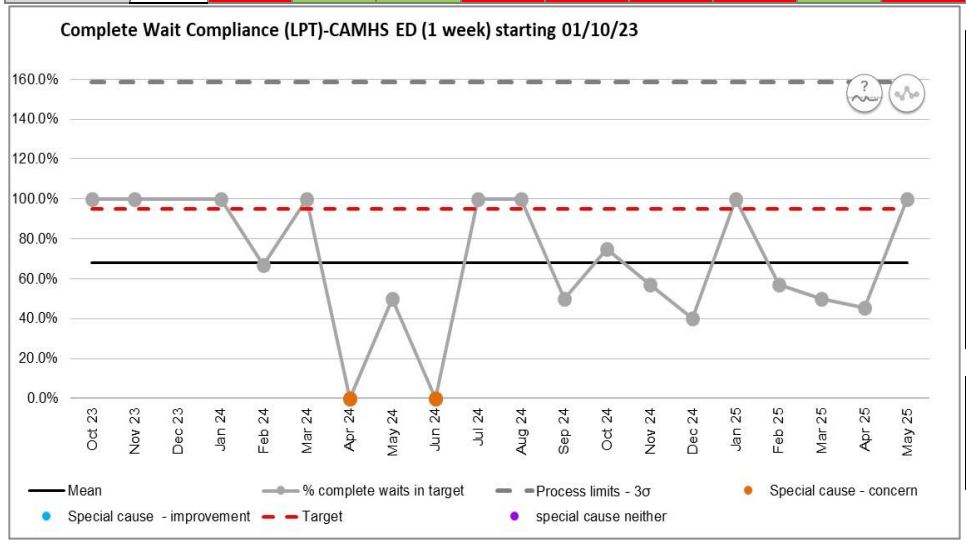
Operational Commentary (e.g. referring to risk, finance, workforce)

Key actions
1. Action: Benchmarking against similar organisations with Stroke/neuro services in the community
Impact: Comparison of service provision and identification of alternative options for referral and caseload management
Timeline: September 2025
2. Action: Service deep dive efficiency and productivity review
Impact: Identify areas for efficiencies and improved productivity to improve compliance with wait times targets
Timeline: October 2025
3. Action: Review of travel time/documentation time allocation through the use of digital solutions (ISLA appa, S1 functionality/templates, Ambient scribe, HiMail – currently being scoped)
Impact: Improvements in efficiency and time allocation
Timeline: January 2026
4. Action: Review of holistic assessment process Impact:
Reduction in time required to complete documentation, so increasing service capacity
Timeline: December 2025
5. Action: Recruit to vacancies and consider skill mix opportunities if posts cannot recruited to
Impact: Increased capacity
Timeline: December 2025
6. Action: Right staff : right job – clinical co-ordination of care responsibilities. Impact: Clinical time focussed on stroke/neuro specialism
Timeline: July 2025
7. Action: Staffing review following benchmarking findings
Impact: Right skill mix

EXCEPTION REPORT - CAMHS Eating Disorder (one week - urgent pathway) - Complete pathway *(Month in arrears)*

	Target	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
FYPCLDA	>=95%	0.0%	100.0%	100.0%	50.0%	75.0%	57.1%	40.0%	100.0%	57.1%	50.0%	45.5%	100.0%

NB. Blank cells = no patients waiting



Analytical Commentary

The metric is showing a common cause variation with no signficant change. There is no assurance that the metric will consistently achieve the target and is showing a common cause variation.

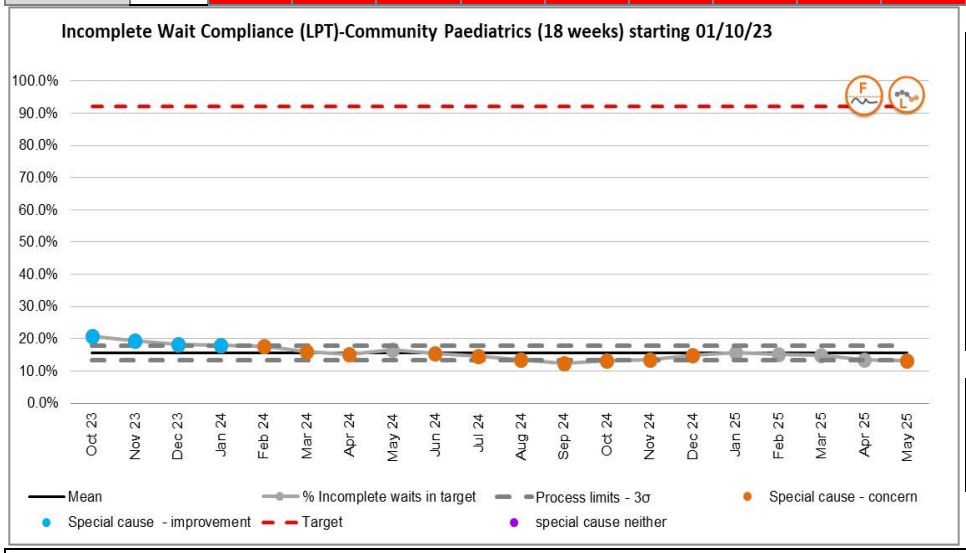
Mean	Lower Process Limit	Upper Process Limit
68.0%	-22.0%	158.0%

Operational Commentary (e.g. referring to risk, finance, workforce):

A recovery plan with a 3-month timescale to clear the backlog on the assessment waiting list and ensure continued processes for maintaining the KPI targets has been developed and presented at DMT, and submitted to NHS England on 7th May 2025. This includes increasing assessment capacity by stepping down non-essential clinical work alongside re-organising job plans/ clinical duties. The service also evaluating the assessment/treatment pathways and processes using learning from other regional CAMHS ED teams. This has supported 100%C achievement of the target in June 2025.

EXCEPTION REPORT - Community Paediatrics Assessment (18 weeks) - Incomplete pathway *(Month in arrears)*

	Target	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
FYPCLDA	>=92%	15.4%	14.5%	13.4%	12.5%	13.2%	13.4%	14.8%	15.6%	15.2%	15.0%	13.6%	13.2%



Analytical Commentary

The metric is showing a special cause variation of a concerning nature due to lower values. The metric will consistently fail to meet the target as demonstrated by the target line falling above the process limits.

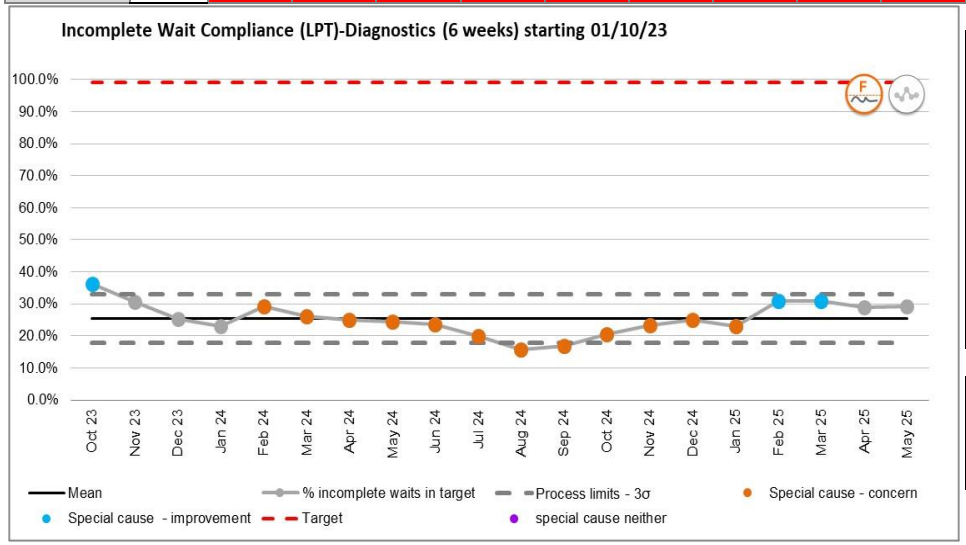
Mean	Lower Process Limit	Upper Process Limit
15.6%	13.0%	18.0%

Operational Commentary (e.g. referring to risk, finance, workforce):

This is a multidisciplinary pathway (with a multi-referral point for access). The KPI is directly impacted by ND waits. Triage system in place based on clinical acuity and safe caseload management. ND precommitment monies have enabled some clinicans to be on boarded to support increased activity and flow. Majority of CYP waiting are for neurodevelopmental assessment, the service continues to prioritise referrals at triage as urgent or routine with urgent patients offered appointments within 18 weeks. Service is part of urgent system work to understand and mitigate the impact of the closure of ADHD Solutions who were contracted to provide pre-diagnositic support for CYP on the ND waiting list. Service leadership seeking to steer developments. Webinar for outcome of benchmarking was attended by service and DMT leadership on 26/06/25. SBARs being produced by service outlining impact of national changes on the service - genetic testing process and FASD task force - these are scheduled for CYP PG in July to ensure the System is aware of impact on capacity of the service.

EXCEPTION REPORT - Childrens Audiology (6 week wait - diagnostic procedure) - Incomplete pathway *(Month in arrears)*

	Target	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
FYPCLDA	>=99%	23.7%	20.0%	15.7%	16.9%	20.4%	23.3%	24.9%	23.0%	31.0%	30.8%	29.0%	29.2%



Analytical Commentary

The metric is showing a common cause variation with no significant change. The metric will consistently fail to meet the target as demonstrated by the target line falling above the process limits.

