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Leicestershire Partnership NHS Trust

Trust Board Public Meeting – 30th September 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:	Date of Annual Declaration:
Angela Hillery CEO	Hospitality - APNA	3935	14.09.23	21st July 2025
	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	
	Loyalty Interest - Member of Advisory Group supporting NHSE- led by Sam Allen CEO (Management and leadership)	6046	30.10.24	
	Loyalty Interest - Member of RCSLT Senior Leaders Network	6357	01.05.25	

Board Member:	Current Declarations:	Declaration Reference:	Date Interest Arose:	Date of Annual Declaration:
	Loyalty Interest - Invited to be part of CQC/NHSP Trust Well Led Reference Group	6433	21.07.25	
	Loyalty Interest - Member of Royal College of Speech & Language Therapists	6434	21.07.25	
	Loyalty Interest - Executive Reviewer for Care Quality Commission	6435	21.07.25	
	Hospitality - Royal Society of Medicine Travel expenses	6436	22.07.25	
Jean Knight Deputy CEO/Managing Director	Loyalty Interests – Northamptonshire Street Pastors	3664	01.04.23	2nd April 2025
	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	3rd April 2025
	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	13th April 2025
	Outside Employment – Washwood Heath Multi Academy Trust	3097	04.09.23	
Liz Anderson NED	Outside Employment – University of Leicester Professor	4285	12.09.23	15th May 2025
Josie Spencer NED	Outside Employment – Staffordshire & Stoke on Trent ICB	3649	01.05.23	8th April 2025
	Loyalty Interests – Leicestershire Police	5584	01.04.24	
Manjit Darby NED	Outside Employment – Magistrate – Leicester Court	5589	01.04.24	8th April 2025
	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	

Board Member:	Current Declarations:	Declaration Reference:	Date Interest Arose:	Date of Annual Declaration:
Faisal Hussain NED	Loyalty Interests – Raising Health Charity	3200	01.07.22	8th April 2025
	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	
Melanie Hall Associate NED	Outside employment - Synlab plc and Mid & South Essex NHS FT - Chair	6362	01.05.25	15th May 2025
	Outside employment - Northamptonshire Healthcare NHS FT	6363	01.04.25	
Kate Dyer Director of Governance	Nil Declaration	6300	NA	9th April 2025
David Williams Director of Strategy and Partnerships	Outside Employment – Northamptonshire Healthcare NHS Foundation Trust	3137	01.04.22	2nd April 2025
	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	2nd April 2025
Sam Leak Director of Community Health Services	Loyalty Interest – NHFT	3730	03.08.23	14th May 2025
	Loyalty Interest – Age UK Northamptonshire	3729	01.04.23	
Tanya Hibbert Director of Mental Health	Nil Declaration	6197	NA	2nd April 2025
Sharon Murphy Director of Finance	Loyalty Interest – Raising Health	5570	01.04.24	2nd April 2025
	Loyalty Interest – Husband works at Northampton ICB	6437	25.07.25	

Board Member:	Current Declarations:	Declaration Reference:	Date Interest Arose:	Date of Annual Declaration:
James Mullins Interim Director of Nursing	Nil Declaration	6359	NA	15th May 2025
Bhanu Medical Director	Outside Employment	4046	01.11.23	9th September 2025
	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	16th May 2025
	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 30th September 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):	Kay Rippin Deputy Trust Secretary 18th September 2025 NA

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	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
29th July 2025 commencing at 9.30am
Meeting held virtually via MS Teams

Present:
Crishni Waring, Chair
Faisal Hussain, Non-Executive Director/Deputy Chair
Josie Spencer, Non-Executive Director
Melanie Hall, Non-Executive Director
Hetal Parmar, Non-Executive Director
Liz Anderson, Non-Executive Director
Jean Knight, Managing Director/Deputy Chief Executive
Sharon Murphy, Director of Finance
Bhanu Chadalavada, Medical Director

In Attendance:
Emma Wallis, Deputy Director of Nursing (on behalf of James Mullins)
Sam Leak, Director of Community Health Services
Tanya Hibbert, Director of Mental Health
Sarah Willis, Director of Human Resources and Organisational Development
David Williams, Group Director of Strategy and Partnerships
Paul Sheldon, Chief Finance Officer
Kate Dyer, Director of Corporate Governance
Sonja Whelan, Corporate Governance Coordinator (Minutes)

TB/25-6/027	**Apologies for absence** Apologies were noted from Angela Hillery, Manjit Darby, James Mullins and Paul Williams. As this would have been Paul Williams' final Board meeting, the Chair, on behalf of the Board, formally recorded appreciation for his valuable contributions to LPT. Emma Wallis was welcomed to the meeting in her capacity as deputy for James Mullins, along with colleagues from the Speech and Language Team. A warm welcome was also extended to our national graduate trainee, with the hope that observing the meeting proves to be a valuable and insightful experience.
TB/25-6/028	**Community Health Services: Mental Health Services for Older People – Speech and Language Therapy Team** Sam Leak introduced the service presentation for Community Health Services which focussed on a small, bespoke Speech and Language Therapy Team in Mental Health Services for Older People. Representatives in attendance were Rachel Finch (Adult Speech and Language Therapy Clinical Service Lead), Rachel McMurray (Clinical Specialist Speech and Language Therapist/Team Lead) and Sarah Collins

	(Senior Speech and Language Therapist). Rachel Finch provided an overview of the Speech and Language Therapy (SALT) Service within Leicestershire Partnership NHS Trust (LPT) Community Health Services (CHS). The service specialises in the assessment and management of communication, eating, drinking, and swallowing difficulties, primarily resulting from acquired conditions or illnesses. The service comprised of three specialist teams:- Voice, Disfluency and Upper Airways Disorders Team – a small, clinic-based team focussing on vocal strain, vocal nodules, stammering and upper airway respiratory issues. Community Team – the largest of the three teams that support individuals with acquired conditions including stroke, Parkinson's disease, dementia, frailty, and end-of-life care. This team provides services within clinics, patients' homes and community hospital wards across Leicestershire. Mental Health Services for Older People (MHSOP) Team – offers highly specialist support for individuals with dementia and covers MHSOP inpatient wards and provides some specialist outreach into the community. The flexibility within the service was highlighted which allowed staff and patients to move across teams as needed. This approach enhanced staff expertise and ensured patients receive care from the most appropriate clinician without unnecessary referral barriers. It was noted that conditions such as dementia often coexisted with physical illnesses, necessitating a holistic and adaptable clinical approach. Today's presentation focussed on the MHSOP service, a small team of approximately 1.8 WTE, primarily funded for inpatient wards. A pre-recorded presentation was then delivered for Grace Zeid, a new Band 5 Speech and Language Therapist, who worked two days per week at the Evington Centre. At the time of joining, Grace had no prior experience in an inpatient mental health setting and was initially unsure of the scope of the SALT role in this environment. However, she reported that she thoroughly enjoyed working with this client group and highlighted the wide ranging nature of the role which encompassed both communication and eating/drinking support and remarked on the significant impact that speech and language therapy could have on patient wellbeing during inpatient stays. Also emphasised was the importance of discharge planning to ensure continuity of care following discharge from the ward. Sarah Collins then provided an overview of her role, primarily based at the Evington Centre. She expressed her passion for supporting individuals with dementia to live well, particularly during what are often highly distressing periods for patients, their families and carers leading up to admission to MHSOP wards. Sarah explained that behaviours prompting admission were frequently rooted in fear, distress and confusion and it felt a privilege to support individuals during these challenging times with the aim of easing their experiences. Her role combined a person-centred approach with an evidence-based understanding of communication, and through observation

	and interaction, she was able to identify effective ways to support patients in understanding, engaging and expressing their thoughts, feelings and preferences. Whilst the team was small and time constraints could be challenging, she felt the work was highly rewarding and had a supportive multi-disciplinary team in place. Rachel McMurray then continued the presentation with an overview of her role and the development of the service. Rachel had been a qualified Speech and Language Therapist for 20 years and joined the MHSOP team 12 years ago, at which point the role was newly established and the service was in its infancy. Despite the initial challenges, Rachel was welcomed and supported by the adult speech and language therapy team, which she described as instrumental to her clinical development. Rachel's clinical work spanned both the Evington Centre and the outreach service and she also held managerial responsibility. Working with patients and families was described as a privilege in supporting individuals during times of distress and helping them maintain meaningful connections with loved ones. Rachel highlighted her particular interest in the communication aspect of speech and language therapy and valued the opportunities within MHSOP to work with individuals experiencing significant communication impairments. Rachel also shared her longstanding interest in quality improvement and research and had led several quality improvement projects within MHSOP and the broader speech and language therapy service. She was currently working one day per week as an Allied Health Professional (AHP) Research Leader with the Clinical Academic Team. The challenges of working within a small team were acknowledged, particularly the difficulty of balancing multiple responsibilities and the desire to make a meaningful impact. Rachel then described how the MHSOP SALT service covered four wards; two organic wards at the Evington Centre, two functional wards at the Bennion Centre, and a small outreach service. The vast majority of patients at the Evington Centre have various types of dementia which is where most of the team's inpatient work takes place. It was estimated that 982,000 people are living with dementia in the UK (Carnel Farrer, 2024) and as the condition progresses, individuals often rely on non-verbal communication which often leads to frustration and distress, contributing to behaviours such as aggression and agitation. The team routinely screen all new admissions with a dementia diagnosis for communication difficulties; where approximately two-thirds of patients identified as requiring input. While some had mild difficulties, the majority experienced significant challenges in expressing themselves and understanding others. Following screening, the team conduct assessments and develop tailored intervention plans in conjunction with family and carers as they often need to adapt their communication styles to facilitate meaningful interactions. To illustrate the importance of understanding patients' experiences a video was shown from Jean, the partner of a former patient, who shared insights into her partner's communication difficulties and the support provided by the speech and language therapy team, particularly the personalised communication plan which outlined effective strategies and provided details of approaches that might cause distress. Jean found the plan to be clear, accessible and immensely helpful not only for staff but for visitors unfamiliar

with dementia care and, two years later, the plan remained a useful reference.

Rachel McMurray then introduced a further pre-recorded video from Grace Zeid which described a service improvement project focused on conversation groups on the ward which Grace had been involved with. The development and delivery of a joint group therapy session, in collaboration with Occupational Therapy (OT) was described. These sessions were held weekly at the Evington Centre and were designed using the enriched model of dementia care ensuring a holistic and person-centred approach. The sessions typically combined conversational activities with practical or creative tasks tailored to the interests and backgrounds of the patients. Activities included painting, crafts, gardening, simple DIY tasks and music-based sessions using visual and auditory prompts. These activities often encouraged conversation, reminiscence, singing and dancing. It was reported that, on average, 26% of ward patients attended the sessions each week and provided valuable opportunities for both therapy and informal screening assessments. Outcomes were measured using the Bradford Wellbeing Indicators with the most frequently observed indicators being signs of pleasure and enjoyment followed by the ability to communicate wants, needs and choices. Patient feedback was overwhelmingly positive with comments reflecting enjoyment, engagement and a sense of personal achievement.

Sarah Collins then provided an overview of the team's work in supporting personal care for patients living with dementia and explained that, over several years, the speech and language therapy team had collaborated with the wider multidisciplinary team to develop personal care support plans. These plans aimed to reduce distress, agitation and aggression often associated with personal care activities which can sometimes lead to restrictive practices such as safe holding. During the Covid-19 pandemic, when ward staffing levels were stretched the speech and language therapy team became more directly involved in personal care and this experience deepened their understanding of the communication challenges faced by care staff and led to closer collaboration with occupational therapy colleagues during wash and dress assessments. Together, they identified communication strategies to help orient patients to the activity, support expression of preferences and reduce distress – transforming personal care into an opportunity for therapeutic engagement.

A case study was shared about a patient who had advanced dementia, significant communication difficulties and who experienced high levels of distress during personal care. A joint assessment was conducted to reduce the patient's distress around building rapport through familiar routines such as offering a cup of tea and playing music. Visual and tactile prompts were used and simple instructions were delivered with ample time for processing and the team prioritised areas the patient was comfortable with in order to maintain dignity. Although the patient still became upset, they were able to express their discomfort and the team responded with empathy and reassurance. The session concluded with the patient engaging in their own grooming and leaving the room smiling.

The outcome of such assessments included reduced patient distress,

	improved comfort, better nutritional intake and preserved skin integrity. For staff, the plans enabled personal care to be delivered with fewer personnel, reduced incidents of aggression and supported safer and more efficient discharge planning. The importance of this work in improving patient experience and supporting staff on the wards was emphasised. Rachel McMurray concluded the presentation by expressing pride in the MHSOP Speech and Language Therapy team and the work they undertake, and emphasised the team's compassion, kindness and commitment to supporting individuals with communication and swallowing difficulties. The importance of strong MDT relationships was highlighted and noted how collaborative working had significantly improved patient outcomes. The team had become more involved in supporting capacity assessments alongside social workers and hoped to expand this further through their outreach work. The team was actively engaged in research and quality improvement initiatives and, notably, were preparing to pilot a national study led by University College, London, on Conversation Partner Therapy for people with dementia and their families. The challenges of working within a small team were acknowledged, particularly in maintaining clinical cover and balancing the desire to seize development opportunities without becoming overstretched. It was noted that the evidence base for speech and language therapy in dementia care was still emerging and the team was actively advocating for its development which was both exciting and demanding. The Chair thanked the team for their presentation and acknowledged the emotional connection many attendees felt, particularly those with personal experience of supporting loved ones with dementia. Tanya Hibbert expressed her gratitude for the team's contributions and commended their passion, compassion and professionalism and recognised the relevance and effectiveness of the strategies presented. Liz Anderson introduced herself as a non-executive director representing the University of Leicester, with a focus on teaching and learning, and highlighted her own work in interprofessional learning and the importance of mutual respect and understanding across professional roles. Liz praised the team's efforts in educating and supporting other professionals through care plans, multidisciplinary collaboration and effective handovers and invited the team to comment on the importance of training others and promoting the value of speech and language therapy within the wider healthcare system. In response, Rachel McMurray agreed that interprofessional collaboration was essential and advised that establishing the role of speech and language therapy within the service had been a gradual process and building strong professional relationships across therapy, nursing and medical teams had been key to demonstrating the team's value. The need for ongoing advocacy particularly given the limited literature on speech and language therapy in dementia care was acknowledged and it was noted the team was actively involved in national work to raise awareness and promote the profession. Jean Knight shared her reflections following a visit to the service in April and expressed admiration for the passion and dedication demonstrated by

	the team which had been clearly reflected throughout today's presentation. Jean further commended the team's efforts in reducing distress and improving transitions to alternative care settings particularly through the development of personalised communication and personal care strategies and suggested, with increased resources, the team could extend its reach and influence across the wider system and, acknowledging the presence of Tanya Hibbert who was the senior responsible officer for the mental health collaborative, proposed this be explored further at a strategic level. Bhanu Chadalavada thanked the team for their impactful presentation and acknowledged the wide-reaching relevance of their work. He noted the presentation had previously been shared at a postgraduate training session where colleagues from other areas also recognised its value. The importance of the team's contribution not only in reducing length of stay and restrictive practice but also in improving the quality and safety of care during inpatient admissions was highlighted. Furthermore, the use of accessible communication tools, such as single-page care plans was praised and suggested their applicability across other services including neurodevelopmental care. Also referenced was ongoing research collaborations, including a dysphagia project with the University of Leicester, and wider system-level consideration of how the team's work could be expanded into community settings to improve quality of life and reduce admissions was encouraged. Faisal Hussain referred to communication challenges within Leicestershire's culturally diverse population and asked whether cultural and linguistic diversity added complexity to the team's work and how they adapted to support patients from different backgrounds. Rachel McMurray acknowledged that cultural and geographical diversity across Leicester, Leicestershire and Rutland (LLR) did present challenges and advised the team was actively exploring national research on dementia in South Asian communities. In addition, the diverse ward staff group, many of whom spoke multiple languages were supporting culturally sensitive assessments and interventions. The Chair concluded this discussion by commending the team once again for their compassion, focus on wellbeing and person-centred approach.
TB/25-6/029	**Questions from the Public (verbal)** There were no public questions.
TB/25-6/030	**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/25-6/031	**Minutes of Previous Public Meeting held 27 May 2025 (Paper B)** The minutes were approved as an accurate record of proceedings. **Resolved:** The Board approved the minutes.
TB/25-6/032	**Matters Arising (Paper C)**

	All actions were complete and approved for closure.
TB/25-6/033	**Trust Board Workplan 2025/26 (Paper D)** Kate Dyer presented the workplan for information and in response to a question from the Chair about reporting on progress against the THRIVE Strategy, confirmed it had been transferred to the Group Trust Board Workplan and would be reported on at Group Board. No further questions or queries were received. **Resolved:** The Board received this report for information and assurance.
TB/25-6/034	**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 June-July 2025. The following key points were highlighted:- • The Fit and Proper Persons submission to NHSE had concluded and the outcome was awaited. • The Long Service Awards event had been very celebratory and it was a delight to recognise all those staff. • Faisal Hussain, appointed formally as the Chair successor, would commence from 1 November 2025 and will be shadowing the Chair at every opportunity in the meantime. **Resolved:** The Board received this report for information.
TB/25-6/035	**Chief Executive's Report (Paper F)** Jean Knight introduced this report which provided an update on current local issues and national policy developments since the last meeting. Key points highlighted were:- • Publication of the 10 Year Plan – LPT had already commenced work with colleagues across the ICB, the wider system and Northamptonshire Healthcare Foundation Trust (NHFT) to ensure alignment with the priorities. The plan's emphasis on neighbourhood models of care was welcomed. • With reference to the forthcoming closure of the National Guardian's Office - with NHS England assuming oversight responsibilities by the end of the year - the Trust reaffirmed its commitment to supporting staff to speak up and would retain its Freedom to Speak Up Guardians. • The ongoing industrial action was acknowledged, and colleagues/staff were thanked for being involved in maintaining safe and high quality care during this period. • Appreciation was expressed to Paul Williams for his significant contribution to the Trust, Faisal Hussain was welcomed into the Chair role and Toby Sanders was welcomed as the new Interim Chief Executive of the ICB across Northamptonshire and LLR. • Thanks were offered to all teams involved in organising the Long Service Awards. • Appreciation was also expressed to the Estates operational, financial and clinical teams for their work in refurbishing the Belvoir Unit.