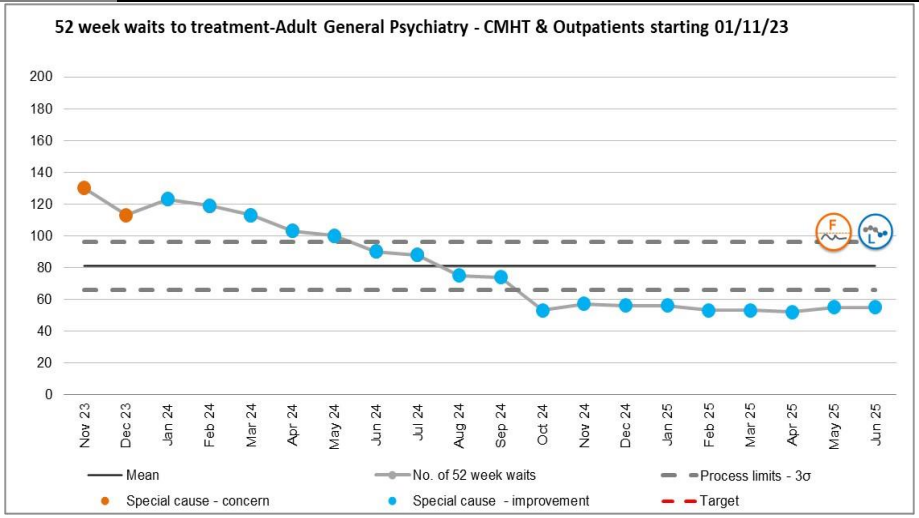
Mean	Lower Process Limit	Upper Process Limit
25.4%	18.0%	33.0%

Operational Commentary (e.g. referring to risk, finance, workforce):

The service remains fragile. System level assurance and governance group remains active, conversations ongoing and progressing around a future direction of service provision. Strategy and Partnerships now supporting the meeting. Waiting list validation ongoing with a focus on mitigation lists. Service currently has no over 52 week waiters, priority being given to patients with longest waits to maintian this position. Still off planned trajectory with narrative provided to ICB / NHSE to explain variance, as well as resubmission of trajectory (with no change to milestones). Planned milestones being met at refurbished estate at Beaumont Leys and plans progressing for refurbishment at Hynca Lodge. Meetings ongoing with ICB re updating service specification. Agreement to extend contract of Health Now to continue to deliver weekend clinics owing to variance to trajectory, as well as agreement for spend on bank agency to deliver joint UHL Super Sundays. Clinical leadership has also stepped down, actions underway to ensure continued safety and replacement. Actions underway to respond to historic incident and investigation.

EXCEPTION REPORT - Adult General Psychiatry - Community Mental Health Teams and Outpatients (treatment) - No of waiters over 52 weeks

	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
DMH	0	90	88	75	74	53	57	56	53	53	52	55	55



Analytical Commentary

The metric is showing a special cause variation of an improving nature due to lower values. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

Mean	Lower Process Limit	Upper Process Limit
80.9	65.6	96.2

Operational Commentary (e.g. referring to risk, finance, workforce):

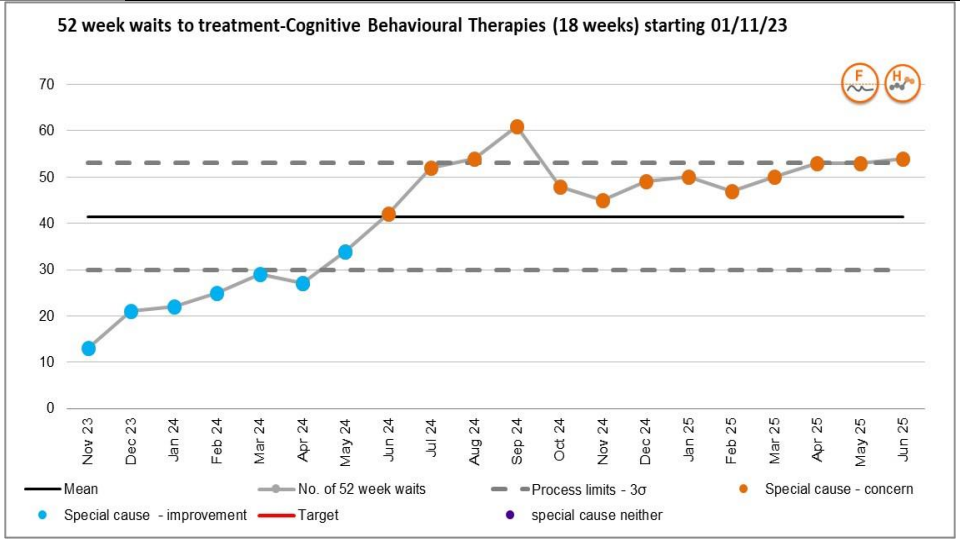
The longest waits for treatment remain focused around psychology and outpatients (medical staff).

Psychology
Identified longer waits in 4 specific teams due to periods of minimal staffing. As a result of recruitment initiatives resource has increased and the number of patients waiting are projected to reduce with agreed targets in place, all patients breaching 52 weeks estimated to be seen by November 2025 at the latest.
The waiting list for each team is reviewed monthly through the Patient Tracker protocol, providing oversight and explanation. Monthly focused performance meeting to scrutinise data and plan actions.
New ways of discussing cases with psychological professions, e.g. Consulter MDT, facilitate better ways of considering needs and mitigate against excessive referrals to psychology.
All patients on the psychology waiting list have a risk management plan in place, and wider team support appropriate to the level of need.

Outpatients
The longest waits for outpatient appointments are due to limitations in medical capacity.
Substantive recruitment to Consultant posts progressing. Expected outcome is increased capacity and improved consistency of care for patients. Recruitment is ongoing.
Work continues to progress the new ways of working which positively impact on wait times. Caseloads review programme - expected outcomes are reduced consultant caseloads to bring these within agreed thresholds which will support increased retention of medical staff and improve patient flow.

EXCEPTION REPORT - Cognitive Behavioural Therapy (treatment) - No of waiters over 52 weeks

	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
DMH	0	52	54	61	48	45	49	50	47	50	53	53	54



Analytical Commentary

The metric is showing a special cause variation of a concerning nature due to higher values. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

Mean	Lower Process Limit	Upper Process Limit
41.5	29.8	53.1

Operational Commentary (e.g. referring to risk, finance, workforce)

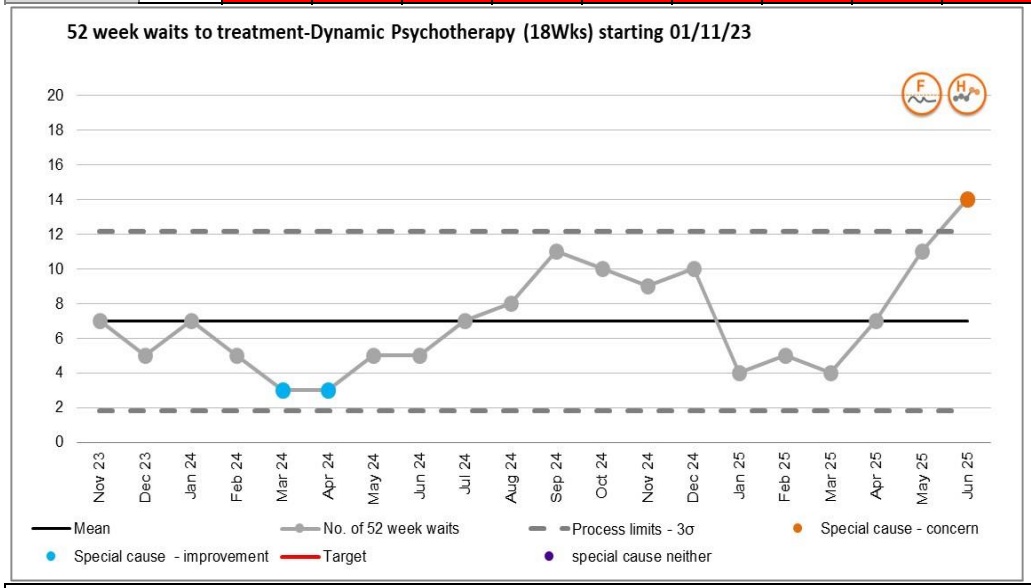
The CBT service continues to target efforts to reduce DNA rates for assessment appointments as a service priority and will require continued cooperation from Neighbourhood teams, setting expectations for patients referred to CBT.

The service is using a new process to reduce the overall number of patients in assessment and also held on the assessment waiting list which continues to work well.

CBT now has representation at all of the neighbourhood mental health team's psychological consulter meetings and contribute to clinical discussions on formulation and psychological interventions which reduces the numbers of referrals for people not ready or able to be helped by a CBT intervention.

EXCEPTION REPORT - Dynamic Psychotherapy (treatment) - No of waiters over 52 weeks

	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
DMH	0	7	8	11	10	9	10	4	5	4	7	11	14



Analytical Commentary

The metric is showing a special cause variation of a concerning nature due to higher values The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

Mean	Lower Process Limit	Upper Process Limit
7.0	1.82	12.18

Operational Commentary (e.g. referring to risk, finance, workforce)

Referrals remain high with caseload review work in CMHTs contributing to this increase in referrals.

Patients with longest waits for treatment are those waiting for individual psychotherapy and MBTi group.

The longest waiters for individual treatment have waited longer than average because of particular requirements (therapist/slot availability), some now have dates to begin therapy.