	Josie Spencer raised two questions. Firstly, she sought clarification on LPTs involvement in the Neighbourhood Health Implementation Programme and whether it was assumed that, as a provider of mental health and community services, LPT would play a significant role in the programme. Secondly, referring to the ADHD Taskforce Interim Report, noted it highlighted lower than expected diagnosis rates and asked whether the findings had implications for LPT particularly in relation to referral volumes and tracking patients through to diagnosis. In response, Jean Knight confirmed that LPT was actively involved in the neighbourhood work both as mental health provider and through community services and advised that Sam Leak was closely linked into the programme and would continue to contribute going forward. With regard to the ADHD Taskforce Report, the Trust was currently reviewing the findings and anticipated further updates later in the year. David Williams provided an update on the Neighbourhood Health Implementation Programme confirming that LPT was coordinating and leading the system-wide application process for the NHS England pilot with submissions due by 8 August 2025. While participation in the pilot offered valuable support, not all areas would be successful and therefore, the strategy was to submit two applications across LLR and Northamptonshire to offer a higher chance of success. Liz Anderson reflected on the significance of the national reports referenced, including the NHS 10 Year Plan and the Penny Dash report and emphasised the importance of understanding how the Trust would respond, and sought clarification on how this would be addressed through future joint board discussions. The other point made was how wonderful it was to see one of our nurses, Anjana Sajeev, receive the international DAISY Award for outstanding compassionate care. The Chair responded by proposing that the upcoming Group Board Development Workshop should include a session to explore the implications of national developments in more detail. There were no further questions. **Resolved**: The Board received this report for information.
TB/25-6/036	**Environmental Analysis (Verbal)** Jean Knight provided an update and highlighted the following key points:- • Thirteen service visits had taken place in June and July where positive feedback had been received. • Two Health and Wellbeing Boards (HWB) had taken place since the last Trust Board. In particular, the Leicester City HWB in June received a presentation around health inequalities and social prescribing where the outcomes had shown some improvement. • An update was received on the outcomes of the Children's Voice Engagement Project in Rutland, which focused on the views of young people aged 11 to 25 regarding healthcare services. It was noted that overall, young people reported positive experiences. However, this

	sentiment was not consistently reflected in the feedback from parents and carers and as a result, further engagement activities had been planned to explore these differences in perspectives.
TB/25-6/037	**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 highest scoring risks by THRIVE domain and advised of a readjustment to the risk score for BAF3.2 (timely access) from 15 back up to 20 to better reflect the risk environment relating to waiting times. Hetal Parmar raised a query regarding the NHS Sustainability Strategy and the goal to achieve net zero by 2040, highlighting the importance of Scope 3 emissions and suggested the Trust consider how these factors are reflected not only in its Sustainability Strategy but also within the Organisational Risk Register. Paul Sheldon confirmed the Group Risk Register was being developed to include an overarching environmental sustainability risk noting the refreshed Green Plan, due to be presented at the next Board meeting, would provide greater detail and address the issues raised. Kate Dyer added that the Group would continue to oversee this area as a strategic risk and confirmed the Green Plan would inform a review of risk scoring and help identify gaps in both causes and impacts related to sustainability. The Chair raised a concern regarding BAF3.2 noting that while the risk description included sources of assurance and controls, there was no reported progress, which appeared to be a gap. The Chair acknowledged that a broader board discussion had been agreed for a future date but questioned whether interim actions were being taken and whether further assurance was needed in the meantime. Kate Dyer responded by acknowledging the complexity of the risk, which involved multiple perspectives including quality, safety and performance across different service areas and would ensure the upcoming LPT Trust Board Development Workshop would provide an opportunity to bring these perspectives together. Melanie Hall added that the Finance and Performance committee had reviewed the performance report and discussed key exceptions particularly around waiting times. Also noted was that future Finance and Performance Committees would include rolling deep dives into specific areas, with a focus on those where LPT had the greatest ability to influence and improve outcomes. **Resolved:** The Board received this report for information and assurance and approved the readjustment to score for BAF3.2.
TB/25-6/038	**Trust Board Development Programme (Paper H)** Kate Dyer presented this programme which provided details of upcoming items on both the LPT and Group Development Workshops. The next Group Development Workshop was scheduled for Tuesday, 26 August 2025 which covered items relevant to both organisations. The subsequent LPT specific session is scheduled for 28 October 2025. The programme continued to evolve to reflect organisational needs. **Resolved:** The Board received this report for information and assurance.

TB/25-6/039	**Audit and Risk Committee AAA Highlight Report: 13 June 2025 (Paper I)** Hetal Parmar introduced this report and drew attention to the following:- • No alert or advisory items to escalate. • Assurance items - a review of ARC effectiveness had been undertaken and concluded it had been effective during the year as it had fulfilled its terms of reference. • Celebratory items – the Trust had a robust process and proactive culture on the completion of internal audit actions and the approval and submission of the annual financial accounts which was a huge piece of work. Melanie Hall requested further clarification on the level of assurance provided around systems and processes in place to support an effective governance and risk framework. In response, Hetal Parmar outlined the progress made in developing the BAF and the evolution of the risk register and confirmed there was a good level of assurance around the infrastructure in place to understand and manage strategic risks aligned to the Trust's objectives. Kate Dyer added that the Trust received third-line assurance over its corporate governance systems, including policy management and core organisational controls and explained that a second-line assurance report was submitted quarterly to ARC summarising outcomes from governance risk-related work which maintains the level of assurance. **Resolved:** The Board received this report for information and assurance.
TB/25-6/040	**Quality and Safety Committee AAA Highlight Report: 20 May 2025 and 17 June 2025 (Paper J)** Josie Spencer introduced this report and drew attention to the following:- • An extraordinary meeting was held in May in an effort to manage agendas and this seemed to work well. • Two advisory areas from the May meeting around process issues were highlighted. • Issues highlighted from the June meeting included waiting times/keeping patients safe whilst waiting and complaints performance and QSC had requested that evidence of the learning and triangulation with improved outcomes be included in future quality summit reports. Of particular note were the ongoing issues with access to electronic patient records and the variability in practice for clozapine medication management. • During the last year there had been some backlogs around the death reviews in mental health services but sadly, there appeared to be a similar picture emerging for FYPC linked to the number of child deaths so more work was required for assurance purposes. • Paediatric audiology service report received – a lot of good work has taken place although there are still some sickness issues, however it was in a much better place than when the last report was received. • National overview report regarding staying safe from suicide – QSC will be receiving a paper looking at self-assessment and gap analysis at its October meeting. Melanie Hall asked about the alignment between the long term Estates

	Strategy (10+ years) and the Clinical Strategy (5 years) and how enabling services were being engaged in the development of the Clinical Strategy. Bhanu Chadalavada confirmed the Clinical Strategy was being aligned with THRIVE and engagement with enabling services had taken place. Feedback had been received from several areas and further in-reach work was ongoing where responses were still outstanding. Over the past 12 months a series of meetings had taken place and in light of recent changes in national direction and the long-term planning context it was considered timely to extend this engagement to support the use of shared metrics and help identify strategic priorities across all services. The Chair then sought clarification regarding Table 1 of the Learning from Deaths report, specifically the 162 cases shown as outstanding for screening in Quarter 4 and queried whether these had since been addressed. Bhanu Chadalavada confirmed the figure of 162 reflected the position at the time the report was produced. Since then, the Directorate of Mental Health has allocated additional resources to address the backlog. The number of outstanding cases was dynamic and continued to change weekly as the work progressed. **Resolved:** The Board received the report for information and assurance.
TB/25-6/041	**Safe Staffing Report (Paper K)** Emma Wallis introduced this report which provided a full overview of nursing safe staffing during the month of May 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:- • Temporary worker utilisation rate had decreased along with trust-wide agency usage. • Short Breaks: below-plan staffing was observed; however, staffing was adjusted to meet patient needs and safety was maintained. • Directorate of Mental Health: over-utilisation was attributed to increased therapeutic observations, higher levels of transfers, admissions and hospital escorts. • Community Health Services: increased staffing was required due to higher patient acuity and dependency. • The Trust is participating in a national programme on enhanced therapeutic observations, aimed at evaluating staff utilisation and improving safe staffing processes. • The Community Nursing Safer Staffing Tool was relaunched in late 2024 with a pilot that commenced at the North West Leicestershire Hub in June 2025. • The light establishment review was completed in April 2025 with data progressing through the usual governance reporting channels. Liz Anderson acknowledged the ongoing challenges related to staff sickness, increasing patient acuity and achieving the appropriate skill mix on wards and referenced a recent visit to the Dalgliesh Ward where concerns were raised about the high number of agency staff, and asked

	what actions were being taken to reduce nurse sickness absence. In response, Emma Wallis highlighted the Trust's strong focus on staff retention and wellbeing over the past few years with key initiatives including access to staff support groups, recognition such as DAISY Awards, implementation of a safe staffing policy and ongoing work to ensure staff have the right skills, roles and essential training. Tanya Hibbert added that a review of May sickness data within the Directorate of Mental Health showed a spike particularly related to respiratory conditions which had contributed to increased staffing pressures during that period. Sarah Willis provided further assurance that the People and Culture Committee conducts a regular deep dive into sickness data and the HR team actively supports directorates in addressing hotspot areas and having wellbeing programmes in place. It was noted that the Trust benchmarked well across the Alliance in terms of wellbeing and sickness absence, although mental health teams nationally were experiencing higher sickness levels. Jean Knight welcomed the inclusion of DMH community teams in the staffing report and expressed support for the appointment of substantive team managers in Community Mental Health Teams (CMHTs) and queried whether any staffing related risks identified through daily reviews had been escalated to the Directorate Quality and Safety meetings or further to Trust-level risk forums. Tanya Hibbert confirmed that daily safety huddles held across all DMH teams are supported by Silver Command Meetings which facilitate the escalation of safety and staffing concerns, and operational staffing escalations are managed daily, including authorisation for bank and agency staff. It was noted that escalation to higher governance levels occurs only when no immediate solutions are available. **Resolved:** The Board received this report for information and assurance.
TB/25-6/042	**Patient Safety Report (Paper L)** Emma Wallis 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, 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. Key areas were highlighted as:- • There was recognition of the new national system for learning from patient safety events which provides data on overall reporting numbers for different organisations. This data can be accessed by Regulators. • During May and June, over 3,000 patient safety incidents were reported but the majority of incidents were no or low harm. • The top 5 reported incidents remain unchanged. • There had been an increase in number of incidents reported in this period for each of the 5 categories. • Current patient safety reviews identified significant progress from clinical directorates in terms of closing reports.

	With regard to the 'degree of harm' reporting on p112 of the paper pack, Josie Spencer stated the figures may be misleading without context as they related to a reporting issue rather than confirmed deaths and clarified the data included patients who may have had historical contact with the Trust, not necessarily at the time of death. The Chair highlighted references to the CAMHS Beacon Unit noting a significant increase in incidents such as restraint and self-harm. Emma Wallis acknowledged that both environmental and patient factors contributed to the rise in incidents but confirmed the Unit had now returned to its original environment and anticipated this return would support a reduction in incident levels. Melanie Hall referred to the ongoing challenges in tissue viability particularly within the community nursing setting and asked if the quality improvement interventions currently underway would be reported through the Safety Forum and subsequently escalated to the Quality and Safety Committee. Also noted was the progress in benchmarking efforts and further insight into how the Trust is engaging to enhance learning from best practice was requested. Emma Wallis confirmed that the Strategic Pressure Ulcer Group which she chairs, reports to the Patient Safety Improvement Group, which in turn reports to the Safety Forum and this governance structure ensured all quality improvement initiatives were appropriately escalated. Sam Leak added that while benchmarking had been conducted, the team had not yet reached out to high performing organisations. **Resolved:** The Board received this report for information and assurance.
TB/25-6/043	**Emergency Preparedness, Resilience and Response (EPRR) Annual Report (Paper M)** Jean Knight presented this report which provided an assessment of capabilities, activities and achievements over the past year. The report offered assurance regarding the instant response processes implemented throughout the year. The section on business continuity highlighted current compliance levels and referred to a recent cyber training exercise which was described as excellent. It was acknowledged that further work is required in relation to the business impact analysis. The benefits of appointing a Group Head of EPRR were beginning to be realised particularly through shared learning and harmonised approaches across both organisations, thereby strengthening overall EPRR arrangements. Sam Leak queried whether there was any risk associated with the completion of the corporate/enabling business continuity plans, particularly in relation to compliance timeframes and the business impact analysis. Jean Knight confirmed that this is being actively managed through EPRR reporting into Health and Safety. As such, the associated risk is considered minimal. Josie Spencer expressed appreciation for the report, noting it was very informative and particularly enjoyed the sections on exercises and training. She commended the quality of work and asked that thanks be passed on.

	Kate Dyer sought clarification on whether the EPRR Risk Register is integrated with the Corporate Risk Register process on Ulysses. Jean Knight was unsure and would follow this up outside of the meeting. The Chair referenced national communications regarding EPRR reporting and compliance which appear to involve Integrated Care Board (ICB) involvement, regional testing and a final sign-off process. The Chair queried whether the Board's role in oversight was now complete or if further updates were required. Jean Knight advised that it is important for the Board to continue receiving these reports to maintain clear oversight and while the report was previously submitted to the Quality and Safety Committee (QSC), the presence of a BAF item relating to EPRR justified bringing these standards back through Board. **Resolved:** The Board received the report for information and assurance.
TB/25-6/044	**Freedom to Speak Up Annual Report 2024-25 (Paper N)** Jean Knight presented this report which provided an overview of speaking up activity, and extended thanks to the Freedom to Speak Up Guardians (FTSU) for compiling the report. Pauline Lewitt was present to respond to any detailed questions from Board members. Key points highlighted included:- • The Trust received 169 contacts during the year, with appropriate action taken in all cases. Reporting aligned with the framework set out by the National Guardian's Office. • The report reflected the Trust's ongoing commitment to fostering a culture of speaking up, listening, and taking action. • Leadership development remained a central theme, with HR playing a pivotal role in delivering conferences and training throughout the year – with further events planned. • The Trust's NHS Staff Survey scores for Speaking Up remained stable and the Trust performed above the national average providing positive assurance of its culture. Melanie Hall raised the issue of the lack of analysis of FTSU data by protected characteristics and whilst acknowledging the challenges of doing so quarterly due to small numbers and anonymity of concerns, suggested an annual analysis could provide valuable insights into representation and support the Trust's efforts to address potential disparities. Jean Knight confirmed this gap had been recognised and reported that work was well underway with the new Ulysses System Manager to develop a bespoke recording system capable of capturing protected characteristic data. This system was nearly operational and would support reporting to both the People and Culture Committee and inclusion in the Annual Report. Liz Anderson noted that the medical profession remained the lowest group in terms of speaking up, which reflected a national trend, and asked what actions were being taken to encourage greater engagement from this staff group. Bhanu Chadalavada responded that this was being addressed through induction sessions for medical trainees and presentations to the

	Medical Advisory Committee. Emphasis was being placed on early engagement, starting from medical student training in order to build confidence in using FTSU channels - although fear of repercussions was acknowledged as an issue and remained a barrier. Josie Spencer queried the data presented in Table 2 (p160) which shows the number of speaking up cases by Directorate and noted that, aside from one quarter, the Directorate of Mental Health consistently reports the highest number of cases. Josie suggested this may be due to DMH having the largest staff group and proposed that future reports include proportional analysis to provide more meaningful insight. Jean Knight agreed this was a valuable suggestion and confirmed that proportionality would be considered in future reporting. It was acknowledged that DMH typically generates more concerns but the importance of contextualizing this with staff numbers was emphasised. The Chair concluded by expressing appreciation for the work undertaken by the FTSU Guardians and reiterated the Board's commitment to this work. **Resolved:** The Board received the report for information and assurance.
TB/25-6/045	**Finance and Performance Committee AAA Highlight Report: 19 June 2025 (Paper O)** Melanie Hall introduced this report and drew attention to the following:- • The delay in awarding the contract for the school aged immunisation service - this was to be carefully managed in terms of impact on staff and budgets as the service transitions to a new model. • Under the finance month 2 report, the Equality and Quality Impact Assessment (EQIA) process was discussed – the importance of monitoring all aspects of change was emphasised and a further discussion to ensure alignment between FPC and QSC would take place. • Several annual reports were received - with particular commendation for the Data Security and Protection Toolkit submission for achieving a substantial assurance rating in a number of areas. Additional assurance was provided through reports from the Caldicott Guardian, Cybersecurity and local Health and Safety Leads. • A number of celebrating success items were acknowledged, including the Trust's financial performance over the past year and the significant efforts of the finance team, operational improvements via the performance dashboard and good examples of team working between transformation leads and service areas to drive forward value and better patient care. Josie Spencer revisited the point on EQIA and confirmed that QSC would be reviewing the process at its next meeting. **Resolved:** The Board received the report for information and assurance.
TB/25-6/046	**Finance Report – Month 3 (Paper P)** 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:- • Income and expenditure - reporting a £1.4m deficit at month 3. Within that, the clinical directorates are overspending by £1.7m, of which £850k is due to CIP under-delivery; that position has been offset by releasing non-recurrent central reserves, however, £500k more of those reserves was used than expected. Whilst the position has been delivered, the persistent overspend was concerning and therefore the executive team discussed additional recovery plans; workforce reductions being a key element and the Trust is working with NHSE to implement those schemes being considered. It is imperative that the run-rate reduces over the next few months and financial year to enable the plan to be delivered, so delivery of the plan was still formally being forecast. The scenarios in Appendix H show the risks the Trust is currently aware of. The delivery of the financial plan is a key element of the Oversight Framework - non-delivery of the financial position overrides all other metrics and would put organisations into Segment 3 which would lead to further NHSE intervention. • Cash – at month 3, the Trust was holding 13 days operating cash (one day below plan). Within that there were delays in receiving income from Local Authorities which impacted on the cash holding balance. • Capital – at month 3, the spend was £2m which was slightly above plan. The total plan for the year is now revised to £18.7m. • Summarised in the report was changes to the operational capital plan. • There was a continued trend of decreasing spend on agency and, at month 3, this figure had dropped below £1m – this was the lowest figure since May 2021. • Better Payment Practice Codes – good progress with all four targets being met for the month of June. This was an improving position. The Chair referred to the run-rate which looked challenging and asked how confident colleagues were with plans being developed. Jean Knight responded that as an executive team, conversations had been ongoing for some time and acknowledged the current very challenging position. **Resolved:** The Board received this report for information and assurance.
TB/25-6/047	**Performance Report – Month 3 (Paper Q)** Sharon Murphy presented this report which provided an overview of the Trust's performance against Key Performance Indicators (KPIs) for June 2025. Key areas highlighted included:- • As per the request at the previous Board meeting, the front cover sheet for this report now included narrative around the exception reports matrix and the movement between those categories. • KPI performance is variable within DMH and CHS – some areas have deteriorated. In FYPC, aside from community paediatrics, all had improved. • Over 52 week waits - most were stabilising or reducing. The Access Delivery Group is overseeing the programme of waiting list validation which ensured the Access Policy is being consistently applied and accurate. • Waiting list data is also reviewed in detail at the Accountability

	Framework Meeting and there were no areas to escalate Board today. Jean Knight advised that Sam Leak would be working in conjunction with Anne Senior to review how waiting lists were being managed. Josie Spencer raised a query regarding inconsistencies in the reported data on neurodevelopmental waiting lists; specifically, the number of waiters appeared to increase from zero to 1,378 and asked for clarification. Sharon Murphy responded that the discrepancy likely resulted from recent disaggregation of FYPC metrics which were previously grouped under a broader category and committed to double-checking the data to ensure there were no reporting errors. Tanya Hibbert provided an update on waiting times for personality disorder treatment and advised a 53% reduction in patients waiting for treatment over 52 weeks was attributed to focussed transformation work and was linked to the wider community transformation efforts. Tanya Hibbert also updated Board on a system-wide improvement group with ICB colleagues to address the ADHD backlog. **Resolved:** The Board received this report for information and assurance.
TB/25-6/048	**Charitable Funds Committee AAA Highlight Report: 18 March 2025 and 26 June 2025 (Paper R)** Faisal Hussain introduced this report and drew attention to the following:- • The review of the fundraising strategy, shifting from the Trust's Step Up to Great strategy to a more systematic and practice alignment with the THRIVE strategy. • In relation to financial security, Raising Health currently holds cash balances exceeding the Financial Services Compensation Scheme (FSCS) protection limit. A review had been undertaken to explore the opening of additional accounts to spread the financial risk – of which Board approval was sought. • The increased visibility and engagement achieved through Raising Health's social media and web presence was celebrated and thanks were offered to all those involved for their significant contributions. **Resolved:** The Board received the report for information and assurance and confirmed its support for the opening of additional accounts as a risk mitigation measure.
TB/25-6/049	**People and Culture Committee AAA Highlight Report: 11 June 2025 (Paper S)** Melanie Hall introduced this report and drew attention to the following:- • A significant improvement in occupational health referral times. • A reduction in recruitment timescales from 30 days to 20 days. • The People Data dashboard continued to evolve positively. • Employee relations data is being reviewed, with a focus on the experiences of colleagues from ethnic and cultural minority backgrounds to identify and address any disproportionate issues. • Progress continued on the medical job planning improvement

	programme. • The Workforce Safeguard self-assessment was approved for submission to NHSE – celebrating the fact that the Trust is compliant with 10 out of the 12 recommendations and almost fully compliant on the remaining two. • The success of Celebrating Excellence nominations process, Long Service Awards and other activities that demonstrated innovative use of sponsorship was celebrated. **Resolved:** The Board received the report for information and assurance.
TB/25-6/050	**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/25-6/051	**Any Other Urgent Business** There was no other business.
TB/25-6/052	**Papers/updates not received in line with the work plan:** • Trust Board Annual Effectiveness Review and Terms of Reference – *deferred to September 2025*
Close – date of next public meeting: Tuesday, 30 September 2025	

C

Leicestershire Partnership NHS Trust

TRUST BOARD 30th September 2025

MATTERS ARISING FROM THE PUBLIC TRUST BOARD MEETING HELD 29th July 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
	No outstanding actions.			