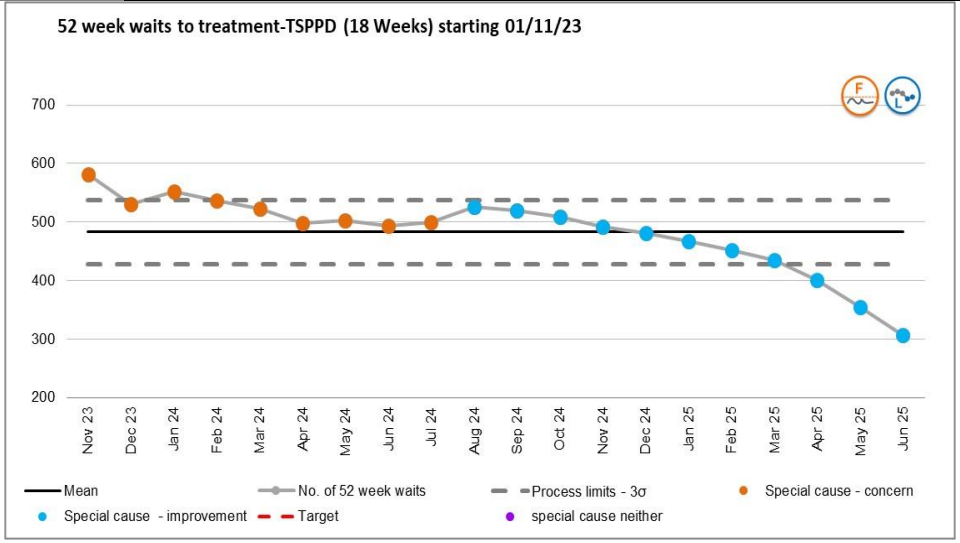
The MBTi waiters waiting over 52 weeks are mainly those offered a start date but could not join group offered initially and therefore need to wait for another group to begin. Team planning extra MBTi group to accommodate increase in people waiting. Action due to be completed by end of August 2025.

Planning to start a new analytic group which will increase capacity. Action due to be completed end of August 2025.

Recruitment to 1.0 WTE vacancy in progress with expected outcome of increasing capacity to reduce the waiting list.

EXCEPTION REPORT - Therapy Service for People with Personality Disorder (treatment) - No of waiters over 52 weeks

	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
DMH	0	499	526	520	509	492	481	467	451	435	401	355	307



Analytical Commentary

The metric is showing a special cause variation of an improving nature due to lower values. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

Mean	Lower Process Limit	Upper Process Limit
483.0	428.1	537.9

Operational Commentary (e.g. referring to risk, finance, workforce)

Development of consultation and training support to community services to enhance the primary care offer (small scale). Advertising 2 x 8a Psychologist posts. Long term action due October 2025 with the expected outcome to provide support to primary care to prevent referrals for low level support entering secondary care services.

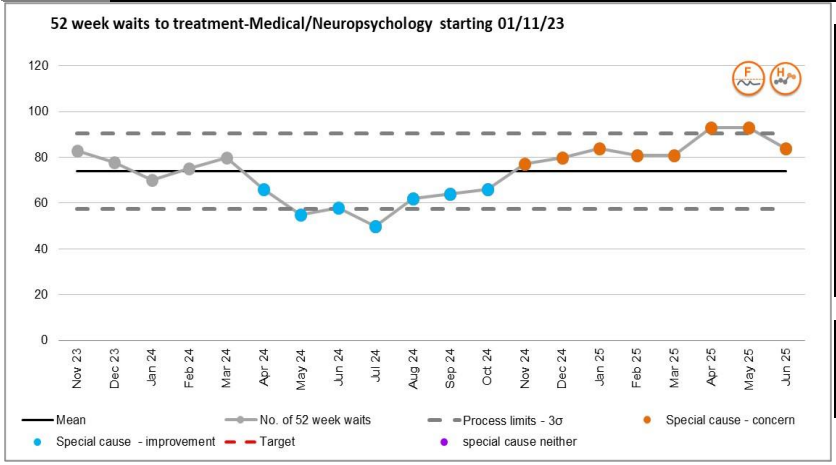
All TSPPD referrals to come through neighbourhood teams with agreed directorate wide secondary care referral criteria with support in place during the transition period. TSPPD Specialist Consulter weekly meeting to continue and will manage TSPPD referrals. Expected outcome is reduced waiting time for secondary mental health input as we focus on severity of need best served, work in progress to assess impact and agree next steps.

Agree a clinical model for current TSPPD waiting list and governance processes and establish target date to begin full implementation. Expected outcome will be improved service offer, increased efficiency, and reduced waits. Expected completion date December 2025.

New neighbourhood team clinical model to be tailored to meet the needs of those with personality difficulties. Meetings in place to take forward. Plan to develop a model for working with people with moderate personality disorders within neighbourhood teams, work underway to review progress and agree next steps.

EXCEPTION REPORT - Medical/Neuropsychology (treatment) - No of waiters over 52 weeks

	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
DMH	0	50	62	64	66	77	80	84	81	81	93	93	84



Analytical Commentary

The metric is showing a special cause variation of a concerning nature due to higher values The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

Mean	Lower Process Limit	Upper Process Limit
74.0	57.6	90.4

Operational Commentary (e.g. referring to risk, finance, workforce)

Medical Psychology

There continue to be long waits for general medical psychology (approx. 52 weeks) and pain psychology (about 104 weeks).There are no waits for assessment and treatment within the specialisms with dedicated funding. Although high demand in the renal service risks growing waits going forward.

Appointed two psychologists to cancer posts and should help reduce some of the pressure on the general medical team, as these referrals currently sit there and often need priority support
Two meetings with the UHL Pain Service to consider how to progress and manage the high level of referrals. A new capacity and demand summary being prepared, highlighting the gap in staffing funded to meet demand.
There are ongoing discussions with high referrers within UHL to think about alternative ways to manage these waits.

Neuropsychology 52 weeks

On trajectory for waiting time in adult neuropsychology to continue to reduce. All patients waiting longer than 52 weeks have been offered appointments – there maybe some outliers unable to attend because of ill health/medical treatments, however, the average wait time is now under 52 weeks.

8b roles has been recruited to and starting to see patients which will reduce the waiting time.

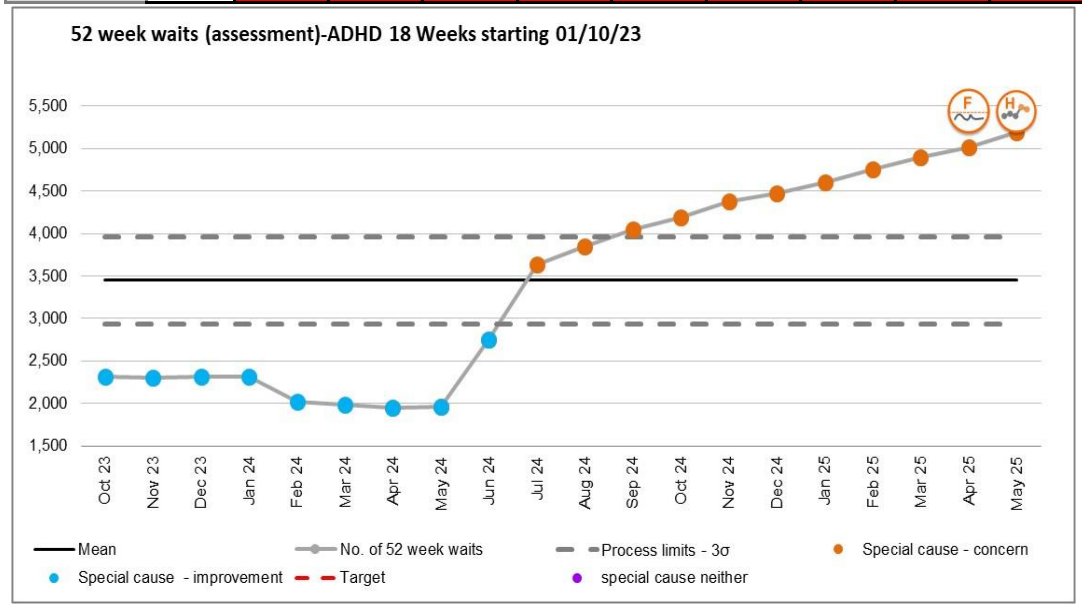
Assistant Psychologist has been providing telephone triage to support waiting list validation, contact is being made with those on the waiting list for over 6 months to ensure treatment remains relevant. Ensuring the waiting list is an accurate illustration of those who still wish to access the service, reducing DNAs and cancellations. The Assistant Psychologist who has been supporting this work is due to leave post in August, awaiting confirmation of recruitment to the post via workforce control meeting. If this post is not recruited to this will impact qualified staff clinical capacity.

Repeat assessments to be offered by Assistant Psychologists if clinically suitable to reduce the need for qualified appointments from 2 appts to 1 appt. As above, current postholder leaving in August and will need replacing or there will be an impact on qualified staff clinical capacity.

Joint Medical Psychology and Neuropsychology Action - Monthly complex case discussions with staff in NHS Talking Therapies (VITA Minds) to facilitate and support people to be seen in the most appropriate services, reduce duplication of work. Ongoing QI project. At the end of a 6 month pilot evaluation – to review data and continue to provide. Data has been reviewed and work is ongoing with Vita Minds

EXCEPTION REPORT - ADHD 18 weeks (assessment) - No of waiters over 52 weeks *(Month in arrears)*

	Target	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
DMH	0	2749	3638	3851	4051	4193	4372	4467	4607	4757	4898	5014	5190



Analytical Commentary

The metric is showing special cause variation of a concerning nature due to higher values. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

Mean	Lower Process Limit	Upper Process Limit
3446.9	2935.9	3957.9

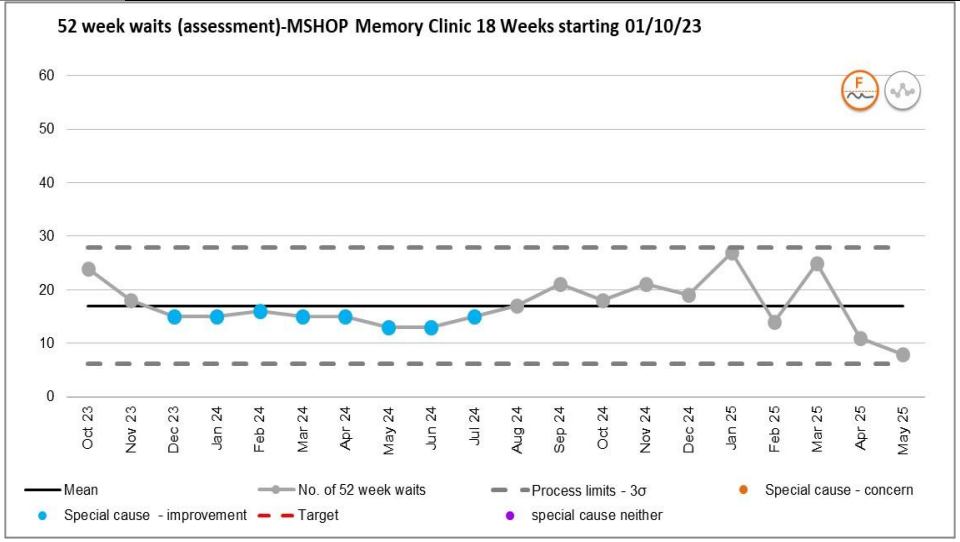
Operational Commentary (e.g. referring to risk, finance, workforce)

An options appraisal has been presented to EMB, further work continues on feasibility of the long term options. Expected outcomes are to develop a more efficient pathway with shorter waits for assessment and treatment, ensuring patients are sign posted to the most appropriate service to meet their needs. Long term action. A new group has been established following System Exec sign off co-chaired by DMH Exec Director and ICB Associate Director to oversee workstreams to take forward transformation of the Adult ADHD pathway which includes increasing productivity (reviewing other service models), development and implementation of Right to Choose framework for LPT, devise a training package for GPs and LPT staff, become an accredited provider of ADHD training in the East Midlands, procurement of replacement service for ADHD Solutions and Communications.

Continue to monitor ADHD medication supply issues and impact on waiting times / capacity. Expected outcomes are to understand the impact on treatment waits within the service. Some medications are now coming back into stock although some shortages are likely to continue until October 2025. Ongoing monitoring of the medication supply in place, seems to be improving.

EXCEPTION REPORT - MHSOP Memory Clinics 18 week local RTT (assessment) - No of waiters over 52 weeks *(Month in arrears)*

	Target	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
DMH	0	13	15	17	21	18	21	19	27	14	25	11	8



Analytical Commentary

The metric is showing a common cause variation with no significant change. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

Mean	Lower Process Limit	Upper Process Limit
17.0	6.1	27.9

Operational Commentary (e.g. referring to risk, finance, workforce)

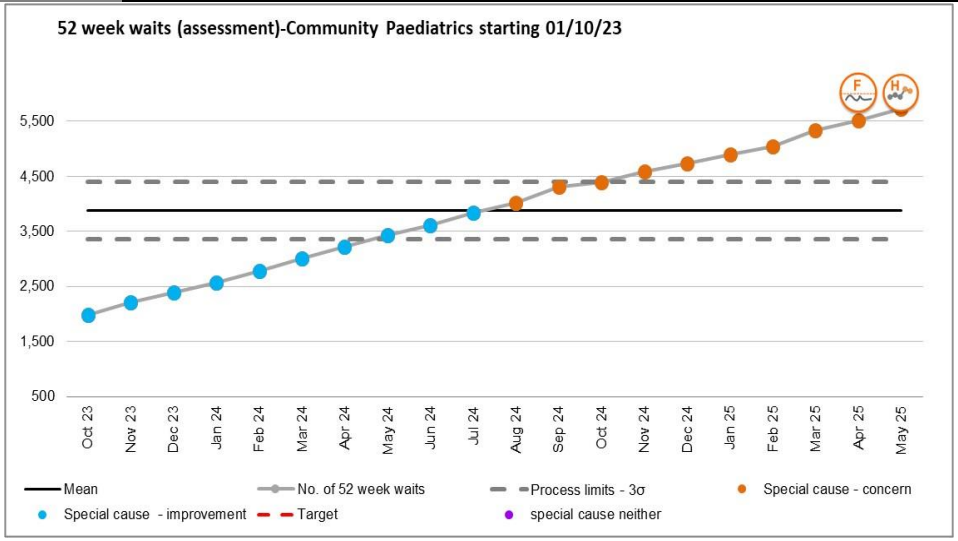
Plan to implement rapid access clinics between now and June 25 is going well, noted improvement in numbers waiting and length of wait where patients diagnosed in fast access clinics.

Meeting arranged with business team to work on capacity and demand in rapid access clinics in context of no opportunity to provide any weekend assessment slots in 2025/26. Team Lead/Manager feedback that clinical team are fully engaged, morale is high, and this has increased productivity and flow.

Work underway to triage waiting list and identify those for advanced dementia pathway which will enable a shortened assessment and more timely diagnosis. Proposal presented to FPP and approved at DMT 09/07/25. Community Manager and Matron to action by 01/09/25.

EXCEPTION REPORT - Community Paediatrics (assessment) - No of waiters over 52 weeks *(Month in arrears)*

	Target	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
FYPCLDA	0	3618	3846	4017	4303	4392	4586	4740	4895	5044	5335	5509	5723



Analytical Commentary

The metric is showing special cause variation of a concerning nature due to higher values. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

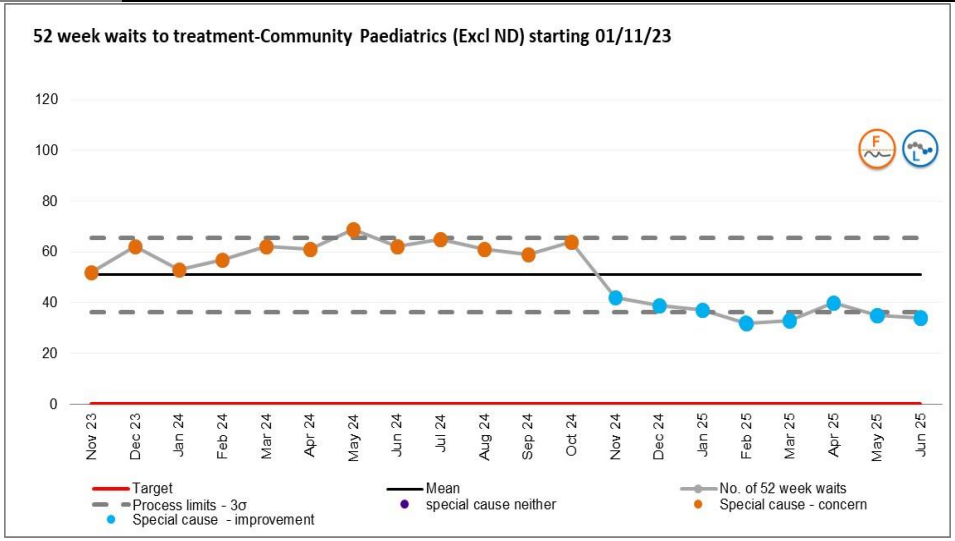
Mean	Lower Process Limit	Upper Process Limit
3880.9	3357.67	4404.03

Operational Commentary (e.g. referring to risk, finance, workforce):

These numbers continue to include a small number of 'core' waits but are largely CYP awaing an ND assessment. Service utilised additional investment (2024/25) to recruit ADHD nurses, SALT and psychology support to release capacity to enable paediatricians to focus on new referrals. The investment is expected to slow down rate of increase but will not reverse the trend of increase in numbers waiting over 52 weeks with some CYP now waiting over 3 years. With this skill mix, we will continue to review and revise the assessment pathways for ASD/ADHD. Referral demand continues at a high level in line with the national picture and exceeds the capacity of the service. The service continues to prioritise referrals at triage as urgent or routine with those classified as urgent offered appointments within a maximum of 18 weeks. The service is working with the System to understand and mitigate the impact of the closure of ADHD Solutions with some limited alternative options now in place. A targeted transformation workstream mobilisation will give closer focus to work underway and drive transformation at pace. Benchmarking webinar scheduled for 26/06/25 and outcomes form this and the outcomes of the national ADHD taskforce will be guide transformation objectives. Working with NHFT to understand and share learning from within Group.

EXCEPTION REPORT - Community Paediatrics (Excl ND) (treatment) - No of waiters over 52 weeks

	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
FYPCLDA	0	65	61	59	64	42	39	37	32	33	40	35	34



Analytical Commentary

The metric is showing a special cause variation of an improving nature due to lower values. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

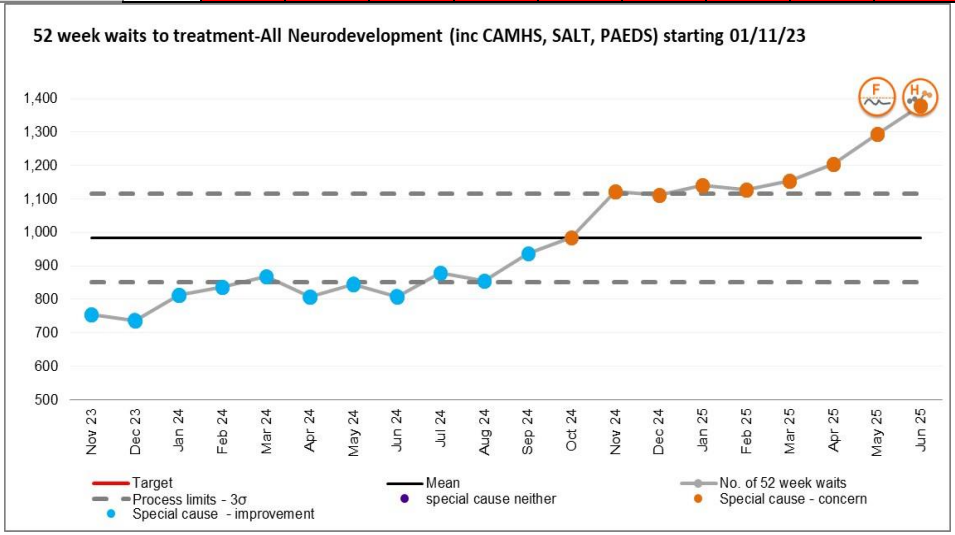
Mean	Lower Process Limit	Upper Process Limit
51.0	36.4	65.5

Operational Commentary (e.g. referring to risk, finance, workforce):

Patients are intertwined with some ND related concerns (SALT, EP, School Observations, etc). Actions underway to ensure effective use of job plans (at individual clinician level) and slot utilisation to minimise numbers going forward.