D

Leicestershire Partnership NHS Trust

LPT Trust Board Workplan 2025/26 v9.1

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
Updates from previous presentations (commencing Nov 25)	Every meeting					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

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
Chief Executive's Verbal Update *(Confidential Agenda)*	Every meeting CEO	X		X	X	X	X	X
Environmental Analysis *(Confidential Agenda)*	Every meeting CEO/MD	X		X	X	X	X	X
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 (as required)								

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
Clinical Plan					X			
Quality, Safety and Compliance								
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

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
Approval of Annual Financial Plan *(Confidential Agenda)*	Annual Dir Fin & Perf							X
People and Culture								
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					

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
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					
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 30 September 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

Chair/NED Appraisals, Recruitment and Succession Planning

As I stand down from my role as Joint Chair at the end of October 2025, I want to express my appreciation for the opportunity to lead this Board and serve the wider community. It has been a privilege to work alongside such committed and thoughtful colleagues, whose passion and integrity is evident. During my time with Leicestershire Partnership NHS Trust (LPT), I am proud of what we have achieved together and confident that the Board is well-placed to build on this momentum with Faisal Hussain confirmed as my successor.

Faisal Hussain will take up the post on 1st November 2025 and we have been working closely to ensure a smooth transition, This is reflected in the broad range of activities undertaken by the Deputy Chair as highlighted in Appendix A. Plans to appoint a Deputy Chair and an additional Associate NED to replace Faisal are in progress.

All NED appraisal documents are on course to be submitted to NHSE by 30th September 2025.

Board Development

We met with colleagues from NHFT for a Joint Board Development Workshop on 26th August 2025 and took the time to discuss the 10-year plan and reflect on progress and plans for the delivery of our Group strategic priorities as part of the THRIVE strategy.

We were joined by the CQC's Deputy Director of Operations, Midlands Network to receive an update on the latest developments within the CQC. We reviewed the Group Board Assurance Framework and reflected on the progress made against our Well-led plans. We also took the opportunity to develop a shared understanding on employment tribunal judgements that now form part of the Fit and Proper Person Test (FPPT) for Directors.

Working with Partners and Stakeholders

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

- NHS Confed Chairs meetings
- System Chair Meetings
- LLR UEC Collaborative

Public, Patient and Staff Engagement

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

- Leicester PRIDE Event
- Raising Health Let's Gardening Open Day at Bradgate
- Internationally Educated Nurses Graduation Ceremony
- Celebrating Excellence Awards
- Consultant Interviews
- Freedom To Speak Up review meetings
- Service Visit: Community Paediatric Team
- Service Visit: Chaplaincy
- Service Visit: Bed Management Team

LPT's Annual General Meeting was held on 11th September. This year the focus was on the Trust's new THRIVE strategy developed across the Group. Rob Melling, Head of Community Development showcased our approach to mental health in neighbourhoods. There were presentations from Angela Hillery, Chief Executive, Sharon Murphy, Director of Finance and and Deanne Rennie, Associate Director of AHPs in which we looked back at 2024/25 and shared highlights from our Annual Report and Accounts and Quality Account.

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 September 2025	
Paper sponsored by:	Crishni Waring, Chair	
Paper authored by:	Sinead Ellis-Austin, Crishni Waring	
Date submitted:	16 September 2026	
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 the Trust (I/E)
Hetal Parmar	15/07/2025	NHS CFA webinar: failure to prevent fraud offence	E
Hetal Parmar	25/07/2025	GGI: The 10 Year Plan - what it means for the NHS	E
Deputy Chair	05/08/2025	Aspirant Chair Talent Programme Pathway Group Meeting	E
Deputy Chair	06/08/2025	People's Council Governance Meeting	I
Hetal Parmar	06/08/2025	Discuss ways to prep for Well-Led review	I
Deputy Chair	07/08/2025	Council of Governors Workshop NHFT	E
Deputy Chair	07/08/2025	Council of Governors Meeting in Public NHFT	E
Deputy Chair	07/08/2025	Council of Governors Meeting in Private NHFT	E
Deputy Chair	07/08/2025	South Asian Heritage Month - APNA NHS	E
Chair/NEDs	11/08/2025	LPT NED catch up	I
Chair/Deputy Chair	12/08/2025	LPT/NHFT Deputy Chairs meeting	I/E
Chair/Deputy Chair	12/08/2025	UHL/UHN/LLR ICB/Northants ICB Chairs	E
Josie Spencer	12/08/2025	FTSU catch up	I
Manjit Darby	12/08/2025	REACH Network Meeting	I
Melanie Hall	13/08/2025	Service visit - Chaplaincy	I
Chair	14/08/2025	Regional Peoples Board Agenda Setting	E
Chair	14/08/2025	NHSE Director of Strategic Transformation	E
Deputy Chair	14/08/2025	Aspirant Chair Talent Programme Mentoring Meeting	E
Melanie Hall	15/08/2025	Service visit - Bosworth Ward	I
Melanie Hall	15/08/2025	Service visit - SALT	I
Melanie Hall	15/08/2025	Service visit – DIANA childrens services	I
Deputy Chair	18/08/2025	NHFT NED Meeting	E
Melanie Hall	19/08/2025	Service visit - Agnes Unit	I
Hetal Parmar	20/08/2025	360 Internal Audit catch-up	E
Chair	21/08/2025	Director of Corporate Governance	I
Manjit Darby	21/08/2025	UEC Collaborative	E
Melanie Hall	28/08/2025	H&WB Champions meeting	I
Manjit Darby	30/08/2025	Leicester PRIDE	E
Chair/NEDs	01/09/2025	LPT NED catch up	I
Chair	02/09/2025	Regional People Board	E

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Chair/Deputy Chair	04/09/2025	LPT Trust Board Agenda Setting	I
Chair/Deputy Chair	04/09/2025	Group Trust Board Agenda Setting	I/E
Liz Anderson	04/09/2025	Service visit – Belvoir Ward/PICU	I
Deputy Chair	04/09/2025	Mental Health Chairs Weekly Call	E
Deputy Chair	04/09/2025	NHFT Board Agenda Sign off Meeting	E
Deputy Chair	05/09/2025	Internationally Educated Nurses Graduation Ceremony	I
Deputy Chair	08/09/2025	Raising Health Let's Get Gardening Open Day at Bradgate	I
Deputy Chair	09/09/2025	Aspirant Chair Talent Programme Module 3	E
Chair	09/09/2025	LLR & Northants ICB Chair	E
Chair	09/09/2025	UHL/UHN Chair	E
Chair/Deputy Chair/ Josie Spencer	09/09/2025	Quarterly F2SU Meeting	I
Josie Spencer	09/09/2025	Community Paediatrics Service Visit	I
Chair/Deputy Chair	11/09/2025	Charitable Funds Committee	
Chairs/NEDs	11/09/2025	LPT AGM	I
Manjit Darby	11/09/2025	Service Visit - bed management team	I
Deputy Chair	12/09/2025	Aspirant Chair Talent Programme Mentoring Meeting	E
Chair/Deputy Chair	15/09/2025	Chair/Deputy Chair/CEO	I
*Melanie Hall	15/09/2025	LPT MECC Training	I
*Manjit Darby	15/09/2025	Consultant Interviews	I
*Deputy Chair	15/09/2025	NHFT AGM	E
*Chair	16/09/2025	Director of Corporate Governance	I
*Melanie Hall	16/09/2025	Monthly Team Brief	I
*Deputy Chair	17/09/2025	Allied Health Professions Fellowship Celebration Day	I
*Deputy Chair	18/09/2025	Mental Health Chairs Weekly Call	E
*Deputy Chair	22/09/2025	Midlands Chairs Call with Regional Director	E
*Deputy Chair	22/09/2025	NHS Confed All Members Chairs Meeting	E
*Chair/ Deputy Chair	26/09/2025	Celebrating Excellence Awards	I
*Melanie Hall	26/09/2025	GGI Webinar - Hospital to Community Care	E
*Melanie Hall	29/09/2025	FPC Agenda Planning meeting	I

*Planned at time of writing

Abbreviations:

AGM = Annual General Meeting
CEO = Chief Executive Officer

CoG = NHFT Council of Governors
F2SU = Freedom To Speak Up
FPC = Finance & Performance Committee
FYPCLDA = Families, young people and children's, learning disabilities and autism services
GGI = Good Governance Institute
ICB = Integrated Care Board
ICS = Integrated Care System
LLR = Leicester, Leicestershire & Rutland
MECC= Making Every Contact Count
NED = Non-Executive Director
NHFT = Northamptonshire Healthcare NHS Foundation Trust
NHSE = NHS England
NHS CFA = NHS Counter Fraud Authority
QI = Quality Improvement
REACH = Race, Ethnicity and Cultural Heritage
SALT = Speech & Language Therapies
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 – September 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

NHS Oversight Framework 2025/26

NHSE have now publicly launched the NHS Oversight Framework 2025/26 and I am pleased to share that through the initial launch of this framework LPT has met the criteria for Segment 2 and placed 17th out of 61 community and mental health trusts for quarter 1 of 2025/26. There are 22 metrics within the framework, spread across six domains, which come together to give each organisation a segment rating of between 1 at the high end, down to 5 for the lowest performing and most challenged. Segment 2 is described as: "The organisation has good performance across most domains. Specific issues exist"

I would like to take this opportunity to thank all of our staff for their hard work and ongoing commitment to the population of Leicestershire.

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

10 Year Health Plan for England: fit for the future

We continue to engage with the delivery of the evolution of the 10-Year Health Plan and I have recently been involved in a number of working groups specifically focusing on the oversight framework, Foundation Trusts and Integrated Health Organisations elements of the plan.

Neighbourhood Health Services Rollout

The first wave of Neighbourhood Health Services in 43 areas across England has been launched. This initiative is a key part of the Plan for Change and the 10-Year Health Plan, aiming to shift care from hospitals to communities and tackle health inequalities.

Each area will establish a Neighbourhood Health Team, led by General Practice and comprising professionals such as community nurses, hospital doctors, pharmacists, dentists, optometrists, paramedics, social prescribers, and voluntary sector partners. These teams will deliver joined-up, person-centred care tailored to local needs, particularly focusing on long-term conditions in areas of high deprivation.

The programme is designed to:

- Reduce hospital admissions and unnecessary referrals.
- Improve access to same-day care and specialist input.
- Address wider determinants of health such as housing and social support.
- Enable proactive care through digital tools like the NHS App.
- GPs will be supported through new voluntary contracts from 2026, allowing them to deliver services across single or multi-neighbourhood footprints.

This rollout marks a significant step toward a community-integrated NHS, with early evidence showing reductions in A&E attendances and improvements in vaccination and screening uptake

Leicester West was selected as part of the first wave of the programme. Through our Group model in partnership with Leicestershire Partnership NHS Trust, we will review the outcomes and share learning across LLR and into Northamptonshire to support wider improvement.

Further information can be found here: Millions of people to benefit from healthcare on their doorstep - GOV.UK

CQC Executive Team

The CQC has announced two senior appointments to the Executive Team following external recruitment. Esther Provins has been appointed as Chief Digital, Data and Registration Officer, replacing her previous interim role. She will lead the development and implementation of CQC's digital and data strategy, oversee the Registration function, and act as the Senior Information Risk Owner (SIRO) and Chris Usher has been appointed as Executive Director of Finance and Corporate Services, with responsibility for Legal, People, Finance, Commercial and Workplace, Governance and Assurance, and the National Customer Service Centre. Both will join the CQC Board as voting members.

Further information can be found here: Two appointments to our Executive Team - Care Quality Commission

Winter Vaccination Programme

The winter vaccination programme has now started, with Children and Pregnant Women being offered the vaccination from 1st September 2025. Vaccine teams across the country are working to ensure it is as easy as possible for those eligible to receive their jabs, including family drop-in clinics in the community. For the first time school immunisation teams in some areas will be offering flu vaccines to 2- to 3-year-olds in nurseries with this expected to roll out more widely.

The NHS National Booking System is now open for all eligible individuals to book their winter flu and COVID-19 vaccinations, with appointments starting from 1st October 2025.

Further information can be found here: Vaccination and booking services - NHS

The government has also announced that a change to prescribing regulations, removing the restrictions around certain flu medications being prescribed outside the usual flu seasons period will allow GPs and pharmacists to respond to flu outbreaks.

Further information can be found here: Government to combat flu outbreaks by removing red tape - GOV.UK

National Review into LGBQT+ Health Inequalities

NHSE has launched its first comprehensive review to address health inequalities experienced by LGBT+ people. The six-month review, led by Dr Michael Brady (National Adviser for LGBT Health), will explore barriers to accessing care and the impact of these inequalities on outcomes and patient safety.

The review will examine data across key areas including mental health, sexual and reproductive health, HIV, perinatal care, cancer screening, and substance misuse services. It builds on evidence showing LGBT+ individuals face poorer access, experience, and outcomes in healthcare compared to the general population.

Aligned with the NHS 10-Year Health Plan, the review will consider how the strategic shifts—hospital to community, sickness to prevention, and analogue to digital—can help reduce disparities. A final report with recommendations will be presented to the Secretary of State for Health and Social Care in December 2025.

NHS England is inviting contributions from healthcare professionals, academics, local authorities, and voluntary organisations to support the evidence base for this work

NHS England » NHS launches first ever review to tackle LGBT+ health inequalities

Local Developments

Chair of LPT and NHFT

I would like to take this opportunity to formally thank Crishni Waring, who will step down from her role as Joint Chair at the end of October 2025, for the significant and lasting contribution she has made across our Group and to both Trusts individually. Her leadership, governance, and support has been instrumental in driving our improvement journey in both organisations. Crishni's impact will be felt well beyond her tenure, and her legacy will continue to shape the future of our organisation.

I look forward to working with Faisal Hussain, who will be taking over the role as Interim Joint Chair from 1st November, to build on the strong foundations in place.

AGM

We held our annual general meeting for the public on 11 September. Held online, it was an opportunity to showcase our performance and improvement outlined in our annual report, highlight our next steps in relation to our new THRIVE strategy, and enable the audience to ask questions. Watch this short film for highlights of our last year, or read the annual report on our website.

New Chair Appointed for LLR and Northamptonshire ICB Cluster

NHSE have confirmed the appointment of Anu Singh as the permanent Chair of the new Leicester, Leicestershire and Rutland (LLR) and Northamptonshire Integrated Care Boards (ICBs) cluster arrangements. Anu will take up the role in October 2025, succeeding Paula Clark, interim Chair.

Anu brings extensive experience in health and local government leadership and we look forward to working closely with her. We would also like to take this opportunity to thank Paula for her hard work for the populations of Leicestershire and Northamptonshire.

Hinckley Hub opens to patients

LPT's space within the Hinckley Hub opened to patients at the beginning of August. LPT staff offer MSK physiotherapy, and children's physiotherapy, occupational therapy, and speech and language therapy, from the area, which has been converted to LPT's specifications.

This is the long term replacement for the Hinckley Portacabin, which closed in summer 2023 to provide space for other NHS developments. An official opening at the Hinckley Hub is being planned in October. The hub itself is a building which hosts a number of public sector organisations, and acts as the headquarters for our landlords, Hinckley and Bosworth Borough Council.

Charnwood Mill relocation

The lease on our base at Charnwood Mill expires this autumn, and we have decided not to renew it to make a significant annual saving. The first team relocated to County Hall in August. Others will be moving between now and October to bases at Loughborough Hospital, Shepshed health centre and Syston health centre, as well as to County Hall.

Voluntary resignation scheme

At the beginning of August we introduced a time-limited opportunity for non-clinical staff to take up a Mutually Agreed Resignation Scheme (MARS) as part of work to address national and local NHS funding challenges. The deadline for applications was on September 2. Similar schemes have been introduced at other local NHS providers.

Celebrating Excellence

We have announced the shortlist for our annual awards event, Celebrating Excellence. The outcomes will be declared at a sponsored event on September 26. Well done to all 240 plus staff and volunteers who were nominated this year and to all the finalists and winners. We are very proud of your commitment to the NHS.

Industrial action

Some of our resident doctors took part in national industrial action in relation to national pay scales between 7am on 25 July to 7am on 30 July 2025. Disruption to any services was minimal.

Anniversary of parent and carers' helpline

In July LPT's Healthy Together Helpline celebrated its second anniversary. It is staffed by health visitors, school nurses and other qualified professionals – and answers around 4,000 calls each month.

The helpline is a reassuring resource that parents and carers can turn to whenever they need it, rather than having to wait for their next appointment with their health visitor or school nurse. The service also helps take pressure off busy hospital and GP services by giving parents and carers a place to turn to for preventative advice and support for non-urgent or serious medical issues.

Vaccination catch-up sessions

We provided a series of "catch up" vaccination sessions during August for children who may have missed out on routine childhood jabs. Our School Age Immunisation Service provided extra protection against the following: human papillomavirus (HPV); meningitis ACWY, tetanus, diphtheria and polio; and measles, mumps and rubella.

Phone support for homeless patients

Our charity Raising Health secured SIM cards from Vodafone to keep 40 homeless people in touch with their healthcare teams and support networks. LPT has a dedicated homeless mental health team, and keeping in touch with homeless individuals and families is one of its biggest challenges.

Waiting list initiative is shortlisted for national award

A project to speed up support for children with mental health issues has been shortlisted for a national award. The project brought together our CAMHS and FYPCLDA Digital Health teams, who created a digital review as an alternative to the children waiting for a face-to-face review with a clinician.