EXCEPTION REPORT - All Neurodevelopment (inc CAMHS, SALT, PAEDS) (treatment) - No of waiters over 52 weeks

	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
FYPCLDA	0	879	855	937	985	1121	1113	1140	1128	1155	1205	1294	1378



Analytical Commentary

The metric is showing special cause variation of a concerning nature due to higher values The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

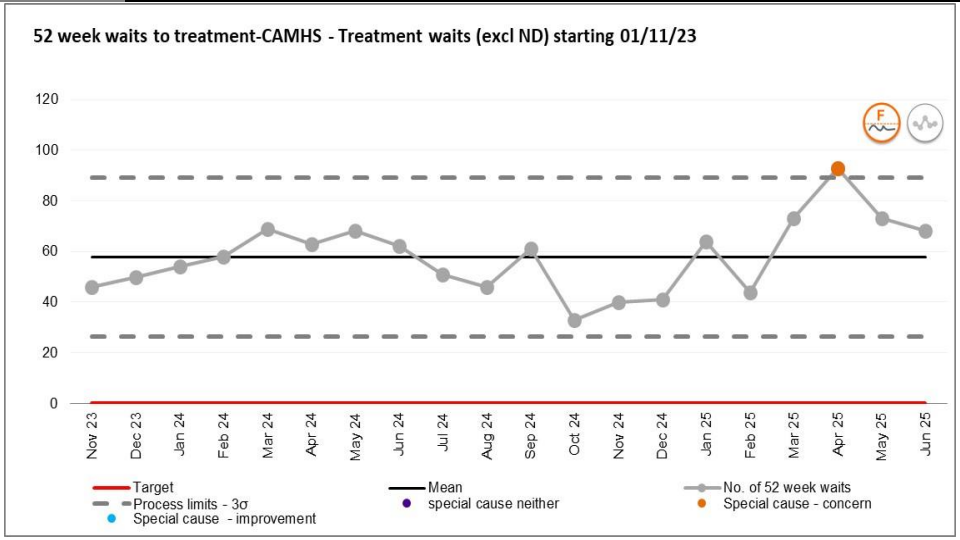
Mean	Lower Process Limit	Upper Process Limit
982.9	851.0	1114.7

Operational Commentary (e.g. referring to risk, finance, workforce):

This tab pulls together all CYP waiting for further intervention for ND post assessment in either community paediatrics or CAMHS. CYP with complex needs i.e. where there are comorbidities will remain on the appropriate specialist lists. Numbers waiting continue to increase as demand outstrips capacity. CYP are provided with advice on where to seek support and advice whilst waiting (including VCS options) as well as options for escalation should there be a change in presentation. PTLs are in place to ensure effective oversight of the waiting list and any changes in priority or status are actioned promptly. Due to the numbers waiting PTL a focus on those waiting longest. Work continues with the ICB to develop a broader, system based approach to ND, recognising that addressing the demand and creating capacity impacts across health, education and social care.

EXCEPTION REPORT - CAMHS (excl ND)(treatment) - No of waiters over 52 weeks

	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
FYPCLDA	0	51	46	61	33	40	41	64	44	73	93	73	68



Analytical Commentary

The metric is showing a common cause variation with no significant change. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

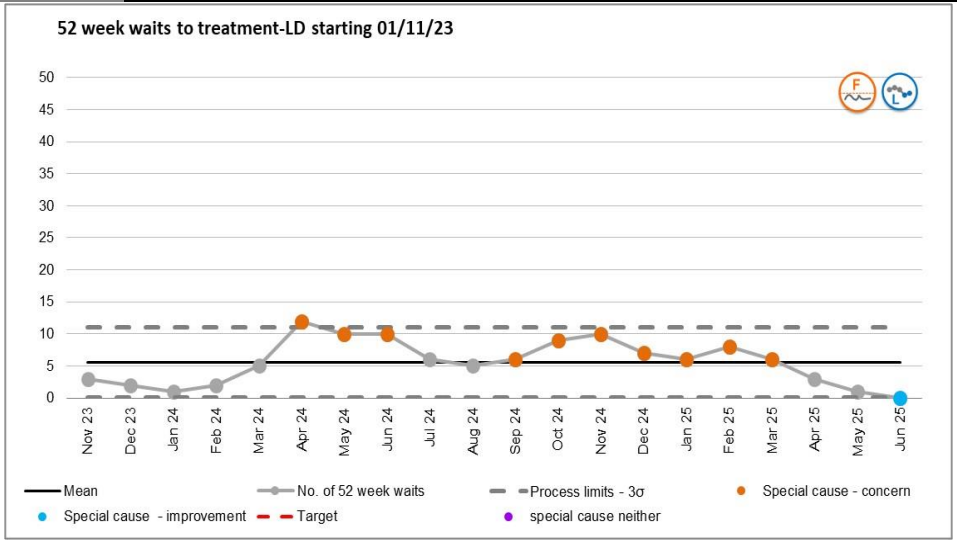
Mean	Lower Process Limit	Upper Process Limit
57.9	26.5	89.2

Operational Commentary (e.g. referring to risk, finance, workforce):

Update on two core actions: 1. Service to monitor longest waiters internally via PTL weekly and monthly meeting between CTL and FSM for more in-depth oversight and allocation, psychiatric opinions have pre-booked appointments with onboarding of new medic this will lead to a reduction in the current waiting list. In terms of treatment waiting list, deep dive into cases was undertaken with some safely removed, with cases allocated to APs and 15 cases identified for CBT. 2. Each service to ensure specific slots allocated to those waiting over 52 weeks, oversight and governance for this is being monitored through the Group 1 weekly performance meeting with the extended leadership team. This is a live position, numbers will fluctuate.

EXCEPTION REPORT - LD&A (treatment) - No of waiters over 52 weeks

	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
FYPCLDA	0	6	5	6	9	10	7	6	8	6	3	1	0



Analytical Commentary

The metric is showing a special cause variation of an improving nature due to lower values. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

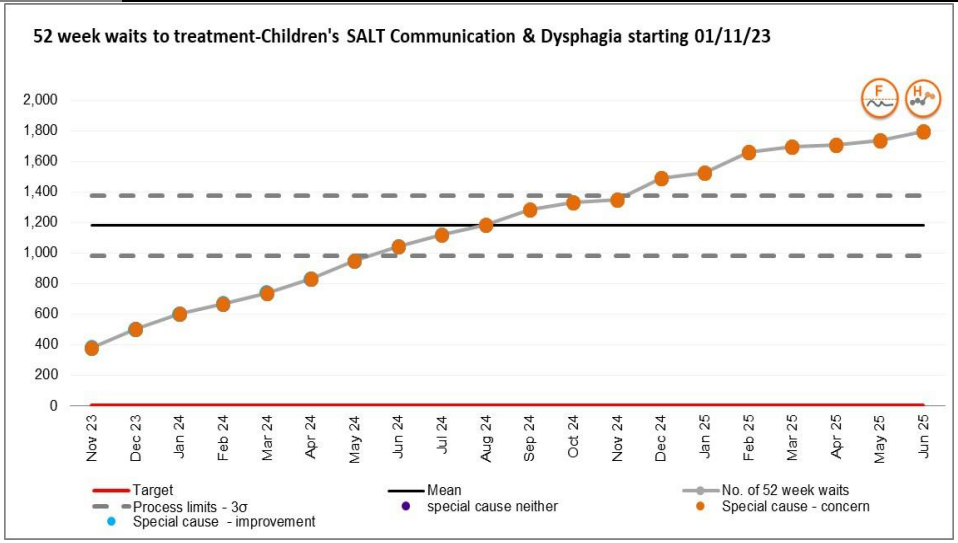
Mean	Lower Process Limit	Upper Process Limit
5.6	0.1	11.1

Operational Commentary (e.g. referring to risk, finance, workforce):

0 52 week waits. Successful recruitment in March to 0.48b and 1 wte B7/8a preceptorship. Vacancy for 0.4 wte B7/8a preceptorship has been advertised twice without applications – team considering future options. Plan: to improve patient flow by implementing 18-week therapeutic break pathway model/process mapping/cause and effect work; onboarding of new recruits.