The project is in the Children's Services category of the Nursing Times awards. The winner will be announced on October 23.

Staff Wellbeing initiative shortlisted for national award

LPT's staff-led Our Future Our Way cultural change programme has been shortlisted in the staff wellbeing award category for the national HSJ Awards. This has included improving the induction process for new staff, improving psychological safety and creating a series of wellbeing spaces.

Hospital Hopper

Following a review which included a staff survey, we have informed staff the Trust will no longer make a contribution to the Hospital Hopper from October 2025. Previously staff with a

valid LPT identity card could have free travel on the bus, however, as usage by LPT staff is very low, LPT will no longer fund this. UHL have recently ended some free travel for its staff on the Hopper. Staff can still use the service and pay the same price as the public.

Leicester Pride

Staff from LPT took part in the annual Leicester Pride march and celebration on August 30.

Safe babies

We encouraged staff to take part in a World Patient Safety Day event themed around "Safe care for babies, children and young people". It was held at Leicester City Council on September 10.

Relevant External Meetings attended since last Trust Board meeting

Chief Executive and Deputy Chief Executive external meetings

August 2025	September 2025
Mental Health Trusts CEOs with Regional Leads and SROs	Group SEB with NHFT
CQC Deputy Director of Operations	CEO East London NHS Foundation Trust
NHSE Task & Finish Groups	Management and Leadership Advisory Group
CEO Nottinghamshire Healthcare NHS Foundation Trust	East Midlands Alliance CEO Meeting
LLR ICB Public AGM	Health Innovation Safety Framework
LLR ICB Board Meeting	Internationally Educated Nurses Graduation ceremony
CEO St Andrews Healthcare	CQC/NHSP Trust well led reference group
UHN / LLR / UHL CEOs	Mental Health Trusts CEOs with Regional Leads and SROs
CEO Working Group	Mental Health and IHOs with NHSE
CEO Herefordshire & Worcestershire Health and Care	HSJ Top CEOs Roundtable
National Mental Health Director NHSE	CEO St Andrews Healthcare
LLR Deputy Chief Executive & Chief Operating Officer	UHN / LLR / UHL CEOs
CEO Mersey Care NHS Foundation Trust	Chair/Deputy Chair/Governance leads LPT/NHFT
Vice-Chancellor of De Montfort University	NHS Leadership Event with NHSE
Together Against Racism Group meeting with NHFT	County Health Overview and Scrutiny Committee
10 Year Plan Delivery with NHSE	Joint Governance & Risk Leadership Group
East Midlands Alliance CEO Meeting	Monthly Urgent & Emergency Care Collaborative Transformation Group
REACH Network Leads with NHFT	Urgent & Emergency Care SRO meeting
CEO Birmingham & Solihull Mental Health NHS Foundation Trust	Develop and Enhance the Care coordination for people with intellectual disabilities and multiple long term Conditions (DECODE) event
LLR ICB System Executive Committee and Northants ICB Executive meetings in common	(Midlands region) Winter Planning Stress Test Exercise
Joint Board Development Workshop with NHFT	LLR Urgent & Emergency Care Collaborative
Joint Board Development Workshop with NHFT	Monthly COO/MD/DoN meeting with NHSE
Mental Health IHO Round Table with NHSE	LLR Health and Wellbeing Partnership (i.e. ICP) - development session
Browne Jacobson	Group Strategic Executive Board
Weekly Urgent & Emergency Care	*NHS Employers Policy Board

August 2025	September 2025
LLR Urgent & Emergency Care Collaborative	*Midlands and East Mental Health CEO Network
Monthly Urgent & Emergency Care Collaborative Transformation Group	*East Midlands Alliance Lead
LLR LHRP	* CEO Nottinghamshire Healthcare NHS Foundation Trust
Group Together Against Racism Group	* CEO Mersey Care NHS Foundation Trust
Trust legal team meetings	*Joint CQC Workshop with LPT
Group Q2 Joint Board Development Workshop	* Midlands CEOs with Regional Director NHSE Midlands
LLR ICB System Executive Committee and NICB System Executive meetings in common	*Group Trust Board with NHFT
SYNC	*REACH Network Leads
Armed Forces Network discussion (LLR)	*Mental Health Collaborative Board
Leicester Council stakeholder briefing	* CEO Working Group
Urgent & Emergency Care SRO meeting	*City Council Health & Wellbeing Board
Joint Executive development session with NHFT	*County Council Health & Wellbeing Board
	*LLR ICB & Northamptonshire ICB Cluster System Exec
	*Local Resilience Forum Board
	*SCG – Medical Assistance meeting
	*QIG expectations & reporting requirements (ICB & LPT)
	*Group People's Council

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
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:	Trust Board	
Paper sponsored by:	Angela Hillery, Chief Executive	
Paper authored by:	Sinead Ellis-Austin, Head of Chair/CEO Office	
Date submitted:	September 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:	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	
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:	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	

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Leicestershire Partnership NHS Trust

LPT Trust Board 30 September 2025

Board Assurance Framework

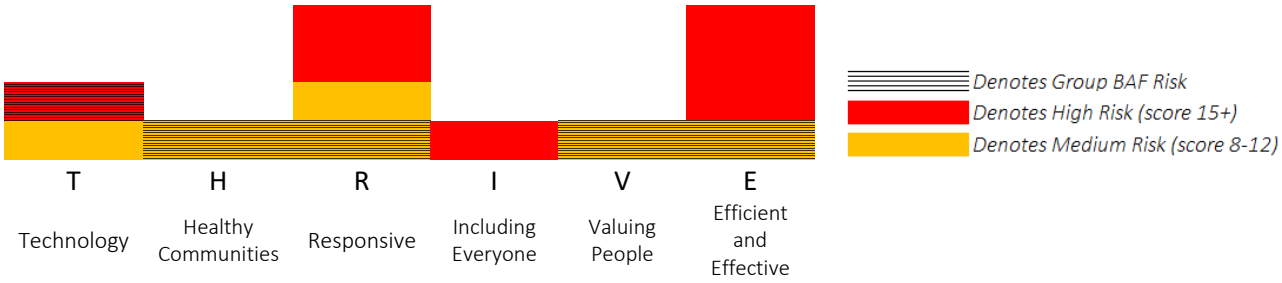
Purpose of the report

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

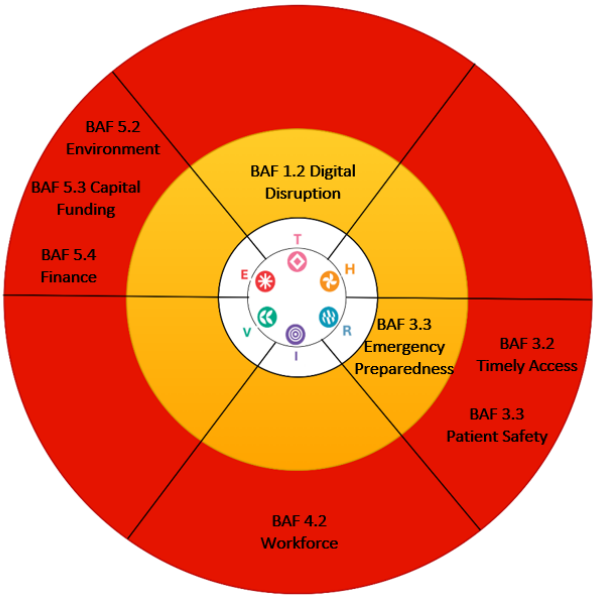
An effective BAF supports the understanding and discussions around delivery of the Trust's strategic objectives underpinning our overarching strategy THRIVE, by identifying the principal risks that may threaten the achievement of those objectives. The full BAF is presented in a separate paper.

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



Summary risk profile for LPT

- There are eight strategic risks for LPT (excluding the five allocated to the Group)
- Of these, six have a high current risk score, mapped to three domains within our strategy.
- The high risks are most concentrated within our Efficient and Effective domain and relate to the delivery of our financial position, the availability of capital funding and the maintaining of our estate.
- The Responsive domain has two high scoring risks relating to our waiting lists and safety of our patients.
- The Including Everyone domain has a high risk focused on our workforce.



Proposal

- We have amended the title of risk 4 to align with NHFT as this is being proposed as one of the Group BAF risks going forward. It does not have any significant impact on the impact of the risk or the scoring.

  Former Risk (BAF5.1)

  If we do not lead with compassion, we will not promote an inclusive culture, resulting in unwanted behaviours and closed cultures.

  New Risk (BAF 4)

  If we do not understand our culture, staff experiences and grow levels of wellbeing in ways that help us to lead and grow with compassion, we will not maintain an inclusive culture, resulting in unwanted behaviours and closed cultures.

- The Group BAF risk pack will be proposed for approval to the Group Board in September.
- We have amended the numbering on the BAF, to allow for a seamless cut of the Group BAF to be taken from the full pack so that collectively and individually they have an appropriate numbering convention.

Decision required

- Approval of the re-wording to BAF 4
- To be assured by the risk management process and that Board remains sighted on key strategic risks relevant to the Trust.

Leicestershire Partnership NHS Trust

Governance table

For Board and Board Committees:	Trust Board 30 September 2025	
Paper sponsored by:	Kate Dyer, Director of Governance and Risk	
Paper authored by:	Kate Dyer, Director of Governance and Risk	
Date submitted:	18 September 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 (full BAF) Level 1 Committees Bi-monthly (relevant excerpt only) Group Board (Group BAF risks only)	
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	
LPT strategic alignment:	**T** - Technology	All
	H – Healthy Communities	
	R - Responsive	
	I – Including Everyone	
	V – Valuing our People	
	E – Efficient & Effective	
CRR/BAF 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

September 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 No.	Risk Title	Score
Section 1 - T Technology [Finance and Performance Committee Oversight]		
GROUP BAF 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 BAF 2	If we fail to evolve our **partnerships and collaboratives**, we will not reduce health inequalities and deliver improved outcomes for our populations	8
Section 3 - R Responsive [Quality and Safety Committee Oversight]		
GROUP BAF 3	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 and **V** Valuing people [People and Culture Committee Oversight]		
GROUP BAF 4	If we do not understand our **culture**, staff experiences and grow levels of wellbeing in ways that help us to lead and grow with compassion, we will not maintain an inclusive culture, resulting in unwanted behaviours and closed cultures.	12
BAF 4.2	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 – E Efficient and Effective [Finance and Performance Committee Oversight]		
GROUP BAF 5	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
BAF 5.2	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
BAF 5.3	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
BAF 5.4	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**	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 16.09.2025
Strategic Link	THRIVE: **TECHNOLOGY**
Governance	**GROUP** LPT and NHFT 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 & NHFT Digital plans • National Digital plan • Digital maturity assessment • Digital Prioritisation Process • ICBs 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 committees decide the level of digital capital spend by evaluating investments in technology infrastructure and initiatives, such as new equipment and system upgrades, alongside other non-digital capital programs. The committees ensure that this capital spending is aligned with the Trusts' long-term strategic goals and system partners. **2nd Line:** The Information Management & Technology/ Digital Data & Technology Groups ensure the relevance of the Digital Plans & commitment to delivery on behalf of the Trusts' Finance & Performance Committees in line with the Trusts' strategic priorities and system partners. The Committees ensure that mechanisms are in place to assure the operational delivery of the Digital Plans for the Trusts through robust reporting and monitoring arrangements. The Committees 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 Committees are provided with a copy of the relevant Digital Plan and the LHIS/DTS annual report to offer assurance on the strategic direction and execution of digital initiatives. By receiving these documents, the committees can assess whether digital investments align with organisational goals, are delivered within budget, and have achieved the expected results. This oversight allows the committees 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 & NHFT digital strategies and deliver their 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 - complete** • Gap analysis of capacity to deliver plan. **Joint Director of Digital July 2025 – EMB Aug 25** • Group Digital Plan to be drafted – Sept 25	Group Digital transformation group in place to oversee delivery with AAA report into FPC/PC. Inclusion within Group Trust Board workplan.
Effect: Unable to support service transformation.					
• Group Digital transformation programme. • Group Digital Transformation Group • Digital Prioritisation Process – LPT & NHFT	• 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 Trusts considers clinical engagement and involvement in decisions to be an essential element of its governance arrangements. As such, the Trusts' 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.** to be presented to LPT digital transformation group and assurance to FPC – **Aug 25** – complete. Gap analysis of clinical leadership to deliver plan. **Joint Director of Digital** to be presented to LPT digital transformation group and assurance to FPC – **August 25** – complete.	Group 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 16.09.2025
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 • Cyber Security assess all software that is required to be installed / DPIAs • Cyber Group formed across LLR/NICB by the ICB CISO • Small number of CSOs who manage clinical safety	• **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)** • **Clinical Digital Leadership especially in relation to Clinical Safety Officers and CNIO is limited and dispersed and sits outside of Digital.**	**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:** 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 **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 SIRO, Deputy SIRO and CDIO all undertaken SIRO training via NHSE	Group (LPT/NHFT) level Digital committee, Plan, Road map. • **Assurance of security posture/compliance from core IT service suppliers.** Impact of training and phishing campaigns	• 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. • Windows 11 implemented across the Trust • CDIO to review clinical digital leadership at a group level to align where possible with NHFT as an exemplar. **Joint Director of Digital throughout 2025/26**	• Pillar under the new Digital Transformation Group in place to review Cyber opportunities • DSPT CAF Complete for LHIS and LPT • Mobile phone replacement programme being started along with rollout of InTune • Nearly 50% complete, needs to be 100% in late October • Agreed with NHFT MD and CFO to undertake the review of clinical digital leadership.
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. • DTAC Process exists to ensure suppliers meet certain cyber and clinical safety standards to safeguard the Trust.	• Finance • Capacity • Cyber awareness / training • Finance • Capacity • Cyber awareness / training • DTAC process is not consistently applied due to lack of ownership and dispersed expertise (IG, CSOs Procurement, Cyber etc)	**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. **2nd Line** Capital has been obtained from NHSE in previous years for key cyber security requirements as well as the new ICB CISO role. **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	Capital might not be sufficient and there are no ring-fenced finances for Cyber	Raise at the capital management committee when appropriate with ongoing oversight DTAC Process needs to be reviewed and consistently applied by Procurement Team to help manage the risk of our supply chain **Joint Director of Digital throughout 2025/26**	Escalation of capital limitations impacting on delivery of digital agenda to EMB Raised at next IMTC to gain clarity on what is currently in place. – NHFT/DTS sharing their approach and process which Audit and NHSE have recommended.

GROUP BAF **2**	If we fail to evolve our **partnerships and collaboratives**, we will not reduce health inequalities and deliver improved outcomes for our populations	
Date	Included 1 April 2025.	Last updated 17.09.2025
Strategic Link	THRIVE: **HEALTHY COMMUNITIES**	
Governance	**GROUP** LPT and NHFT 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/NHFT and from LPT/NHFT with the VCSE and other stakeholders • Organisational monitoring of system meetings • Named executive leads attending place-based meetings • 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 Boards and other internal formal meetings. Leadership support within Collaboratives / DMT oversight Directorate delivery plans	Consistent feedback from system meetings	Action learning within directorates to identify opportunities using DNA data to improve health equity. Leadership Matters Conferences Oct 2025 **Group Director of Strategy & Partnerships** Work to implement high impact actions for LeDeR to reduce premature age of death in people with LDA System LeDeR Reports now available November 25 **Group Director of Strategy & Partnerships**	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. System working on integrated neighbourhood teams, **successful application Sept 2025**
		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, Commissioning & Contracting Group Transformation Committee / engagement in formal ICB meetings - feedback into the Strategic Executive Boards.	Self-assessment / gap analysis SMART actions / KPIs Success reporting Effectiveness of Collaborative, Commissioning & Contracting Group / Escalation via SEBs		
		3rd Line: Feedback from our well-led review, the CQC and other organisations; Mental Health Collaborative Joint Project Engagement meetings with CQC, NHS England, ICBs Regional & national recognition of effective joint working 3rd Line: Feedback from our well-led review, the CQC and other organisations; Mental Health Collaborative Joint Project			
Effect: **Limited contribution to social value, and providing place-based care**					
• Social Value Charter • Trusts' Green Plans • People Plan • Social Value Community of Practice • NHSE national policy on integrated care • Social value charter • ICB 5-year strategy • Group 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.		Alignment of directorate delivery plans and the Trust transformation programme with the ICB 5-year strategy **LPT & NHFT Round Table** will be included in planning processes being completed Autum/Winter 2025 – **Group Director of Strategy & Partnerships**	Action Plan approved
		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.	Success reporting (longer term)		
		3rd Line ICB Health Inequalities Meetings			

GROUP BAF **3**	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	16th September 2025
Strategic Link	THRIVE: **RESPONSIVE**		
Governance	**GROUP** LPT and NHFT 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 & NHFT integration with system (LANHP partnership working) • Web-based platforms to support QI activity and QI Training Programmes • 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 Data being presented quarterly to Accountability framework meeting in LPT	Assurance over uptake and PRES survey outcomes	• Group Research Strategy and delivery plan **Medical Directors October 2025 –** being progressed through the Generating New Knowledge workstream as part of the University Hospital status. • Group Joint Roles with clinical/AHP research element – 'Principal Investigators' **Medical Director October 2025 –** identification of number of principal investigators and those requiring training • Ongoing work on progressing from Associate university status to university status. • Mapping current research activity for Joint working group to support University status application. Information presented to Board development day. • Assurance over uptake and PRES survey outcomes **Medical Director: quarterly data presented to respective AFMs - ongoing** • SORT self-assessment action plan **Medical Director September 2025 – complete** • Associate Professor in old age being progressed through UoL for NHFT	Generation of New Knowledge Workstream Oversight of research participant recruitment numbers to form part of reporting to QSCs LB to present SORT data findings to joint working group – complete – presented Jul 25
		2nd Line: Joint Working Group (Generating New Knowledge) oversight of Group research and innovation programme Research programme to Quality and Safety Committees Local clinical research network Transformation and QI Delivery Groups Oversight of LAHP papers at SEBs 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 programmes • Transformation Programmes • Directorate objectives aligned to strategy • Deputy Medical Director for R&D • Trust Leads 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 October 25**	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 16 September 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 • Monitoring NHS111/2 activity 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 **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	Linkage of health inequalities to access group actions Clarity over policy compliance measures and rates ADHD Solutions closure – reduction in support across LLR	• Health Inequalities work to support Access Group actions. **Director of Strategy - Ongoing** • Policy compliance with Access policy **– Access Group– September 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 established with a set of actions - **Director of Nursing & Medical Director Sept 2025**	
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 **2nd Line** Monthly performance report with clinical outcomes measures to Quality and Safety Committee and AFM **3rd Line** Internal audit patient experience August 2022 significant assurance Coroner feedback	Clarity over policy compliance measures and rates • Comprehensive quality dashboard focusing on outcome measures, including those attributed to waiting External review of waiting times on patient safety	• Quality & Safety Metrics dashboard Report which will enable teams and services to have oversight of their key quality and safety metrics as defined by the CNO **Director of Nursing – phase 1 live - June 25.** Phase 2 to consider additional metrics to support patient safety. • 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–** mapping complete - to be presented to Safety Forum Sept 25	Quality dashboard delivery framework developed (3-year programme)