EXCEPTION REPORT - Children's SALT Communication & Dysphagia (treatment) - No of waiters over 52 weeks

	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
FYPCLDA	0	1117	1181	1284	1328	1346	1489	1524	1661	1692	1704	1734	1794



Analytical Commentary

The metric is showing special cause variation of a concerning nature due to higher values. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

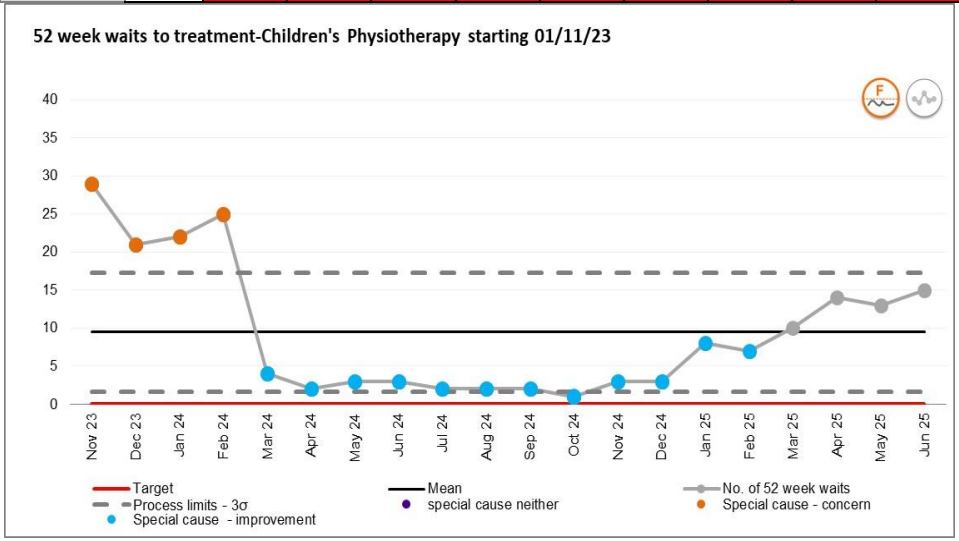
Mean	Lower Process Limit	Upper Process Limit
1177.8	979.65	1375.85

Operational Commentary (e.g. referring to risk, finance, workforce):

Updated service specification and referral guidelines launched to reinforce the Speech and Language Therapy Service at a specialist level and support referrals to be made to the most appropriate agency .
Early Language Support for Every Child (ELSEC) pathway in place to support mild-moderate SLCN from initial referral, part of SEND and Alternative Programme Change Programme funded by DfE and NHSE.
Development of time limited episodes of care for mild-moderate clinical needs, to support flow through the service.
Weekly patient tracking list and performance tracking meetings.
Robust digital offer to support families and settings whilst CYP are waiting.
SLCN "toolkit" of supporting resources and training offer will ensure skilled universal and targeted levels of a balanced system for SLCN across LLR.
Robust demand and capacity modelling, and monitoring of job plans and activity data.
Group and 1:1 listening opportunities for staff to share opportunities for improvement and raise any concerns.
Evidence-based competency and training framework for support workers and newly qualified staff.
Detailed action plan in place for next steps - shared with CYP Partnership Group in June 2025 and to be shared with ADG August 2025.

EXCEPTION REPORT - Children's Physiotherapy (treatment)- No of waiters over 52 weeks

	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
FYPCLDA	0	2	2	2	1	3	3	8	7	10	14	13	15



Analytical Commentary

The metric is showing a common cause variation with no significant change. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

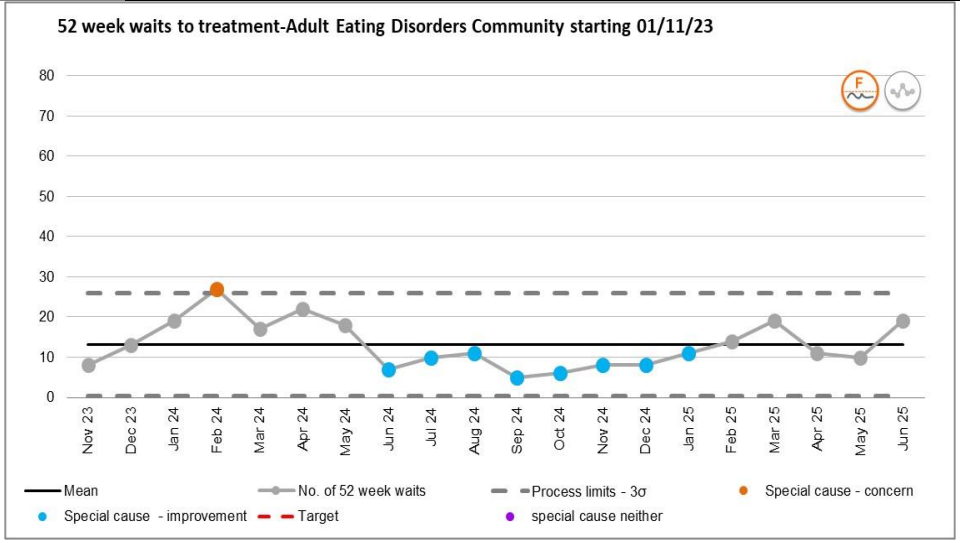
Mean	Lower Process Limit	Upper Process Limit
9.5	1.6	17.3

Operational Commentary (e.g. referring to risk, finance, workforce): 15 CYPs waiting over 52 weeks:

All 15 CYPs waiting over 52 weeks are for a joint tone management appointment with community paediatrics. Awaiting capacity from Comm Paeds team. Quality Improvement Project commenced to support options for long term intervention for these CYP. Advice sought from ADG on reporting of joint waits to avoid risk of double countiing.

EXCEPTION REPORT - Adult Eating Disorders Community (treatment) - No of waiters over 52 weeks

	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
FYPCLDA	0	10	11	5	6	8	8	11	14	19	11	10	19



Analytical Commentary

The metric is showing a common cause variation with no significant change. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

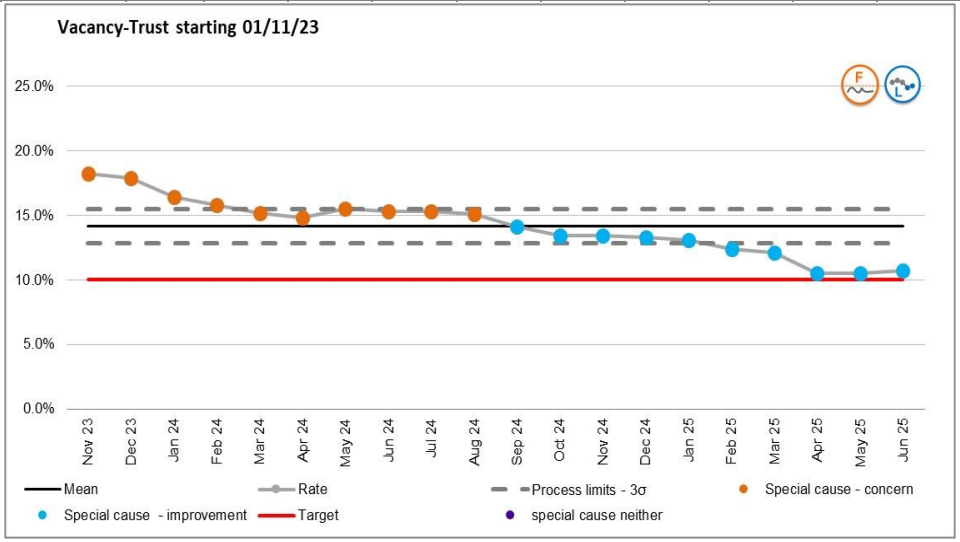
Mean	Lower Process Limit	Upper Process Limit
13.2	0.41	25.89

Operational Commentary (e.g. referring to risk, finance, workforce):

19 patients waiting over 52 weeks. Patients are being reviewed as wait is >52 weeks despite having completed Guided Self Help (GSH). Service to review application of clock stop whree GSH recommended to ensure appropriate and accurate measurements of wait. The service continues to utilise the LPT Access policy to ensure patients are being reviewed in terms of wait after 2 reasonable offers. All patients are now offered My Guidance at first offer of support / information giving. Those who are not taking this offer up are being reviewed by assessors and may be discharged. Some have also been offered transfer to First Steps, who are commissioned to provide interventions to under-25s, but have declined this option and next steps are being considered.

EXCEPTION REPORT - Vacancy Rate

	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
TRUST	<=10%	15.3%	15.1%	14.1%	13.4%	13.4%	13.3%	13.1%	12.4%	12.1%	10.5%	10.5%	10.7%
DMH		17.4%	16.5%	17.2%	16.4%	15.9%	15.7%	16.4%	15.5%	14.9%	13.2%	13.4%	13.8%
CHS		15.9%	16.1%	15.4%	14.1%	13.4%	13.1%	12.9%	12.4%	12.8%	11.0%	10.2%	9.7%
FYPCLDA		14.9%	14.7%	13.3%	13.0%	13.9%	14.2%	12.7%	11.9%	11.3%	9.0%	9.0%	9.9%



Analytical Commentary

The metric is showing special cause variation of an improving nature due to lower values. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

Mean	Lower Process Limit	Upper Process Limit
14.2%	13.0%	15.0%

Operational Commentary (e.g. referring to risk, finance, workforce)

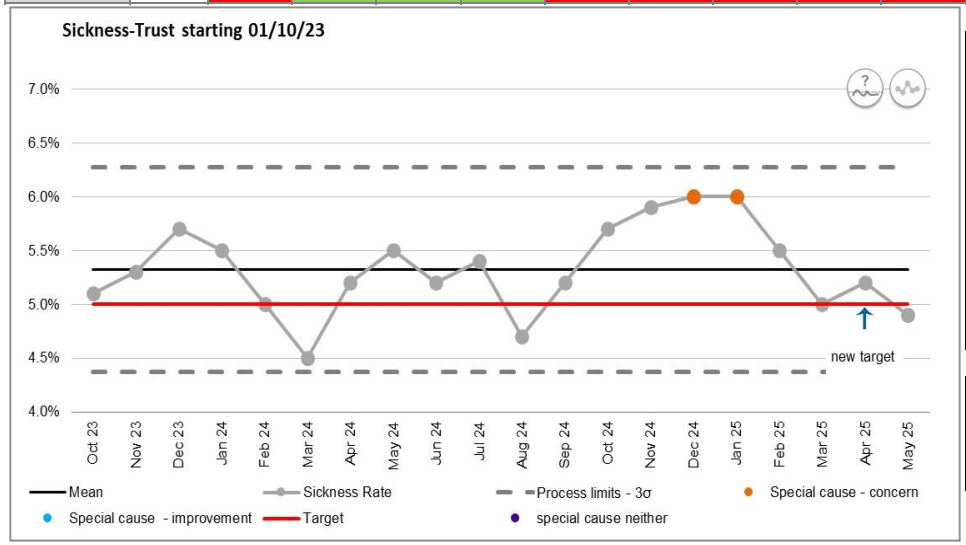
For Jun-25, the Trust vacancy rate remains the same as the previous month. The number of staff in post reduced during in this month, but the budgeted establishment also reduced resulting in no change to the percentage.