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 19 August 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	• Patient Safety Improvement Programme – approved as closed EMB Aug 25. EMB to oversee BAU areas – review Oct 25 • PSIRF priorities agreed at EMB (trust level) directorate level work ongoing to agree closure of 24/25 priorities • Suicide prevention work & training **Medical Director, update August 25** • Head of Safeguarding recruited & induction underway **Director of Nursing Aug 2025**	• 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 Policy compliance oversight	• 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 – phase 1 complete, phase 2 underway **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 16.09.25
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 approved at SEB in September 2025.**	Joint EPRR lead in place and in process of reviewing all related policies Submitted core standards assessment to NHSE
		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	1st draft LLR winter plan 25/26 – 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** • Submitted EPRR core standards assessment 2025/26 **Managing Director ongoing.**	Taken part in industrial action audit for national review.
		2nd Line: Training oversight and management	Submitted EPRR core standards assessment for 2025/26		
		3rd Line • Internal Audit – Business Continuity August 2022 Significant Assurance			

BAF **4**	If we do not understand our **culture**, staff experiences and grow levels of wellbeing in ways that help us to lead and grow with compassion, we will not maintain an inclusive culture, resulting in unwanted behaviours and closed cultures.
Date	Included 1 April 2025 — Last updated 18th September 2025
Strategic Link	THRIVE: **VALUING PEOPLE**
Governance	**GROUP** LPT and NHFT People and Culture Committees, Group Strategic Executive Board, Group 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 Groups • Joint OD Working 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** • Launch of 2025 Staff Survey – 15th Sept – 28th Nov 2025 – joint working across group on staff survey engagement • Inclusive recruitment programme launched Sept 2025	Anti racism listening events & FAQS following civil unrest/racist riots Workplace Safety & Security Sessions planned in Medical Trainees Inductions from December 24 Leadership Programme for medics - planning underway Team Time Out year 2 ongoing
		2nd Line: • Reasonable adjustment clinics & meetings established • Leadership Development Conferences • F2SU Guardian, NED F2SU role • Learning from speaking up and sickness review • Workforce Development Groups; People and Culture Committees • Schwartz Rounds • Group programme reporting to SEB every month for oversight	• Staff survey Oct 25 • 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	• Leadership Conferences – focussed on psychological safety & speaking up within the 25/26 programme **Director of HR/OD** • Speak Up Events planned October 2025	• Jan, April & November 25 Team Leadership Conference • THRIVE leadership conference held July 25
		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 **4.2**	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 18th September 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 medics • International recruitment • Nursing Recruitment & Retention High Impact Actions • LLR AHP faculty & Council • L2 Committee Workforce Development Group in place • Benchmarking against workforce metrics • Jobtrain Effectiveness review	• 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 **2nd Line:** Workforce Development Group; Directorate Workforce groups & HCA Retention Working Group Strike Action Group (as required) including organisational debriefs; People & Culture Committee **3rd Line:** System people and culture board System CPO meetings	• 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 medical workforce plan • Delivery of the workforce and agency reduction plan	• Delivery of the workforce and agency reduction plan 2025/26 **Ongoing Director of HR/OD** • WDG to monitor time to hire Ongoing **Director of HR/OD** • Directorate level time to hire reports ongoing **Director of HR/OD** • WRES & WDES action plans signed off WDG 18.9.25 – to PCC Oct 25 for approval	Engagement with the NHSE price cap work for medical agency costs commenced Feb 2025 People Dashboard launched through PCC Jobtrain/time to recruit reviewed Aug 25
Effect: **High Agency Usage**					
• Agency Reduction Plan	None	**1st Line** EQIAs DRA and break glass criteria to stop deployment of Thornbury HCA **2nd Line** Agency reduction group AAA to People & Culture Committee **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	Delivery of the workforce and agency reduction plan	• Delivery of the workforce and agency reduction plan 25/26 Ongoing - **Director of HR/OD** • Deep dive into agency & bank us to EMB Oct 25.	• No off-framework usage outside of break glass • THP numbers reducing • Bank incentives stopping agreed subject to EQIA

GROUP BAF **5**	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 16.09.25
Strategic Link	THRIVE: **EFFICIENT AND EFFECTIVE**	
Governance	**GROUP** LPT and NHFT 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:** Sustainability Programme Delivery Group	• Plans to start Group Sustainability Forum July 25 - commenced	• 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 - complete** • To share revised green plan with NHSE and DHSE. **Chief Finance Officer July 2025 - complete** • Gap analysis of available funding and impact of any resource gap on delivery of the revised green plan. **Chief Finance Officer November 2025** • Green Plan going to September LPT TB for sign off • Green Plan signed off July NHFT TB	• Funding secured for LPT solar panel installations at Hinkley & Bosworth and Loughborough plus 4 more
		2nd Line: Finance & Performance Committees 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** Sustainability Programme Delivery Group	• Plans to start Group Sustainability Forum July 25 - commenced		
		2nd Line Finance & Performance Committees 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 **5.2**	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 16.09.2025
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 – ongoing** • Medical Directorate rep at relevant Estates meetings to be identified – **Medical Director**	Space Utilisation Study started Sept 24 – Feb 25 full completion – signed off 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

BAF 5.3	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 12.09.25
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 • Underspend risk due to delayed receipt of NHSE bid funding	• Policy compliance audit and oversight **Director of Finance and Performance.** • Escalate in NHSE review meeting 15/09/25 **Director of Finance and Performance.** • External audit of 25/26 accounts **Director of Finance and Performance.**	
		2nd Line: Accounting policies / SFIs and SORD [Audit and Risk Committee]	Policy compliance		
		3rd Line: External Audit 2024/25 annual accounts unqualified opinion	25/26 annual accounts audit		
Cause: **Inadequate reporting and management**					
• Monthly finance report with exec level oversight • Capital management committee 3A report • ICS capital Committee	None	**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 External audit of 25/26 accounts. **Sharon Murphy, DoF / March 26**	In progress
		2nd Line			
		3rd Line KPMG 2024/25 annual accounts and VFM conclusion			
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		• Submit LPT 26/27 & medium term plan. **Director of Finance Dec 25** • Manage Trust's capital plan **DoF / March 26** • Policy compliance audit and oversight **Director of Finance and Performance.**	In progress
		2nd line:			
		3rd line:	25/26 annual accounts audit		

BAF **5.4**	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 12.09.25
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	Spend run rate is not reducing fast enough to deliver plan Reducing cash balances Supplier challenge of contract awards	• DMH to manage private provider costs **Director of DMH;** additional recovery actions implementation **ALL** • Enhanced cash reporting • Ensure transparent & compliant contract awards • Policy compliance audit and oversight **Director of Finance and Performance tbc** • External audit of 25/26 accounts **Director of Finance and Performance**	Ongoing In place Review processes Being scheduled
		2nd Line: Accounting policies / SFIs and SORD [Audit and Risk Committee]	Policy compliance		
		3rd Line: External Audit 2024/25 annual accounts unqualified opinion	25/26 annual accounts audit		
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 **DoF ongoing** • Close plan gap **–** additional recovery actions implementation **ALL** • Enhanced cash reporting • Ensure transparent & compliant contract awards • Policy compliance audit and oversight **DoF** • External audit of 25/26 accounts **DoF** • Deep dive reporting **Director of Finance and Performance ongoing** • DoF/service financial escalation meetings	Ongoing -work prioritised In place in place for DMH
		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**	
		2nd Line			
		3rd Line KPMG 2024/25 annual accounts and VFM conclusion	25/26 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 **DoF** • Develop & submit 26/27 & medium term financial plan **DoF** • Manage delivery of 2025/26 financial plan **DoF / March 26**	
		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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Leicestershire Partnership NHS Trust

3As Highlight Report
Meeting Name: Audit and Risk Committee
Meeting Chair & Report Author: Hetal Parmar / Val Glenton
Date: 12 September 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				
HFMA Checklist	ARC/25/060	Deputy Director of Finance	An update was provided on the Trust's progress against actions that arose from the HFMA Checklist which was initially considered in quarter 3 of the 2022/23 financial year. The checklist had contained 36 areas the HFMA considered to be best practice, ARC noted 8 were still to be completed which was the same position as reported in quarter 4 2024/25. The committee agreed the proposal to close this exercise as there were other checklists that were now in use which were more pertinent to the current position, with actions that were more likely to improve the financial position. It was also agreed that a status update would be noted against each of the 8 incomplete actions to reference where else these were being picked up (for example, alternative checklist etc), before the HFMA checklist was closed down.	N/A
ASSURE: Inform the Board where positive assurance has been received				
Internal Audit Progress Report	ARC/25/052	Client Manager 360 Assurance	Good assurance was provided on internal audit activity since the previous meeting. Two final reports had been issued; the Data Security and Protection Toolkit with low risk / high confidence level which was an NHSE assessment level; and Strategic Level Governance with significant assurance opinion.	N/A

Agenda Item:	Reference:	Lead:	Description:	BAF Ref:
			All internal audit actions had been implemented giving a 100% first follow rate for high and medium risks and 100% overall implementation rate.	
Counter Fraud Progress Report	ARC/25/053	Anti-Crime Team Manager, 360 Assurance	A new corporate offence of *failure to prevent fraud* came into effect from 1 September 2025 affecting all public sector organisations. 360 Assurance was supporting the Trust on the implications and next steps to ensure risks associated with this legislation were mitigated. The Anti-Crime Team Manager did not expect there to be a significant amount of work to be done on this for the Counter Fraud Authority as robust fraud prevention measures were already in place.	N/A
Governance & Risk Report	ARC/25/056	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. • Delivery of the 18 recommendations made by Deloitte in the external review of governance and leadership in July 2024 was almost complete, planning for a CQC well led review continued. • An inaugural meeting of the Group Strategic Executive Board took place on 1 September 2025 to discuss items pertinent to both trusts. • All policies were in date, there were 220 in total. • The Risk Management Policy was being updated and would be presented to the next meeting.	N/A
Level 1 Committee Annual Effectiveness Reviews 24/25	ARC/25/057	Director of Governance and Risk	A full review of the effectiveness of each of the level 1 committees had taken place and been approved by each of the committees. The reviews had concluded that the committees had been effective during the year and had fulfilled their terms of reference. ARC agreed that future reviews would provide views from each committee on how they were contributing to delivering high quality, safe and compassionate care and on the triangulation between committees to address key performance issues.	N/A
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding				
There were no items to highlight to Board.				

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Leicestershire Partnership NHS Trust

Audit and Risk Committee – 13 June 2025

Audit and Risk Committee Annual Effectiveness Review 2024-25

Purpose

To provide an annual review of the effectiveness of the Audit and Risk Committee for 2024-25

Analysis of the issue

The role of the Audit and Risk Committee is to seek and provide assurance to the Trust Board in relation to the effectiveness of their internal system of governance, risk management, and control. It is a level one statutory committee of the Board and is chaired by a non-executive director.

A full review of the effectiveness of the Committee has been provided in Appendix A which has concluded that the Committee has been effective during the year and has fulfilled the current Terms of Reference (ToR).

Proposal

To demonstrate that the ARC has been effective during the year and has been subject to ongoing development and improvement.

Decision required

To confirm a level of assurance over the effectiveness of the ARC during 2024/25.

Governance table

For Board and Board Committees: Paper sponsored by:	Audit and Risk Committee 13 June 2025 Kate Dyer Director of Governance and 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	Kate Dyer Director of Governance and Risk 6 June 2025 None NA Annual	
LPT strategic alignment:	**T** - Technology	
	H – Healthy Communities	
	R - Responsive	
	I – Including Everyone	
	V – Valuing our People	
	E – Efficient & Effective	Yes
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:	BAF NA CRR25 Gaps in Governance Yes None	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed	
Equality considerations:	None	

Appendix A ARC Annual Effectiveness Review 2024/25

1. Fulfilling the Terms of Reference

1.1 Governance Arrangements

All meetings continue to be held virtually on Microsoft Teams and this is both efficient and effective. The ARC does not have any feeder level 2 committees within the corporate governance structure.

1.2 Terms of Reference and Work Plan

The duties of the ToR were covered through the work plan and agendas during the year. The latest ToR was approved in March 2025. The work plan has been updated to reflect any changes as a result of this review.

1.3 Membership

Membership attendance has been satisfactory, and each meeting was quorate. The Committee is comprised of three independent non-executive Directors; quoracy is two non-executive directors. A number of officers including the Finance Director and the Director of Governance and Risk attend meetings of the Committee.

The ToR states that the Committee shall meet no less than four times a year. A total of four meetings were held during the year with the following attendance:

Attendance at ARC meetings 1 April 2024 to 31 March 2025:
Key - P = present, NA = not applicable, X = non-attendance, X – initials = nominated representative

Member	Role	14.6.24	13.9.24	13.12.24	7.3.25
Hetal Parmar	NED & Chair	P	P	P	P
Alexander Carpenter (Until Aug 24)	NED	P	NA	NA	NA
Faisal Hussain	NED	X	P	P	X
Manjit Darby (from Aug 24)	NED	NA	P	P	P
Sharon Murphy	Director of Finance	P	P	P	P
Kate Dyer	Director of Governance & Risk	P	P	P	P
360 Assurance Representative	Internal Audit	P	P	P	P
360 Assurance Representative	Counter Fraud	P	P	P	P
KPMG Rep	External Audit	P	P	P	P

2. Committee Effectiveness

2.1 The meetings have been considered as well-run throughout the year. Papers are issued five working days ahead of the meeting and are of good quality. The minutes of the meetings continue to reflect thorough and informed debate for items with a rigour for matters not proceeding as expected and support for positive progress as assured. After every meeting the Committee provides a 3A Highlight Report for assurance levels received for agenda topics to SEB & to the Trust Board.

3. Members and Attendees Feedback 2024/25

We have collated feedback from members and attendees of the Committee relating to areas of achievement and success, and any challenges and barriers during 2024/25

3.1 Achievements and successes in 2024/25

- Strong Head of External Audit opinion.
- Best in class follow-up rate on internal audit actions (c.94%), including high and medium rated actions.
- High assurance on risk management and risk culture.
- Feels like an efficient & effective committee – challenging but fair discussions in all areas.
- Effective oversight and robust challenge throughout the year.
- Internal audit work.
- Good working relationships in committee.

3.2 Challenges and barriers during 2024/25

No challenges or barriers were identified by the committee members.

4. Future Plans

The future plans for the 2024/25 year were met during the year and included the following;

- Further development of the BAF. The BAF continued to be updated through the year, with supporting board development activity and updates provided to the ARC.
- The Governance and Risk paper was redesigned to provide a succinct and focused update on relevant activity.
- The bulk of the agenda was determined by the agreed audit plan and other statutory duties.
- The workplan was subject to ongoing review to ensure it remained relevant during the year.

The future plans and recommendations identified for 2025/26 will support the Committee to continue to focus on the right agenda during the year;

- Support further development of BAF in light of the new strategy (THRIVE).
- Ongoing assurance around the use of waivers (through the auditor panel), procurement and the appointment of external auditors.
- Audit outturn for 2025/26
- Effective oversight of all committees work on tracking impact of financial position.

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Leicestershire Partnership NHS Trust

Trust Board 30th September 2025

Trust Board Annual Effectiveness Review 2024/25

Purpose

To provide an annual review of the effectiveness of the Trust Board for 2024/25.

Analysis of the issue

NHS Trust Boards play a key role in shaping the strategy, vision, and purpose of an organisation. They are responsible for holding the organisation to account for the delivery of the strategy and to ensure value for money. They are also responsible for assuring that risks to the organisation and the public are managed and mitigated effectively. Led by an independent chair and composed of a mixture of both executive and independent non-executive members, the Trust Board has a collective responsibility for the performance of the organisation.

The Trust Board meets virtually to hold Public & Confidential meetings on a bi-monthly basis. A development meeting is held face-to-face on the alternate months and additional development sessions take place with the Board of Northamptonshire Healthcare NHS Foundation Trust as part of our Group arrangement. From May 2025 a Group Public Trust Board is in place to review group related activity.

Effectiveness of the Trust Board Meetings

Trust Board meetings have been evaluated and deemed to be effective during 2024/25. Items on the Trust Board work plan were received during the 2024/25 year and to date either in line with expectations or deferred and noted on our Board agenda.

Membership attendance has been satisfactory; each meeting was quorate, and each meeting has included clinical representation across 2024/25.

Attendance at Public & Confidential Trust Board meetings 1 April 2024 to 31 March 2025:

P = present, NA = not applicable, X = non-attendance, X – initials = nominated representative

Member	Role	28.5.24	25.6.24 EGM	30.7.24	24.9.24	26.11.24	28.1.25	25.3.25
Crishni Waring	Chair	P	P	P	P	P	P	X
Faisal Hussain	NED & Deputy Chair	P	P	P	P	P	P	P
Hetal Parmar	NED		P					P
Alexander Carpenter	NED	P	P	P	X	P	P	X
Manjit Darby	NED	NA	P	X	P	P	P	P
Josie Spencer	NED	P	P	P	P	P	P	P
Ruth Marchington	NED (until May 2024)	P	NA	NA	NA	NA	NA	NA
Elizabeth Anderson	NED	P	P	X	P	X	P	X
Angela Hillery	CEO	P	P	P	P	P	P	P
Jean Knight	DCEO	X	X	X	P	P	P	P
Sharon Murphy	Director of Finance	P	P	P	P	P	P	P
Bhanu Chadalavada	Medical Director	P	P	P	P	P	P	P

Anne Scott	Executive Director of Nursing (until June 2024)	P	X (JM)	NA	NA	NA	NA	NA
James Mullins	Acting Executive Director of Nursing	P	P	X (DR)	P	P	P	P
Kate Dyer	Director of Governance & Risk	P	X	P	P	P	P	P
Samantha Leak	Executive Director of Community Health Services	P	P	P	X (NB)	P	P	P
Tanya Hibbert	Executive Director of Mental Health	P	P	P	P	P	P	P
Helen Thompson	Executive Director of FYPCLDA (until June 2024)	P	P	NA	NA	NA	NA	NA
Paul Williams	Acting Executive Director of FYPCLDA (from June 2024)	NA	NA	P	P	X (MR)	P	P
Sarah Willis	Executive Director of HR & OD	P	X	P	X (DN)	P	P	P
Paul Sheldon	Chief Finance Officer	X	X	P	P	P	X	P
David Williams	Executive Director of Strategy & Partnerships	X (AG)	P	P	P	P	X	P

Trust Board meetings have been considered as well-run throughout 2024/25. Papers are issued five working days ahead of the meeting. It has been raised in previous year's annual reviews that the size of the agenda and length of the papers was an issue. Whilst this remains an ongoing challenge, the mapping of governance across the Level 1 Committee continues to support the clarity of work planning for the Trust Board. The Group Trust Board should ease the burden further and prevent duplication of work across the Trusts.

The minutes of the meetings continue to reflect thorough and informed debate for items with a rigour for matters not proceeding as expected and support for positive progress as assured. Actions are managed with a dynamic action log which demonstrates good responsiveness across the year.

Each of the level 1 Committees (the Board sub committees) have undertaken a review of effectiveness for 2024/25, these have been approved by each of the committees. The level 1 annual effectiveness reviews have concluded that the Committees have been effective during the year and have fulfilled their Terms of Reference. The reviews have identified several improvement actions for the Committees for 2025/26 onwards. Assurance over the effectiveness of the reviews was confirmed at the 4th September 2025 Audit and Risk Committee and this is reported to Board in the ARC AAA report.

Key Findings from the external review of leadership and governance

During the 2023-24 period and in line with guidance from NHS England (NHSE), the Trust conducted an externally facilitated, developmental review of its leadership and governance arrangements using the well-led framework. Deloitte found that the Trust is led by a highly regarded Chief Executive and Chair, who leads a unitary board, that is open, transparent and sets the tone for the organisation. During the 24-25 period the Trust has made further refinements to strengthen and align governance and risk management arrangements at board and in committees in line with the recommendations from the review. As a result of the Deloitte Well Led Review an action plan was drafted and improvements executed throughout the year. Actions from the review are now closed as implemented, with the final action being presented for closure at the 30th September 2025 Trust board.

Trust Board Compliance with the Code of Governance

- The Code of governance Section C: Composition, succession and evaluation 1.3 states *Annual evaluation of the board of directors should consider its composition, diversity and how effectively*

members work together to achieve objectives. Individual evaluation should demonstrate whether each director continues to contribute effectively.

As part of our annual evaluation of the Board of Directors, we have considered the composition and diversity of the Board, ensuring that it continues to reflect a broad range of skills, experiences, and perspectives necessary for effective governance. We regularly consider how well Board members collaborate and function as a cohesive unit in pursuit of the organisation's strategic objectives. Ongoing individual evaluations are conducted to determine whether each director continues to contribute effectively, both in terms of their engagement and the value they bring to the Board's collective performance.

- The Code of governance Section C: Composition, succession and evaluation 4.5 states *There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors…NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.*

  We conduct a formal annual evaluation of the performance of the Board of Directors and its committees. The Chair and individual directors all undertake annual appraisals and regular one to ones. These processes are designed to ensure accountability, enhance effectiveness, and support continuous improvement in governance practices. Ongoing evaluation includes both internal assessments and external reviews to provide objective insights. Outcomes from evaluations are reviewed by the Board and used to inform development plans, succession planning, and strategic alignment.

Members and Attendees Feedback 2024/25

We have collated feedback from members and attendees of the Committee relating to areas of achievement and success, and any challenges and barriers during 2024/25

Achievements and successes in 2024/25:

- The board development sessions improve our collective growth as a Board and builds relationships further, including across the group.
- The staff, patient and service stories are key to bringing everything we do to life which provide Board and the public with a real sense of what and how we deliver care each day – good to see enabling teams being able to share going forward too. The feedback from teams that share at Board is overwhelmingly positive and they find such encouragement and an extra sense of value from the feedback they receive.
- The risk-based approach of the board and the introduction of the BAF and its development through Board meetings and how it is now the golden thread running through.
- Patient and staff stories at the start of each Board meeting continue to be excellent.
- Bringing in the system / national issues and ensuring we are all briefed via the Chair CEO report.
- Development of Thrive the first joint group strategy, and delivery/close down of the SUTG strategy.
- Working on the outputs from the Deloitte "Well – Led" review.
- Effective oversight and strong governance – particularly effective framework on reporting back from committees and use of BAF.
- Transparency of financial position, and delivery of financial balance and strong oversight of safety and workforce agendas.
- Effective relationships and dynamics which allow confirm and challenge and open and honest discussion.
- Board has good balance of knowledge, skills and expertise.
- Strong risk and audit focus with high levels of audit assurance.
- ICB collaboration.

Challenges and barriers during 2024/25:

- Face to face meetings may further develop and strengthen the relationships of Board members
- Noting the extremely challenging and turbulent external environment.
- The need to maintain focus on delivery of LPT priorities whilst engaging on joint approach across the group.
- Papers can be more strategic and to-the-point.
- Continuing with work on Well-Led.

Future Plans for 2025/26:

- Oversight and assurance on the LPT delivery of our THRIVE strategy and the delivery of associated plans for 25/26.
- The ongoing development of our group board and governance to embed.
- Ensuring that we balance financial control and the delivery of safe services.
- Maintaining a focus on system issues, continuing to consider the impact on the Trust and our place in resolving system issues. Be a good system partner.
- Keeping abreast of NHS reforms and implications, including regulatory changes and sector changes. Continue with strategic horizon scan and 10 year plan.
- Remain focussed on improvement journey and ensuring we move to good/ outstanding CQC rating with a focus on quality, and a community focus on our neighbourhoods.
- Delivery of financial balance and productivity / efficiency.

Proposal

To receive assurance over the effectiveness of the Trust Board during 2024/25.

Decision required

To confirm a level of assurance over the effectiveness of the Trust Board

Governance table

For Board and Board Committees:	Trust Board 30th September 2025	
Paper sponsored by:	Kate Dyer Director of Governance and Risk	
Paper authored by:	Kay Rippin Deputy Trust Secretary	
Date submitted:	18th September 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):	NA	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	NA	
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 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):*		
Is the decision required consistent with LPT's risk appetite:		
False and misleading information (FOMI) considerations:	NA	
Positive confirmation that the content does not risk the safety of patients or the public	Y	
Equality considerations:	Considered	

K

Leicestershire Partnership NHS Trust

Leicestershire Partnership Trust Board

Clinical Plan 2025 - 30

Purpose of the Report

Introduction

This Clinical Plan will describe the themes and priorities for all clinical and enabling directorates at Leicestershire Partnership NHS Trust for the next five years. It is a culmination of our ideas and ambitions, reflecting on what is most important to us on our journey to improving patient care and staff wellbeing. The material within this framework has been obtained through consultation with staff and services to support the development of our Trust within a rapidly changing and challenging environment.

We provide mental health, learning disability and community health services for the one million people of Leicester, Leicestershire and Rutland – touching the lives of all ages through our 7,800 staff (including bank staff) and over 200 volunteers. This is delivered through three directorates: Community Health Services (CHS), the Directorate of Mental Health (DMH) and the Families, Young People, Children, Learning Disabilities and Autism Services (FYPCLDA).

Our main aims are to ensure every patient receives high quality, safe and effective care that is:

- Needs led
- Person-centred
- Evidence-based
- Encouraging of self-care

The Clinical Plan aligns with:

- Our Group strategy, THRIVE.
- Fit for the Future: NHS 10 year plan
- NHS Operational Plan
- LLR ICB Clinical Strategy
- LPT Operational Plan
- Directorate(s) Transformation Plans
- People Plan
- Estates Strategy, Digital Plan

Current context

Following the COVID-19 pandemic, the challenges facing the NHS have been amplified and accelerated to an unprecedented level. This includes a significant increase in waiting times, complex presentations and financial challenges. In addition, this has exacerbated the existing barriers for people to access healthcare.

Waiting lists can increase pressure on emergency services and lead to worsening social inequalities due to problems with employment, housing and social isolation. We also have a very ethnically diverse population which requires an inclusive approach to ensure everyone can access the healthcare they need. Health inequalities are a pressing issue and a key area of focus through our transformation and quality improvement projects.

We are also working through issues relating to our ageing estates. Due to financial challenges, prioritisation of work on estates and facilities has become a difficult, but extremely important, process using safety and quality domains to guide decision making.

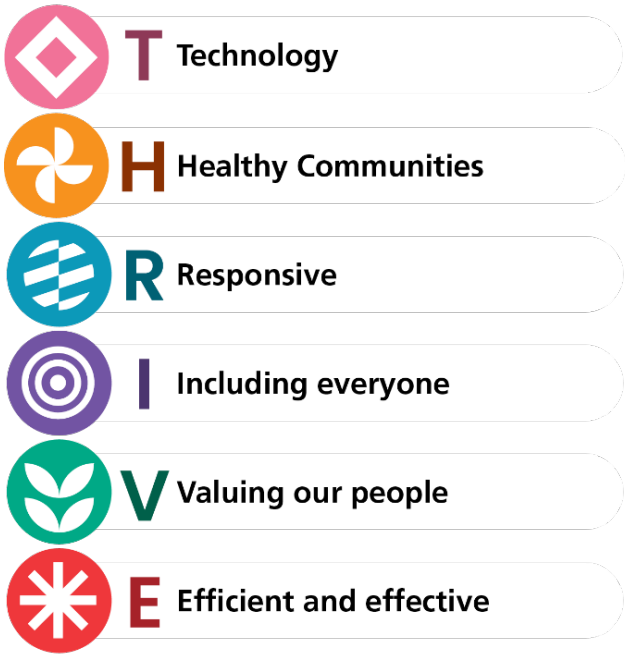
Through consultation we have identified a list of challenges and areas of focus for the next five years at LPT as well as enablers which are the tools we will use to achieve our priorities.

Our vision

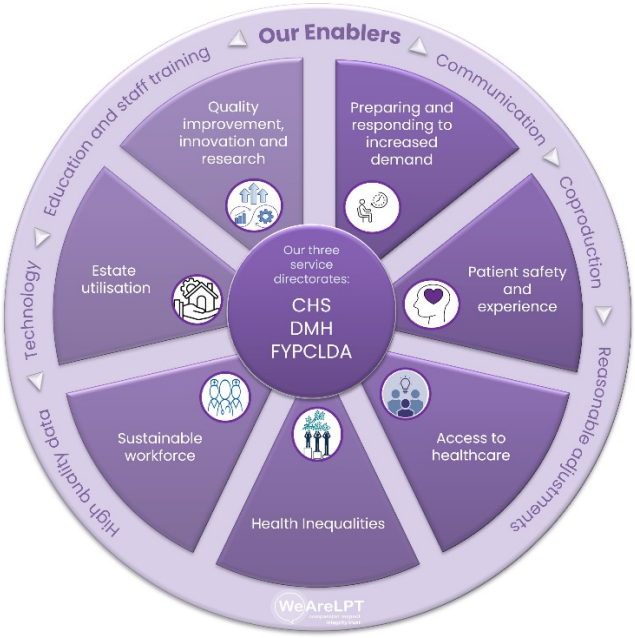
‘Together we thrive; building compassionate care and wellbeing for all.’

The importance of THRIVE is described by the LPT Finance and Performance directorate as: ‘making a difference together by harnessing our collective skills, expertise, energy and experience to deliver excellence.’ This is our Group Strategy in partnership with Northamptonshire Healthcare NHS Foundation Trust and represents our values within our vision.

This Clinical Plan sets out the background of the national and local challenges with clear prioritisation and a solution-focused approach to meet the needs of LPT’s local population. Our patients are at the heart of our priorities and we will use these as a blueprint for the delivery of high-quality compassionate care.



Core areas of focus and our alignment to our Group strategy, Together we thrive



A. Preparing and responding to increased demand

Maintaining healthy communities is key when empowering patients to live with independence, avoiding hospital admissions and tackling health inequalities. This is also incredibly important when managing demand on healthcare services.

The NHS 10-year health plan details three shifts for reinvention: hospital to community, analogue to digital and sickness to prevention. The final shift of sickness to prevention is particularly pertinent to healthy communities as we aim to build prevention of ill health into everything we do. This includes promoting selfcare and developing specific strategies to break down barriers in areas with reduced access.

Our Community Health Services are continuing to focus on co-producing a system-owned neighbourhood model to enable care to be delivered in the right place at the right time, closer to home.

This year our Integrated Care System has collectively developed a winter plan to respond to the potential for significant pressure on urgent and emergency care. This includes a strategy with key priorities to improve communication, patient flow, mental health support and vaccination uptake.

Within the DMH, we will work with partnership organisations to promote healthier communities. Our Neighbourhood Mental Health Cafés are drop-in centres run in partnership with Voluntary and Community Sector organisations. In 2024 and 2025, 39 café sessions were delivered per week across Leicestershire and Rutland with 9,147 people attending. The

team are also continuing to promote the JOY app. This is a social prescribing app for guided self-help which allows individuals to find activities and support local to them. Within secondary care, the team are further developing strategies for empowering services to deliver interventions and improve early identification. This includes the Consulter model, which involves training from specialist services for local teams, and the 'Pull' model. The 'Pull' model uses a hub and spoke approach as specialist services proactively seek referrals by attending the local multi-disciplinary team meetings. The aim is to improve early access to patients in the community and within secondary care teams.

The Community Paediatrics and CAMHS (child and adolescent mental health services) are working innovatively using multidisciplinary approach and digital technology to address the neurodevelopmental waiting lists.

The priorities for this area of focus are: the empowering of our communities to live with greater independence, avoiding unnecessary hospital stays through early identification of needs and tackling health inequalities. This will be supported by CHS using bed-based modelling to ensure patients receive care in the right setting and, wherever possible, closer to home.

B. Patient safety and experience

The safety of patients is the number one priority for our organisation. The NHS Patient Safety Strategy describes the strategic aims as "improving understanding of safety by drawing intelligence from multiple sources of patient safety information", "equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system" and "designing and supporting programmes that deliver effective and sustainable change in the most important areas".

LPT has adopted the patient safety incident response framework (PSIRF) and through involvement of staff, patients and carers has developed Trust-wide and directorate-specific priorities.

All three directorates have identified prioritisation areas with commonality in themes relating to communication, access to information and care coordination. The CHS team noted areas of improvement to communication surrounding frailty and advanced disease to inform patients for advanced care planning. DMH has also identified areas of improvement within multi-agency communication and information sharing with families. Similarly, FYPCLDA are looking to improve care coordination when multiple services were involved.

In the context of mental health, people with severe mental illness (SMI) die 15-20 years earlier than the general population and this is largely due to preventable physical illnesses. These include heart disease, diabetes and cancer. We need to take urgent action to close the mortality gap. This work across directorates is focussed on awareness and digital solutions for improving the data collection and interventions.

We will have a focus on personalised care to further enhance the experience of our patients and service users, empowering individuals to take an active role in their healthcare by giving them choices and control over their treatment and support, aligning it with their values and

what matters most to them, rather than following a one-size-fits-all approach. An example of this would be our valued Recovery College.

The priorities in this area are improving SystmOne functionality to ensure comprehensive information is available to all teams involved in the care of the patient, improving access to requesting and reviewing pathology results and improved care coordination through clarity of roles and responsibilities.

C. Access to healthcare

The current challenges facing the NHS are complex and demanding. Our health systems must be responsive to the changing needs and expectations of our patients while prioritising the delivery of high-quality care.

Due to increasing demand, waiting lists are growing and patients are not always able to access healthcare in a timely manner. This is an area in which responsiveness of systems is key as a new approach is required to tackle this issue.

An example of this is the waiting list initiative within the 'Personality Disorder' transformation project. With the development of a directorate-wide vision, the waiting list has significantly decreased due to the implementation of:

- A multi-professionally led weekly meeting formulating the needs of people referred to TSPPD and identification of a person-centred treatment option drawing on system-wide provision.
- Cross-service planning to reduce duplication in assessment and treatment.
- A weekly TSPPD Senior Management Task and Finish Group who work to improve flow via implementation of a guided digital self-help programme for those with milder personality difficulties.

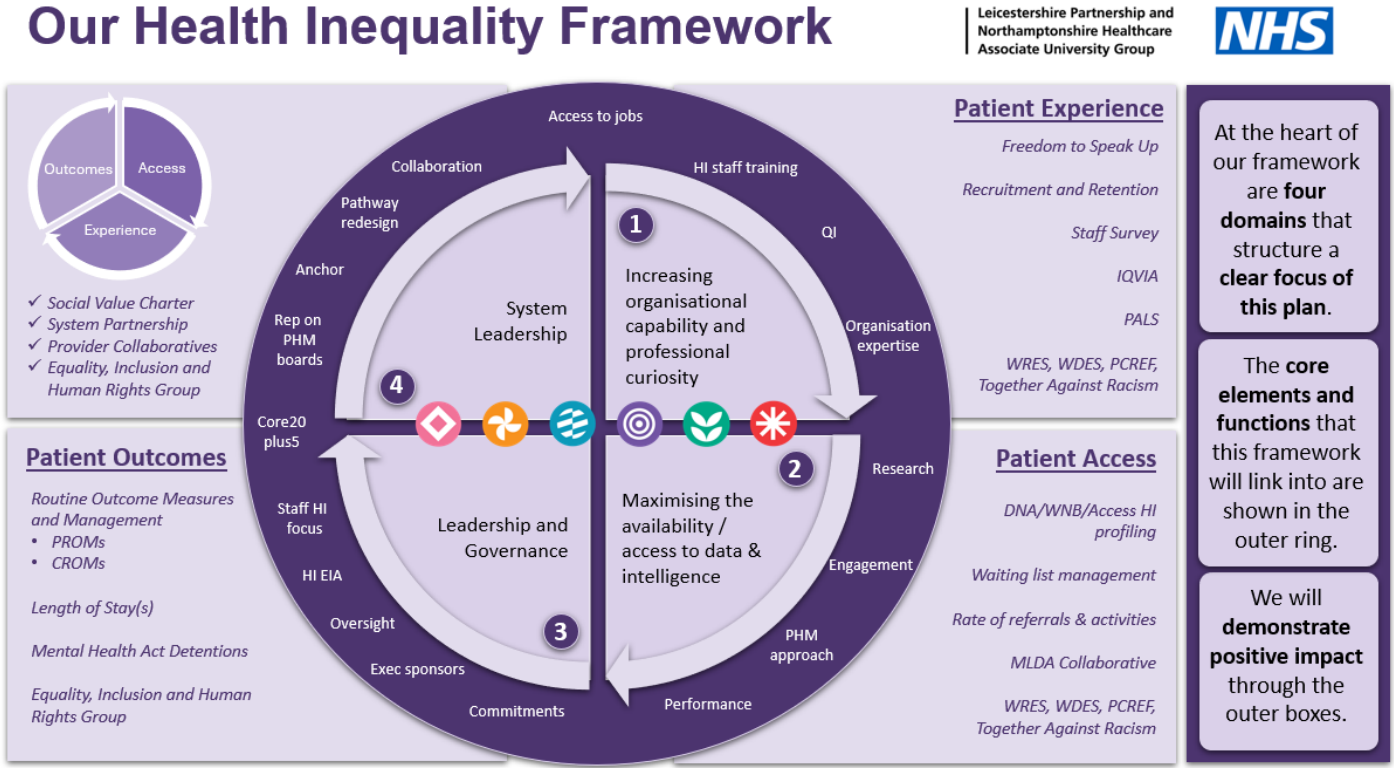
We are keen to use technology in a positive and sustainable way with a view to improving access, experience and outcomes. A large part of this is ensuring our service users and their carers have access to digital technology and the knowledge of how to use this safely. We will address this by monitoring equitable access to services and supporting those in digital poverty to prevent isolation of individuals within our communities.

The priorities are to further develop integrated neighbourhood teams, caseload reviews to reduce community caseloads and specific clinic redesign such as clozapine and depot clinics to improve access. The FYPCLDA directorate are reviewing skill mix and role utilisation through their Northwest ADHD pilot (using reviews from primary care pharmacists to reduce the consultant clinic burden) as part of a wider package of solutions to address neurodevelopmental waits.

D. Health inequalities

We have worked hard to embed a culture of inclusivity at LPT where everyone's voice matters and we aim to create a centre of excellence for mental and physical healthcare for all of our communities. However, we are aware that this cannot be achieved without addressing health inequalities.

Described as ‘unfair and avoidable’ by NHS England, health inequalities are a serious issue as communities with poorer access often experience multiple health challenges, higher rates of adult and child obesity, premature mortality and limited disease prevention. We will turn our listening into action by using lived experience from patients and families at the heart of our planning. Co-production is an extremely important tool and something we are placing a large emphasis on in our priorities for year one. We will also address barriers such as language, misinformation and trust towards health care services using our Health Inequality Framework.