During 2025-26 our workforce plan shows a reduction in the vacancy rate from the 2024/25 outturn position of 12.1% down to 9.9% by year end. This work is overseen by the Agency Reduction Group and Workforce Development Group which report into People and Culture Committee.

BAF4.1 - 1 If we do not adequately utilise workforce resourcing strategies, we will have poor recruitment, retention and representation, resulting in high agency usage.

EXCEPTION REPORT - Sickness Absence *(Month in arrears)*

	Target	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
TRUST	<=5.0%	5.2%	5.4%	4.8%	5.2%	5.7%	5.9%	6.0%	6.0%	5.5%	5.0%	5.2%	4.9%
DMH		5.9%	6.6%	6.2%	6.4%	6.8%	6.4%	6.3%	7.1%	6.4%	5.7%	6.1%	5.1%
CHS		5.8%	5.9%	5.1%	5.7%	6.2%	6.7%	6.9%	6.7%	5.8%	5.2%	5.3%	5.5%
FYPCLDA		4.5%	4.4%	3.8%	4.3%	5.0%	5.6%	5.5%	5.2%	5.1%	4.6%	4.6%	4.3%



Analytical Commentary

The metric is showing a common cause variation with no significant change. There is no assurance that the metric will consistently achieve the target and is showing a common cause variation.

Mean	Lower Process Limit	Upper Process Limit
5.3%	4.0%	6.0%

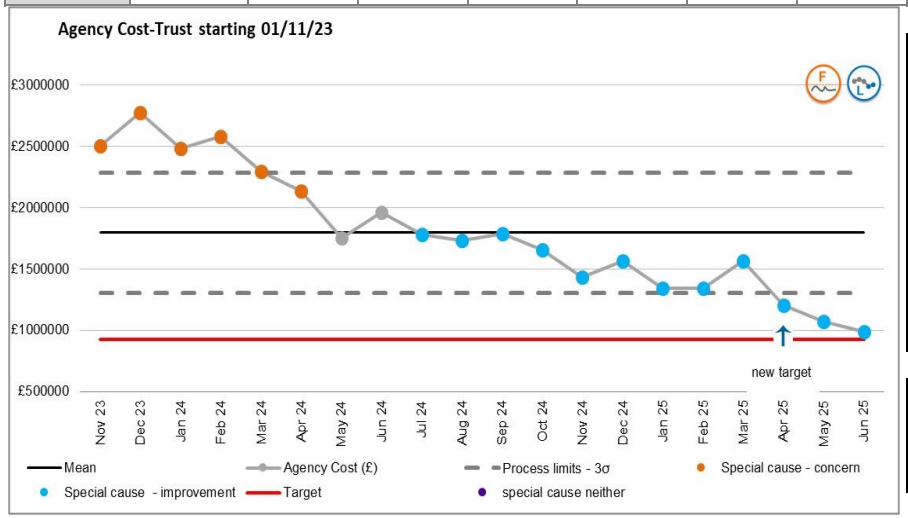
Operational Commentary (e.g. referring to risk, finance, workforce)

LPT are committed to providing a safe and healthy working environment and to promoting the wellbeing of its staff. Research suggests that work is essential in promoting good health, wellbeing and self-esteem. The Trust recognises the importance of having a robust policy that encourages staff to maintain good physical and mental health and facilitates staff to return to work following a period of either a short or long-term sickness. The target for 2025/26 is to have a YTD sickness absence rate of no more than 5.0%.

Data on sickness absence is shared at operationally on a monthly basis and high-level reports monitoring trends and patterns are provided to Workforce Development Group. Concerns are escalated to Trust Board via People and Culture Committee.

EXCEPTION REPORT - Agency Costs

	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
TRUST	<=£922,333	£1,960,763	£1,781,388	£1,733,239	£1,790,193	£1,652,392	£1,430,863	£1,563,021	£1,339,895	£1,564,366	£1,202,759	£1,068,736	£984,921
DMH		£810,906	£744,967	£700,309	£699,373	£662,096	£613,750	£570,697	£512,094	£876,766	£615,701	£585,755	£548,266
CHS		£902,070	£844,311	£728,299	£796,173	£726,933	£645,533	£779,216	£653,190	£538,428	£446,756	£353,928	£301,236
FYPCLDA		£193,354	£182,845	£280,540	£252,964	£273,926	£175,987	£197,407	£159,573	£143,524	£134,518	£123,986	£129,128



Analytical Commentary

The metric is showing special cause variation of an improving nature due to lower values. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

Mean	Lower Process Limit	Upper Process Limit
1796552.7	1305779.8	2287325.6

Operational Commentary (e.g. referring to risk, finance, workforce)

Planned agency spend for 2025-26 is £11,068,000. The planned spend for each month shows a month-on-month decrease as actions to reduce the volume and cost of agency use come to fruition. However for this purposes of the report, the target shown is the total planned spend divided equally across the 12 months. Reductions in agency spend over the last 12 months have been driven by a reduced need for agency staff and reductions to the rates payable to agency staff. Plans are in place for 2025/26 to enable us to continue to reduce agency spend. This work is overseen by the Agency Reduction Group and Workforce Development Group which report into People and Culture Committee.

BAF4.1 - 1 If we do not adequately utilise workforce resourcing strategies, we will have poor recruitment, retention and representation, resulting in high agency usage.

SPC Business Rules

Assurance: Failing

Assurance	Variation	Understanding the Icons	Business Rule
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.	Metric is expected to consistently Fail the Target and is showing a Special Cause for Concern. An exception page is required on the Board Performance Report to support actions and delivery of a performance improvement.
		Common Cause - no significant change. Assurance indicates consistently (F)ailing the target.	Metric is expected to consistently Fail the Target and is showing Common Cause variation. An exception page is required on the Board Performance Report to support actions and delivery of a performance improvement.
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.	Metric is expected to consistently Fail the Target and is showing a special cause variation for improvement. An exception page is required on the Board Performance Report to support actions and delivery of a performance improvement.

SPC Business Rules

Assurance: Hit and Miss

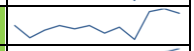
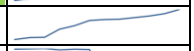
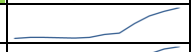
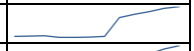
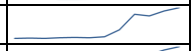
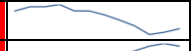
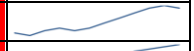
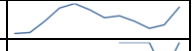
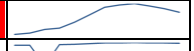
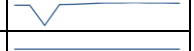
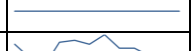
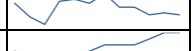
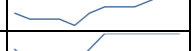
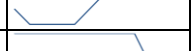
Assurance	Variation	Understanding the Icons	Business Rule
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates the metric may achieve or fail the target due to random variation.	There is no assurance that the metric will consistently achieve the target and is showing a Special Cause for Concern. Metric to be monitored at Directorate Performance Reviews.
		Common Cause - no significant change. Assurance indicates the metric may achieve or fail the target due to random variation.	There is no assurance that the metric will consistently achieve the target and is in Common Cause Variation. Metric to be monitored at Directorate Performance Reviews.
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates the metric may achieve or fail the target due to random variation.	There is no assurance that the metric will consistently achieve the target and is showing a Special Cause for Improvement. Metric to be monitored at Directorate Performance Reviews.

SPC Business Rules

Assurance: Achieving

Assurance	Variation	Understanding the Icons	Business Rule
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates consistently (P)assing the target.	Metric is expected to consistently Achieve the Target and is showing a Special Cause for Concern. Metric to be monitored at Directorate Performance Reviews.
		Common Cause - no significant change. Assurance indicates consistently (P)assing the target.	Metric is expected to consistently Achieve the Target and is showing Common Cause variation. Metric to be monitored at Directorate Performance Reviews.
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (P)assing the target.	Metric is expected to consistently Achieve the Target and is showing a special cause variation for improvement. Metric to be monitored at Directorate Performance Reviews.