The independent review of the Mental Health Act (2018) notes the need to respect the wishes, preferences and choices of patients detained under the Mental Health Act. The report also notes the disproportionate over-representation of black African and Caribbean men in MHA detentions. The Culture of Care programme aims to improve the culture of inpatient mental health and recognises the importance of using an equity-based approach as patients from racialised and neurodivergent communities have some of the worst experiences and outcomes. We have created a Culture of Care project team and we aim to successfully embed positive changes within daily operations across all directorates.

The “Thinking **AHEAD**” app is proving instrumental in helping us identify potential health inequalities within our appointments, disaggregating data by protected characteristics and highlighting communities and neighbourhoods that struggle and face barriers to access. The embedding of this app across all directorates will be key in addressing health inequalities.

The priorities in this area are to ensure equitable access to healthcare including vaccinations for all our communities. We will prioritise using technology to identify did not attend/ was not

brought patients and innovations to improve efficiency. The Mental Health Act office identified the need for a digital solution through our information management and technology team to improve the implementation and documentation of Section 132 rights as a priority. Additionally, in line with NHS England's Equality Delivery System, we will continue to have annual reporting of progress including the number of services graded and their improvement plans.

E. Sustainable workforce

According to research submitted by The King's Fund, NHS staff are 50% more likely to experience chronic stress, which can in turn lead to burnout. This is a complicated issue that must be addressed as it can lead to significant physical and mental health impacts.

Our People Plan is designed to look after our staff by ensuring we are safe, healthy and able to work flexibly while making effective use of our full range of skills and experience. We have used feedback from staff to generate areas for improvement in line with the NHS People Plan. This includes ensuring our staff feel they belong.

In 2020, we launched our Together Against Racism programme jointly with Northamptonshire Healthcare Foundation Trust to take proactive steps towards becoming a truly inclusive and anti-racist organisation. This is supported by the REACH (Race, Ethnicity and Cultural Heritage) networks to promote wellbeing and representation for our people. We will continue to use this programme to challenge unequal and discriminatory behaviours, structures and attitudes within the Trust over the coming years.

The Directorates have also identified specific additional challenges such as recruitment, retention and new workforce models leading to reduced training pathways due to trainer capacity and experience of the new working models.

Within our Clinical Plan, we will offer visible opportunities for career development, ensure that caseloads are manageable, staff have suitable working environments and support flexible working requests such as hybrid working when appropriate. We will also make sure staff feel psychologically safe to speak up and be actively involved in decision making.

The priorities are to promote an inclusive workplace culture and staff experience, to develop our people through grow our own initiatives, ensuring they have the skills, and all staff have equitable career progression and development opportunities. In addition, the workforce agency reduction, including improving recruitment of substantive workforce, is a priority which will in turn be beneficial to the delivery of our financial plan.

F. Estate utilisation

Leicestershire Partnership NHS Trust has unique challenges with multiple sites and ageing estate. The Estates team have made significant progress in the timeliness of response and working through the backlog of maintenance tasks.

The focus is on maximising our estate, to help us deliver good clinical outcomes, improve staff satisfaction and help us use our financial resources efficiently. The estates strategy aligns with and supports delivery of service plans.

All three Directorates have identified Estates utilisation as a theme, the commonalities being “suitable place for the specified clinical activity”, “availability of meeting rooms” and “coordination of the necessary works to reduce disruption”. This can be achieved using technology to identify capacity and allow for an efficient booking process.

We take great pride in the achievements of our estates team as in March 2025, Leicestershire Partnership Trust was rated best Mental Health Trust for cleanliness in a Health Services Journal article, as judged by patients and staff.

The priority areas are site utilisation for an ongoing review of agile/hybrid working policies to ensure the Trust facilities are used economically, and a centralised control of meeting rooms for real-time meeting availability/staff booking system through a digital system. The focus on reducing the number of leased sites will continue to improve utilisation and contribute to the financial planning. Our Estates strategy is closely aligned with the Green plan for maximising efficiency and sustainability.

G. Quality improvement, innovation and research

Efficient and effective care is critical in improving access and outcomes. We will continue to use research and innovation to increase productivity and provide high quality, evidence-based care.

Evidence-based care is the “integration of best research evidence with clinical expertise and patient values.” The NHS Getting It Right First Time (GIRFT) programme is using this to improve treatment by sharing best practice between trusts and reducing unnecessary procedures. We are committed to being a part of this initiative and improving through shared learning.

Additionally, our research team aim to support the national research priorities via the NIHR portfolio and support for the Life Science industry.

We will embed clinical outcome measures and regular audits to drive improvements in quality of care while triangulating this with performance data. We also aim to become recognised leaders and partners in healthcare research and intend to achieve this through our joint working group with Northamptonshire Healthcare Foundation Trust.

The Waterlily Inpatient Prevention Programme was successfully piloted by the East Midlands NHS Provider Collaborative. The service aimed to prevent inpatient admission for adults with anorexia nervosa and received outstanding feedback in combination with improved outcome measures. We will continue to use quality improvement and research to develop our services in an efficient and effective manner.

Additionally, we aim to use technology to improve long term planning and delivery of care. This will involve embedding AI into clinical practice to increase efficiency and productivity. For example, we have already started to explore this through our DECODE research project, in collaboration with Loughborough University. This focusses on using AI algorithms and machine learning to study the prognosis of long-term conditions from existing datasets.

The priorities are to improve the safety and quality of our services through the projects developed and supported through our joint working group for shared learning and maximising benefits. We also aim to achieve university hospital status with the support of the University of Leicester to improve the quality of research and education.

Our Clinical Plan themes and how they align to our Group strategy, Together we thrive:						
THRIVE	Technology	Healthy Communities	Responsive	Involving everyone	Valuing our People	Efficient and Effective
Theme A Preparing and responding to increased demand	✓		✓	✓	✓	✓
Theme B Patient safety and experience	✓	✓	✓	✓	✓	✓
Theme C Access to healthcare	✓	✓	✓	✓		✓
Theme D Health inequalities	✓	✓	✓	✓	✓	✓
Theme E Sustainable workforce	✓			✓	✓	✓
Theme F Estate utilisation	✓					✓
Theme G Quality improvement, innovation and research	✓	✓	✓	✓	✓	✓

Our enablers

Our enablers are the tools and skills we will use to achieve the priorities in our Clinical Plan. We have 6 key enablers.

- Communication

NHS England has identified that ‘the most common reason for complaints is poor communication’. We believe this is an essential skill in order to ensure high quality patient care and improved outcomes by empowering patients to make informed decisions. This relates to several of our core areas of focus, namely patient safety and experience, access to care, health inequalities and workforce.

- Co-production

Co-production is instrumental in delivering the best possible experience of care in systems. Collaborating with patients with lived-experience allows for enhanced patient-centred care and provides unique insight through an equal partnership. This is a key enabler for patient safety and experience, access to healthcare and health inequalities. Through our triangle of care approach we will ensure that patients and families are actively involved in their care planning and to develop a whole family approach. Additionally, we will use co-production to deliver the Patient and Carer Race Equality Framework (PCREF) on our journey to reducing racial inequalities.

- Reasonable adjustments

Reasonable adjustments are hugely important for both patients and staff. For patients, we are strengthening the reasonable adjustments digital flag which will alert staff to their individual needs. This will help our services prepare for increased demand, improve patient safety and experience and increase participation in research studies. Additionally, this is also an enabler for the focus area of a sustainable workforce. We will support staff to ensure they are able to fulfil their potential by providing the necessary adjustments to tailor their work environment to their needs.

- High quality data

Ensuring that we have timely access to high-quality data is crucial to improving patient care, supporting population health management and accurate planning within our trust. We intend to develop dashboards to help with visualisation of the data and provide early warning signs relating to quality and safety. This enabler relates to all our core areas of focus and is therefore an extremely important tool in our Clinical Plan.

- Technology

In line with the shift of analogue to digital detailed in the NHS 10-year plan, we recognise the value of technology as a key enabler across all areas of focus and it is a crucial component of our transformation and quality improvement plans. The use of technology to improve patient safety, productivity and efficiency has already been hugely successful and we are keen to build on this.

- Education and staff training

The NHS currently has the highest staffing levels in its history, however, due to increased demand and a growing ageing population, there are significant workforce shortages. Therefore, staff training and education is a major enabler in ensuring a sustainable workforce that is able to deliver excellent patient outcomes. This will be supported by our Joint Working Group and Partnership with universities. We aim to give our staff all the tools needed to excel in their professional careers and highlight opportunities for career development whilst improving job satisfaction.

Year one priorities

Preparing and Responding to Increased Demand

- Promote neighbourhood models of care to connect people and making use of wider public services and voluntary, community sector support to improve flow through community mental health services.

Patient Safety and Experience

- Improving SystmOne functionality to ensure comprehensive information is available to all teams involved in the care of the patient.
- Improving access to requesting and reviewing pathology results and improved care coordination through clarity of roles and responsibilities.

Access to Healthcare

- Further develop integrated neighbourhood teams
- Caseload reviews to reduce community caseloads and specific clinic redesign such as clozapine and depot clinics to improve access.

Health Inequalities

- Ensure equitable access to health care including vaccinations for all our communities.
- Using technology to identify did not attend/ was not brought patients and innovations to improve efficiency.
- The Mental Health Act office identified the need for a digital solution through our information management and technology team to improve the implementation and documentation of Section 132 rights as a priority.

Sustainable Workforce

- Promote an inclusive workplace culture and staff experience, to develop our people, ensuring they have the skills, and all staff have equitable career progression and development opportunities.
- Continued progression with workforce agency reduction including improving recruitment of medical workforce, which will in turn be beneficial to the delivery of our financial plan

Estate Utilisation

- Utilisation for an ongoing review of agile/hybrid working policies to ensure Trust facilities are used economically, centralised control of meeting rooms for real-time meeting availability/staff booking system through a digital system.
- The focus on reducing number of leased sites will continue to improve utilisation and contribute to the financial planning.

Quality Improvement, Innovation and Research

- Improve the safety and quality of our services through the projects developed and supported through our joint working group for shared learning and maximising benefits**.**
- Continue work towards university hospital status with the support of the University of Leicester to improve the quality of research and education.

Success criteria

In order to ensure we are delivering the goals listed in this Clinical Plan, the plan will be shared with Directorates and Enabling Servies to track and report progress. The medical directorate will provide six monthly reports to be shared through EMB and Quality and Safety Committee, with an annual report being submitted to the Trust Board.

Transformation and PMO team have an excellent track record of supporting all clinical directorates to develop and deliver transformation plans including clinical priorities and pathways that will have improved access and reduced health inequalities**.**

To support effective delivery and transparency, a dedicated action tracker will be developed to monitor progress against the actions and priorities outlined in this Clinical Plan

This reporting will include:

- Narrative updates on key achievements and progress to date.
- Identification of risks and challenges to future delivery.
- A quantitative assessment of performance against defined targets and priorities.

We will review the impact of initiatives to improve physical health monitoring, medication management and address health inequalities as part of patient safety.

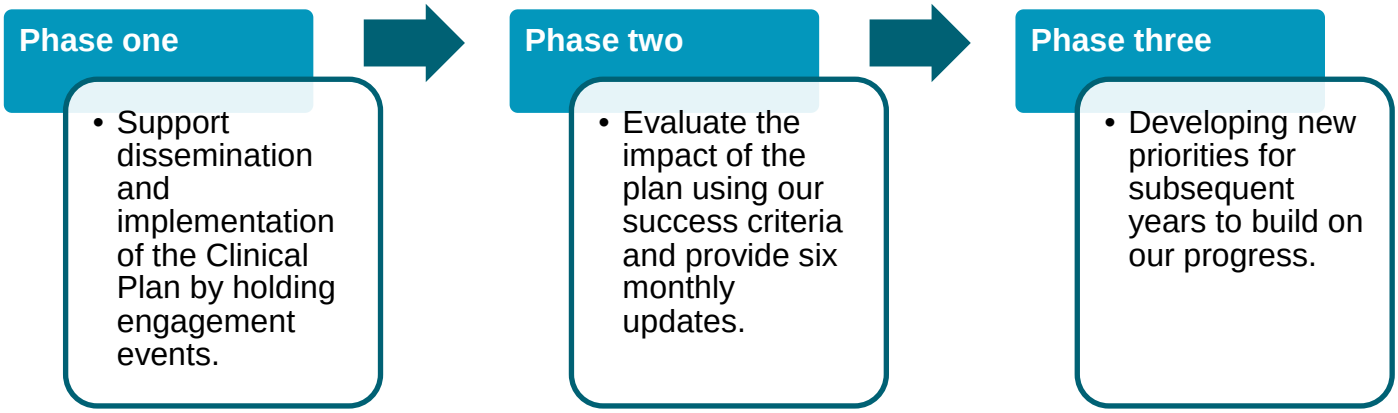
Additionally, we will monitor data including (but not limited to): staff turnover rates, the average length of stay for hospital admissions and the number of missed appointments. We will combine this with patient, carer and staff feedback to achieve a comprehensive reflection of our progress.

This will be supported and evaluated through our WeImproveQ team.

“It is clear that the work undertaken by this team provides critical enabling support to services, in particular local and national clinical audits, monitoring services, QI initiatives, service evaluations and NICE compliance.” – (NED Board Service visit to WeImproveQ 27 June 2025).

Next steps

We will use the Clinical Plan to adapt to current and future challenges by using the following steps.



Conclusion

In conclusion, this Clinical Plan provides an overview of the challenges facing our population, the identified current priorities and the strategies we will use to address these. It is recognised that while some of the priorities listed in our plan may be initiated in the first year, the completion may extend beyond to achieve full realisation of the potential of some initiatives. We are dedicated to the improvement of patient and staff satisfaction and will endeavour to meet these aims by integrating the principles of this plan into all aspects of our work.

Patients are at the centre of this plan and we will work towards demonstrating an improvement in clinical care and outcomes, using the principles from our group strategy, 'Together we Thrive', to transform services.

Decision required – Please indicate:

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

- Trust Board are requested to review and approve the Clinical Plan and the year 1 priorities identified.

Governance table

For Board and Board Committees:		
Paper sponsored by:	Angela Hillery	
Paper authored by:	Catherine Holland, Lisa Hydes, Glyn Edwards, Bhanu Chadalavada	
Date submitted:	22/09/25	
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):	Trust Board	
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		
LPT strategic alignment:	**T** - **T**echnology	x
	H – **H**ealthy Communities	x
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	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):*	1.1, 2.1,3.1, 3.2,3.3,6.1,4.1	
Is the decision required consistent with LPT's risk appetite:		
False and misleading information (FOMI) considerations:		
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Equality considerations:		

NHS
Leicestershire Partnership
NHS Trust

Clinical Plan 2025- 2030

Contents

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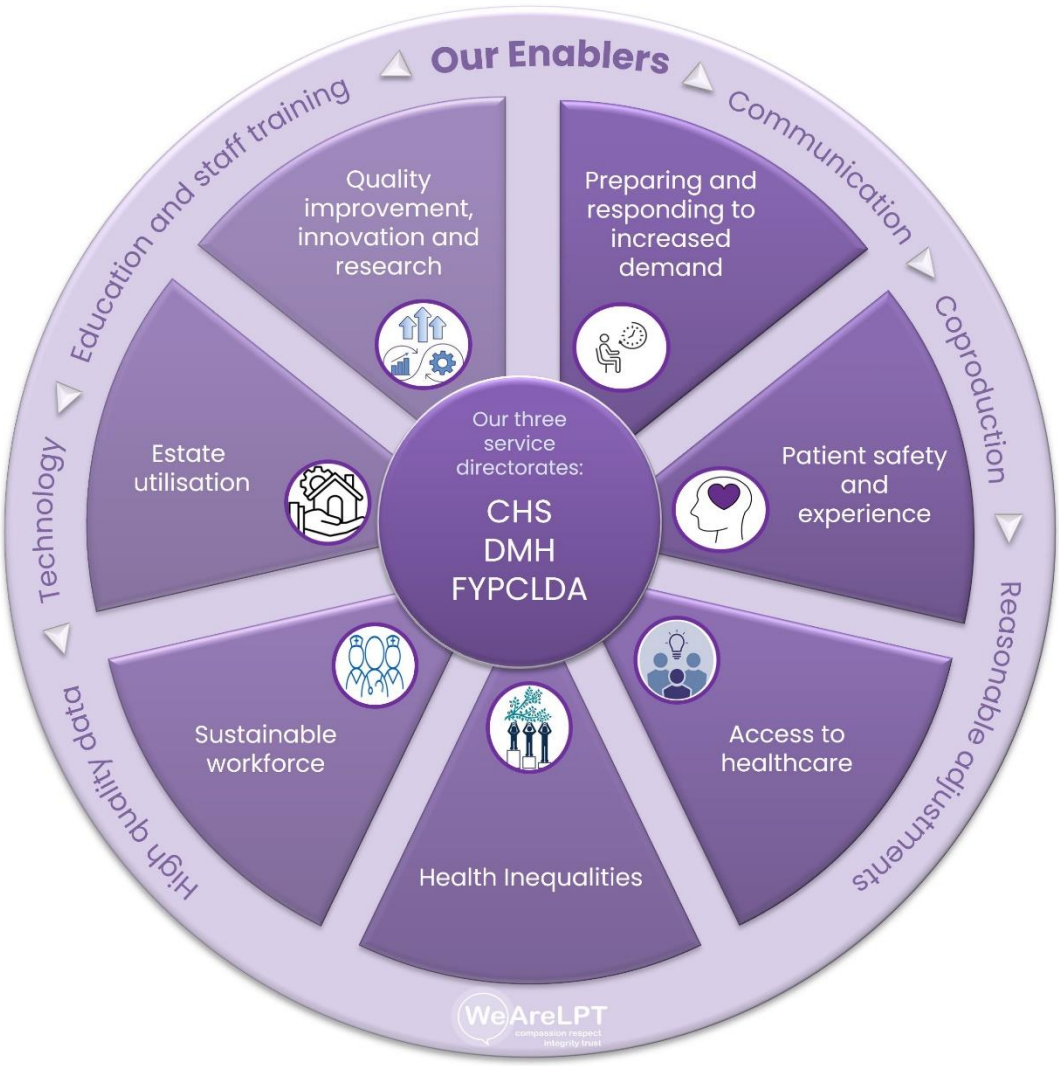
This Clinical Plan sets out the background of the national and local challenges with clear prioritisation and a solution-focused approach to meet the needs of LPT’s local population. Our patients are at the heart of our priorities and we will use these as a blueprint for the delivery of high-quality compassionate care.

Core areas of focus and our alignment to our Group strategy, Together we thrive



A. Preparing and responding to increased demand

Maintaining healthy communities is key when empowering patients to live with independence, avoiding hospital admissions and tackling health inequalities. This is also incredibly important when managing demand on healthcare services.

The NHS 10-year health plan details three shifts for reinvention: hospital to community, analogue to digital and sickness to prevention. The final shift of sickness to prevention is particularly pertinent to healthy communities as we aim to build prevention of ill health into everything we do. This includes promoting selfcare and developing specific strategies to break down barriers in areas with reduced access.

Our Community Health Services are continuing to focus on co-producing a system-owned neighbourhood model to enable care to be delivered in the right place at the right time, closer to home.