Appendix - Mental Health Core Data Pack

Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline
MHSDS 72hr Follow-Up - LLR		Apr-25	86.0%	84.0%	
MHSDS 72hr Follow-Ups - LPT	>=80%	Apr-25	90.0%	87.0%	
MHSDS CMHealth 2+ Contacts - LLR	6979	Apr-25	14830	14905	
MHSDS CMHealth 2+ Contacts - LPT		Apr-25	14755	14860	
MHSDS CMH referrals-spells waiting for a full clock stop - LLR		Apr-25	9740	12245	
MHSDS CMH referrals-spells waiting for a full clock stop - LPT		Apr-25	9670	12195	
MHSDS CMH referrals-spells waiting more than 104 weeks for a 2nd contact - LLR		Apr-25	235	270	
MHSDS CMH referrals-spells waiting more than 104 weeks for a 2nd contact - LPT		Apr-25	220	250	
MHSDS open CMH referrals-spells waiting for a 2nd contact - LLR		Apr-25	3350	3375	
MHSDS open CMH referrals-spells waiting for a 2nd contact - LPT		Apr-25	3330	3345	
MHSDS CYP 1+ Contacts - LLR	17745	Apr-25	18565	18745	
MHSDS CYP 1+ Contacts - LPT		Apr-25	10370	9925	
MHSDS CYP referrals-spells waiting for a full clock stop - LLR		Apr-25	5960	8620	
MHSDS CYP referrals-spells waiting for a full clock stop - LPT		Apr-25	5540	8060	
MHSDS CYP referrals-spells waiting more than 104 weeks for a 1st contact - LLR		Apr-25	635	625	
MHSDS CYP referrals-spells waiting more than 104 weeks for a 1st contact - LPT		Apr-25	615	605	
MHSDS open CYP CMH referrals-spells waiting for a 1st contact - LLR		Apr-25	2105	2535	
MHSDS open CYP CMH referrals-spells waiting for a 1st contact - LPT		Apr-25	1940	2250	
MHSDS CYP ED Routine (Interim) - LLR		Apr-25	21.0%	24.0%	
MHSDS CYP ED Routine (Interim) - LPT	>=95%	Apr-25	21.0%	22.0%	
MHSDS CYP ED Urgent (Interim) - LLR		Apr-25	48.0%	57.0%	
MHSDS CYP ED Urgent (Interim) - LPT	>=95%	Apr-25	48.0%	60.0%	
MHSDS EIP 2 Week Waits - LLR		Apr-25	60.0%	50.0%	
MHSDS EIP 2 Week Waits - LPT	>=60%	Apr-25	61.0%	52.0%	
MHSDS Individual Placement & Support (IPS, Rolling 12 month) - LLR	752	Apr-25	800	735	
MHSDS Individual Placement & Support (IPS, Rolling 12 month) - LPT		Apr-25	800	745	
OAPs Bed Days (inappropriate only) - LLR		Apr-25	595	435	
OAPs Bed Days (inappropriate only) - LPT		Apr-25	405	290	
OAPs active at the end of the period (inappropriate only) - rolling quarter - LLR		Apr-25	5	5	
OAPs active at the end of the period (inappropriate only) - rolling quarter - LPT		Apr-25	5	5	
MHSDS Perinatal Access - (Rolling 12 month) - LLR	1259	Apr-25	1225	1200	
MHSDS Perinatal Access - (Rolling 12 month) - LPT		Apr-25	1220	1210	
MHSDS Restrictive Interventions per 1000 bed days - LLR		Apr-25	-	-	
MHSDS Restrictive Interventions per 1000 bed days - LPT		Apr-25	24	19	
MHSDS - Data Quality Consistency - LLR		Apr-25		92.0%	
MHSDS - Data Quality Consistency - LPT		Apr-25		100.0%	
MHSDS - Data Quality Coverage - LLR		Apr-25		83.0%	
MHSDS - Data Quality Coverage - LPT	>=98%	Apr-25		100.0%	
MHSDS - Data Quality DQMI - LLR		Jan-25	54.2%	49.4%	
MHSDS - Data Quality DQMI - LPT	>=95%	Jan-25	92.0%	93.0%	
MHSDS - Data Quality Outcomes - LLR		Apr-25		23.0%	
MHSDS - Data Quality Outcomes - LPT	>=50%	Apr-25		23.0%	
MHSDS - Data Quality SNoMED CT - LLR		Apr-25	95.0%	95.0%	
MHSDS - Data Quality SNoMED CT - LPT	>=100%	Apr-25	100.0%	100.0%	

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Leicestershire Partnership NHS Trust

3As Highlight Report
Meeting Name Charitable Funds Committee:
Meeting Chair & Report Author: Faisal Hussain, Chair
Meeting Date: Relating to Committee meetings that took place on 18.03.2025 and 26.06.2025
Quorate: Y

Agenda Item Title:	Minute Reference:	Lead:	Description:	BAF Ref:	CRR Ref:	Directorate Risk Ref:
ALERT: Alert to matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the Trust's strategy						
None						
ADVISE: Advise the Board of areas subject to on-going monitoring or development or where there is negative assurance						
None						
ASSURE: Inform the Board where positive assurance has been received						
Quarterly Finance Report including Pipeline Report, investment performance & legacies (18.3.25)	CFC/25/009	Jackie Moore	• The financial position up to 31 December 2024 was reviewed. • The overall fund balance for Quarter 3 closed at £2.56m. • Total cumulative income is £295k, comprising of real income of £275k, and unrealised investment gains of £20k. • Realised income of £130k was generated in Quarter 3, which was above previous quarterly trends.			
Review of Fundraising Strategy and Annual Priorities Review of Strategic Priorities (26.6.25)	CFC/25/020	Magdalena Korytkowska	This document outlines how the strategic direction for Raising Health can be strengthened to align with our new Group THRIVE strategy. The Committee welcomed this paper as it shows how Raising Health are supporting the Trust to deliver the Thrive strategy.			
Approval of Investment Strategy (26.6.25)	CFC/25/021	Jackie Moore	The Raising Health Investment Strategy provides the framework for the management of Investment Assets of Raising Health. The Committee received the strategy and noted the contents within the strategy.			
Annual review of the effectiveness of the	CFC/25/022	Faisal Hussain	The Committee noted the review of the effectiveness of the Committee and approved the Terms of Reference subject to one			

Committee, review of the Terms of Reference, approval of the annual work plan and review of Committee membership for submission to AAC (26.6.25)			addition. The Fundraising Manager was added to list of those attendees for CFC meetings.			
Quarterly Finance Report including Pipeline Report, investment performance & legacies (26.6.25)	CFC/25/024	Jackie Moore	• The financial position up to 31 March 2025 was reviewed. • The final overall fund balance for Quarter 4 closed at £2.41m. • Total cumulative income is £284k, comprising of real income of £345k. • The top three income sources made up 70% of the total realised income, and related to lottery income (£89k), dividends (£82k) and foundation and grant applications (£71k). • The closing cash balance at the end of the year is £492k. • For 2024/25, we had a planned income of £343k, but we received £344k thanks to the hard work from Lorraine Newstead and Magdalena Korytkowska.			
AOB - Opening of a new bank account (26.6.25)	CFC/25/030	Jackie Moore	• To protect more of the charity's cash under the Financial Services Compensation Scheme (FSCS), it was agreed to open a new bank account which would bring the total of the charity's cash protected under the scheme to £170k and generate additional interest income. • Under the SFIs and Treasury management policy, the Director of Finance has responsibility for opening bank accounts, Trust Board has responsibility for approving the banking arrangements.			
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding						
Updated Raising Health Strategic Plan on a Page 2025 (18.3.25)	CFC/25/004	Kamy Basra	Chair noted that the level of alignment with our strategic objectives and as LPT as a Trust has significantly improved due to the great work of Magdalena Korytkowska, Adele Stacy, Kamy Basra, Jackie Moore and Lorraine Newstead. We have continued to grow in both our reach and income and also the impact we are making as a charity.			

Promoting Charitable Funds and Delivering the Strategy: Fundraising Managers' Report (18.3.25)	CFC/25/007	Kamy Basra	• New document called 'Raising Health Business Partnership Opportunities Document'. • Sponsorship Opportunities Document. This is a document created for the celebrating excellence awards and long service awards to secure sponsors. • Staff members continue to sign up to the staff lottery scheme. • We continue to receive funds for the Flow Headsets as they have been a great success. • Team Time Out – this initiative has been well received by staff.			
Promoting Charitable Funds and Delivering the Strategy: Fundraising Managers' Report (26.6.25)	CFC/25/023	Magdalena Korytkowska	• There has been a significant improvement to our webpage visitors (1000 more in comparison to this time last year and 500 more in comparison to the last reported period). • Raising Health has been visible on the professional business network on sector and national level. • A new Trusts and Foundations Lead has been appointed. • Lets Get Gardening appeal at Bradgate Unit has been completed. • We have focused on the celebrating excellence and long service awards over the last 3 months. We have secured £14k from the joint sponsorship across both events so far. There were new categories introduced this year at the long service awards so there were three events instead of one. Both awardees and sponsors have given positive feedback on how great the long service awards were.			

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Leicestershire Partnership NHS Trust

3As Highlight Report
Meeting Name: People and Culture Committee (PCC)
Meeting Chair & Report Author: Manjit Darby, Non-Executive Director
Meeting Date: 11 June 2025
Quorate: Yes

Agenda Item Title:	Minute Reference:	Lead:	Description:	BAF Ref:	CRR Ref:	Directorate Risk Ref:
ALERT: Alert to matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the Trust's strategy						
ADVISE: Advise the Board of areas subject to on-going monitoring or development or where there is negative assurance						
AFM Triple A Summary	PCC/25/53	JK	Report received with positive progress on many areas, community nursing recruitment, EDI ambassadors and reduction of agency in community beds. Mandatory training local level compliance is an area of focus but assurance is good on oversight			
Workforce Development Group Triple A	PCC/25/51		Numbers of DNA's for training is being monitored and will continue to monitor Training nonattendance to ensure maximum capacity is utilised.			
ASSURE: Inform the Board where positive assurance has been received						
Workforce Development Group Triple A	PCC/25/51		Report received good assurance on occupational health referral timescales reduction and recruitment timescales.			
Our People Data M1	PCC/25/50	NW	Received the report providing oversight of all people data metrics and tracking of our progress against the workforce and agency reduction plan. New format and oversight well received with good assurance noted.			
Employee Relations Update	PCC/25/50	CT	Received the report in the revised format which includes tracking casework of staff from an ECM background to identify are disproportionate issues. Case work remain high additional capacity has been allocated to the tea. New format and oversight well received with good assurance noted.			
Policy Progress Report	PCC/25/57	KD	Good assurance received with all policies in date.			
Developing Workforce Safeguards Compliance	PCC/25/59	EW	Approved the self-assessment and requirement for submission to NHSE. Good assurance received.			

Medical Job Planning Improvement Programme	PCC/25/63	BC	Paper on medical job planning improvement programme received agreed to review progress through workforce development group and highlight areas of concerns on progress.			
GROUP Update OD / TAR	PCC/25/56	SW	Received presentation on the Group OD joint working group which also incorporates together against racism work. Good assurance on work plan for the group agreed to bring through joint board at some point.			
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding						
Celebrating Excellence Nominations	PCC/25/61	SW	Over 240 celebrating excellence nominations received. Getting ready for long service awards with additional categories this year which again has sponsorship. Comms, OD, fundraising and volunteering team thanked for their assistance with putting the events together.			