This year our Integrated Care System has collectively developed a winter plan to respond to the potential for significant pressure on urgent and emergency care. This includes a strategy with key priorities to improve communication, patient flow, mental health support and vaccination uptake.

Within the DMH, we will work with partnership organisations to promote healthier communities. Our Neighbourhood Mental Health Cafés are drop in centres run in partnership with Voluntary and Community Sector organisations. In 2024 and 2025, 39 café sessions were delivered per week across Leicestershire and Rutland with 9,147 people attending. The team are also continuing to promote the JOY app. This is a social prescribing app for guided self-help which allows individuals to find activities and support local to them. Within secondary care, the team are further developing strategies for empowering services to deliver interventions and improve early identification. This includes the Consulter model, which involves training from specialist services for local teams, and the 'Pull' model. The 'Pull' model uses a hub and spoke approach as specialist services proactively seek referrals by attending the local multi-disciplinary team meetings. The aim is to improve early access to patients in the community and within secondary care teams.

The Community Paediatrics and CAMHS (child and adolescent mental health services) are working innovatively using multidisciplinary approach and digital technology to address the neurodevelopmental waiting lists.

The priorities for this area of focus are: the empowering of our communities to live with greater independence, avoiding unnecessary hospital stays through early identification of needs and tackling health inequalities. This will be supported by CHS using bed-based modelling to ensure patients receive care in the right setting and, wherever possible, closer to home.

B. Patient safety and experience

The safety of patients is the number one priority for our organisation. The NHS Patient Safety Strategy describes the strategic aims as "improving understanding of safety by drawing intelligence from multiple sources of patient safety information", "equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system" and "designing and supporting programmes that deliver effective and sustainable change in the most important areas".

LPT has adopted the patient safety incident response framework (PSIRF) and through involvement of staff, patients and carers has developed Trust-wide and directorate-specific priorities.

All three directorates have identified prioritisation areas with commonality in themes relating to communication, access to information and care coordination. The CHS team noted areas of improvement to communication surrounding frailty and advanced disease to inform patients for advanced care planning. DMH has also identified areas of improvement within multi-agency communication and information sharing with families. Similarly, FYPCLDA are looking to improve care coordination when multiple services were involved.

In the context of mental health, people with severe mental illness (SMI) die 15-20 years earlier than the general population and this is largely due to preventable physical illnesses. These include heart disease, diabetes and cancer. We need to take urgent action to close the mortality gap. This work across directorates is focussed on awareness and digital solutions for improving the data collection and interventions.

We will have a focus on personalised care to further enhance the experience of our patients and service users, empowering individuals to take an active role in their healthcare by giving them choices and control over their treatment and support, aligning it with their values and what matters most to them, rather than following a one-size-fits-all approach. An example of this would be our valued Recovery College.

The priorities in this area are improving SystmOne functionality to ensure comprehensive information is available to all teams involved in the care of the patient, improving access to requesting and reviewing pathology results and improved care coordination through clarity of roles and responsibilities.

C. Access to healthcare

The current challenges facing the NHS are complex and demanding. Our health systems must be responsive to the changing needs and expectations of our patients while prioritising the delivery of high-quality care.

Due to increasing demand, waiting lists are growing and patients are not always able to access healthcare in a timely manner. This is an area in which responsiveness of systems is key as a new approach is required to tackle this issue.

An example of this is the waiting list initiative within the ‘Personality Disorder’ transformation project. With the development of a directorate-wide vision, the waiting list has significantly decreased due to the implementation of:

- A multi-professionally led weekly meeting formulating the needs of people referred to TSPPD and identification of a person-centred treatment option drawing on system-wide provision.
- Cross-service planning to reduce duplication in assessment and treatment.
- A weekly TSPPD Senior Management Task and Finish Group who work to improve flow via implementation of a guided digital self-help programme for those with milder personality difficulties.

We are keen to use technology in a positive and sustainable way with a view to improving access, experience and outcomes. A large part of this is ensuring our service users and their carers have access to digital technology and the knowledge of how to use this safely. We will address this by monitoring equitable access to services and supporting those in digital poverty to prevent isolation of individuals within our communities.

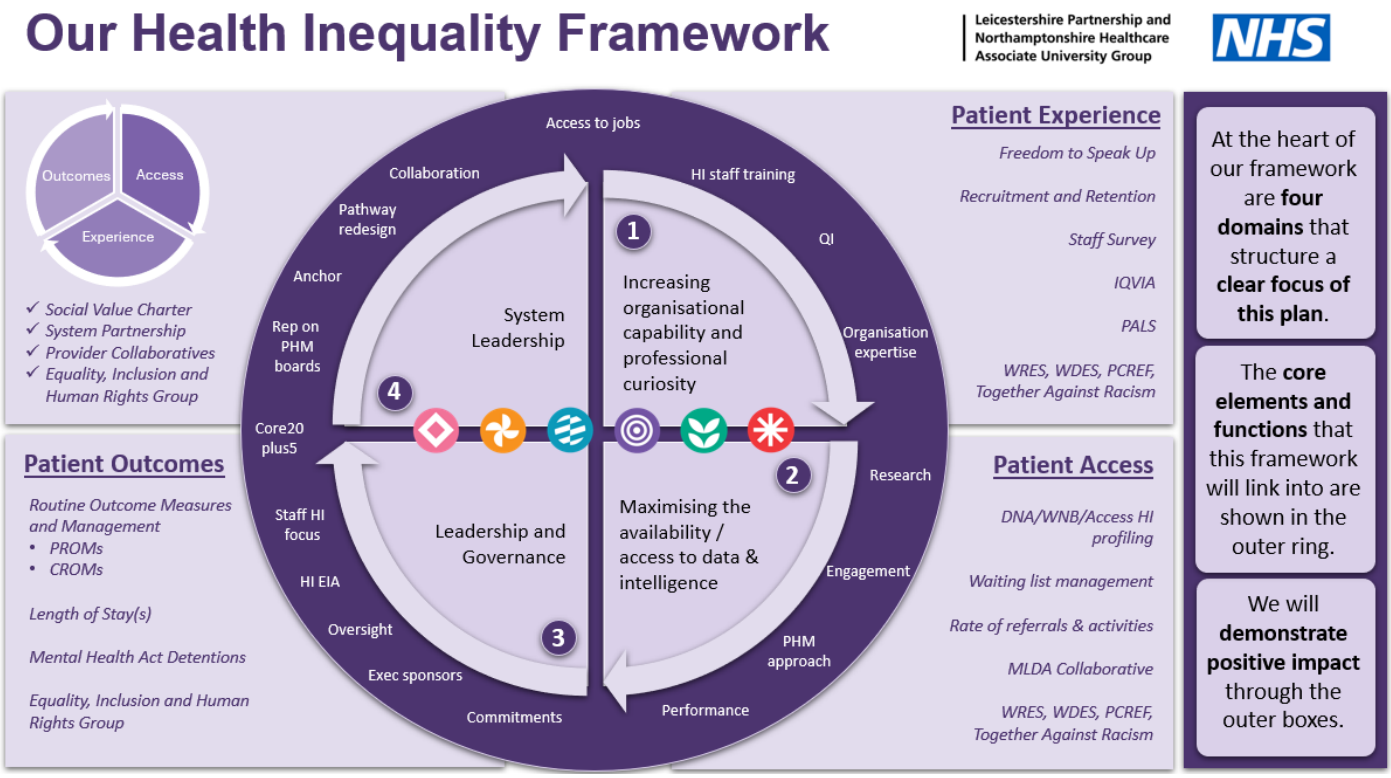
The priorities are to further develop integrated neighbourhood teams, caseload reviews to reduce community caseloads and specific clinic redesign such as clozapine and depot clinics to improve access. The FYPCLDA directorate are reviewing skill mix and role utilisation through their

Northwest ADHD pilot (using reviews from primary care pharmacists to reduce the consultant clinic burden) as part of a wider package of solutions to address neurodevelopmental waits.

D. Health inequalities

We have worked hard to embed a culture of inclusivity at LPT where everyone's voice matters and we aim to create a centre of excellence for mental and physical healthcare for all of our communities. However, we are aware that this cannot be achieved without addressing health inequalities.

Described as 'unfair and avoidable' by NHS England, health inequalities are a serious issue as communities with poorer access often experience multiple health challenges, higher rates of adult and child obesity, premature mortality and limited disease prevention. We will turn our listening into action by using lived experience from patients and families at the heart of our planning. Co-production is an extremely important tool and something we are placing a large emphasis on in our priorities for year one. We will also address barriers such as language, misinformation and trust towards health care services using our Health Inequality Framework.



The independent review of the Mental Health Act (2018) notes the need to respect the wishes, preferences and choices of patients detained under the Mental Health Act. The report also notes the disproportionate over-representation of black African and Caribbean men in MHA detentions. The Culture of Care programme aims to improve the culture of inpatient mental health and recognises the importance of using an equity-based approach as patients from racialised and neurodivergent communities have some of the worst experiences and outcomes. We have created a Culture of Care project team and we aim to successfully embed positive changes within daily operations across all directorates.

The "Thinking **AHEAD**" app is proving instrumental in helping us identify potential health inequalities within our appointments, disaggregating data by protected characteristics and highlighting communities and neighbourhoods that struggle and face barriers to access. The embedding of this app across all directorates will be key in addressing health inequalities.

The priorities in this area are to ensure equitable access to healthcare including vaccinations for all our communities. We will prioritise using technology to identify did not attend/ was not brought patients and innovations to improve efficiency. The Mental Health Act office identified the need for a digital solution through our information management and technology team to improve the implementation and documentation of Section 132 rights as a priority. Additionally, in line with NHS England's Equality Delivery System, we will continue to have annual reporting of progress including the number of services graded and their improvement plans.

E. Sustainable workforce

According to research submitted by The King's Fund, NHS staff are 50% more likely to experience chronic stress, which can in turn lead to burnout. This is a complicated issue that must be addressed as it can lead to significant physical and mental health impacts.

Our People Plan is designed to look after our staff by ensuring we are safe, healthy and able to work flexibly while making effective use of our full range of skills and experience. We have used feedback from staff to generate areas for improvement in line with the NHS People Plan. This includes ensuring our staff feel they belong.

In 2020, we launched our Together Against Racism programme jointly with Northamptonshire Healthcare Foundation Trust to take proactive steps towards becoming a truly inclusive and anti-racist organisation. This is supported by the REACH (Race, Ethnicity and Cultural Heritage) networks to promote wellbeing and representation for our people. We will continue to use this programme to challenge unequal and discriminatory behaviours, structures and attitudes within the Trust over the coming years.

The Directorates have also identified specific additional challenges such as recruitment, retention and new workforce models leading to reduced training pathways due to trainer capacity and experience of the new working models.

Within our Clinical Plan, we will offer visible opportunities for career development, ensure that caseloads are manageable, staff have suitable working environments and support flexible working requests such as hybrid working when appropriate. We will also make sure staff feel psychologically safe to speak up and be actively involved in decision making.

The priorities are to promote an inclusive workplace culture and staff experience, to develop our people through grow our own initiatives, ensuring they have the skills, and all staff have equitable career progression and development opportunities. In addition, the workforce agency reduction, including improving recruitment of substantive workforce, is a priority which will in turn be beneficial to the delivery of our financial plan.

F. Estate utilisation

Leicestershire Partnership NHS Trust has unique challenges with multiple sites and ageing estate. The Estates team have made significant progress in the timeliness of response and working through the backlog of maintenance tasks.

The focus is on maximising our estate, to help us deliver good clinical outcomes, improve staff satisfaction and help us use our financial resources efficiently. The estates strategy aligns with and supports delivery of service plans.

All three Directorates have identified Estates utilisation as a theme, the commonalities being “suitable place for the specified clinical activity”, “availability of meeting rooms” and “coordination of the necessary works to reduce disruption”. This can be achieved using technology to identify capacity and allow for an efficient booking process.

We take great pride in the achievements of our estates team as in March 2025, Leicestershire Partnership Trust was rated best Mental Health Trust for cleanliness in a Health Services Journal article, as judged by patients and staff.

The priority areas are site utilisation for an ongoing review of agile/hybrid working policies to ensure the Trust facilities are used economically, and a centralised control of meeting rooms for real-time meeting availability/staff booking system through a digital system. The focus on reducing the number of leased sites will continue to improve utilisation and contribute to the financial planning. Our Estates strategy is closely aligned with the Green plan for maximising efficiency and sustainability.

G. Quality improvement, innovation and research

Efficient and effective care is critical in improving access and outcomes. We will continue to use research and innovation to increase productivity and provide high quality, evidence-based care.

Evidence-based care is the “integration of best research evidence with clinical expertise and patient values.” The NHS Getting It Right First Time (GIRFT) programme is using this to improve treatment by sharing best practice between trusts and reducing unnecessary procedures. We are committed to being a part of this initiative and improving through shared learning.

Additionally, our research team aim to support the national research priorities via the NIHR portfolio and support for the Life Science industry.

We will embed clinical outcome measures and regular audits to drive improvements in quality of care while triangulating this with performance data. We also aim to become recognised leaders and partners in healthcare research and intend to achieve this through our joint working group with Northamptonshire Healthcare Foundation Trust.

The Waterlily Inpatient Prevention Programme was successfully piloted by the East Midlands NHS Provider Collaborative. The service aimed to prevent inpatient admission for adults with anorexia nervosa and received outstanding feedback in combination with improved outcome measures. We will continue to use quality improvement and research to develop our services in an efficient and effective manner.

Additionally, we aim to use technology to improve long term planning and delivery of care. This will involve embedding AI into clinical practice to increase efficiency and productivity. For example, we have already started to explore this through our DECODE research project, in collaboration with Loughborough University. This focusses on using AI algorithms and machine learning to study the prognosis of long-term conditions from existing datasets.

The priorities are to improve the safety and quality of our services through the projects developed and supported through our joint working group for shared learning and maximising benefits. We also aim to achieve university hospital status with the support of the University of Leicester to improve the quality of research and education.

Our core areas of focus and how they align to our Group strategy, Together we thrive:						
THRIVE	Technology	Healthy Communities	Responsive	Involving everyone	Valuing our People	Efficient and Effective
A Preparing and responding to increased demand	✓		✓	✓	✓	✓
B Patient safety and experience	✓	✓	✓	✓	✓	✓
C Access to healthcare	✓	✓	✓	✓		✓
D Health inequalities	✓	✓	✓	✓	✓	✓
E Sustainable workforce	✓			✓	✓	✓
F Estate utilisation	✓					✓
G Quality improvement, innovation and research	✓	✓	✓	✓	✓	✓

Our enablers

Our enablers are the tools and skills we will use to achieve the priorities in our Clinical Plan. We have 6 key enablers.

- Communication

NHS England has identified that ‘the most common reason for complaints is poor communication’. We believe this is an essential skill in order to ensure high quality patient care and improved outcomes by empowering patients to make informed decisions. This relates to several of our core areas of focus, namely patient safety and experience, access to care, health inequalities and workforce.

- Co-production

Co-production is instrumental in delivering the best possible experience of care in systems. Collaborating with patients with lived-experience allows for enhanced patient-centred care and provides unique insight through an equal partnership. This is a key enabler for patient safety and experience, access to healthcare and health inequalities. Through our triangle of care approach we will ensure that patients and families are actively involved in their care planning and to develop a whole family approach. Additionally, we will use co-production to deliver the Patient and Carer Race Equality Framework (PCREF) on our journey to reducing racial inequalities.

- Reasonable adjustments

Reasonable adjustments are hugely important for both patients and staff. For patients, we are strengthening the reasonable adjustments digital flag which will alert staff to their individual needs. This will help our services prepare for increased demand, improve patient safety and experience and increase participation in research studies. Additionally, this is also an enabler for the focus area of a sustainable workforce. We will support staff to ensure they are able to fulfil their potential by providing the necessary adjustments to tailor their work environment to their needs.

- High quality data

Ensuring that we have timely access to high-quality data is crucial to improving patient care, supporting population health management and accurate planning within our trust. We intend to develop dashboards to help with visualisation of the data and provide early warning signs relating to quality and safety. This enabler relates to all our core areas of focus and is therefore an extremely important tool in our Clinical Plan.

- Technology

In line with the shift of analogue to digital detailed in the NHS 10-year plan, we recognise the value of technology as a key enabler across all areas of focus and it is a crucial component of our transformation and quality improvement plans. The use of technology to improve patient safety, productivity and efficiency has already been hugely successful and we are keen to build on this.

- Education and staff training

The NHS currently has the highest staffing levels in its history, however, due to increased demand and a growing ageing population, there are significant workforce shortages. Therefore, staff training and education is a major enabler in ensuring a sustainable workforce that is able to deliver excellent patient outcomes. This will be supported by our Joint Working Group and Partnership with universities. We aim to give our staff all the tools needed to excel in their professional careers and highlight opportunities for career development whilst improving job satisfaction.

Year one priorities

Preparing and Responding to Increased Demand

- Promote neighbourhood models of care to connect people and making use of wider public services and voluntary, community sector support to improve flow through community mental health services.

Patient Safety and Experience

- Improving SystmOne functionality to ensure comprehensive information is available to all teams involved in the care of the patient.
- Improving access to requesting and reviewing pathology results and improved care coordination through clarity of roles and responsibilities.

Access to Healthcare

- Further develop integrated neighbourhood teams
- Caseload reviews to reduce community caseloads and specific clinic redesign such as clozapine and depot clinics to improve access.

Health Inequalities

- Ensure equitable access to health care including vaccinations for all our communities.
- Using technology to identify did not attend/ was not brought patients and innovations to improve efficiency.
- The Mental Health Act office identified the need for a digital solution through our information management and technology team to improve the implementation and documentation of Section 132 rights as a priority.

Sustainable Workforce

- Promote an inclusive workplace culture and staff experience, to develop our people, ensuring they have the skills, and all staff have equitable career progression and development opportunities.
- Continued progression with workforce agency reduction including improving recruitment of medical workforce, which will in turn be beneficial to the delivery of our financial plan

Estate Utilisation

- Utilisation for an ongoing review of agile/hybrid working policies to ensure Trust facilities are used economically, centralised control of meeting rooms for real-time meeting availability/staff booking system through a digital system.
- The focus on reducing number of leased sites will continue to improve utilisation and contribute to the financial planning.

Quality Improvement, Innovation and Research

- Improve the safety and quality of our services through the projects developed and supported through our joint working group for shared learning and maximising benefits**.**
- Continue work towards university hospital status with the support of the University of Leicester to improve the quality of research and education.

Success criteria

In order to ensure we are delivering the goals listed in this Clinical Plan, the plan will be shared with Directorates and Enabling Servies to track and report progress. The medical directorate will provide six monthly reports to be shared through EMB and Quality and Safety Committee, with an annual report being submitted to the Trust Board.

Transformation and PMO team have an excellent track record of supporting all clinical directorates to develop and deliver transformation plans including clinical priorities and pathways that will have improved access and reduced health inequalities**.**

To support effective delivery and transparency, a dedicated action tracker will be developed to monitor progress against the actions and priorities outlined in this Clinical Plan

This reporting will include:

- Narrative updates on key achievements and progress to date.
- Identification of risks and challenges to future delivery.
- A quantitative assessment of performance against defined targets and priorities.

We will review the impact of initiatives to improve physical health monitoring, medication management and address health inequalities as part of patient safety.

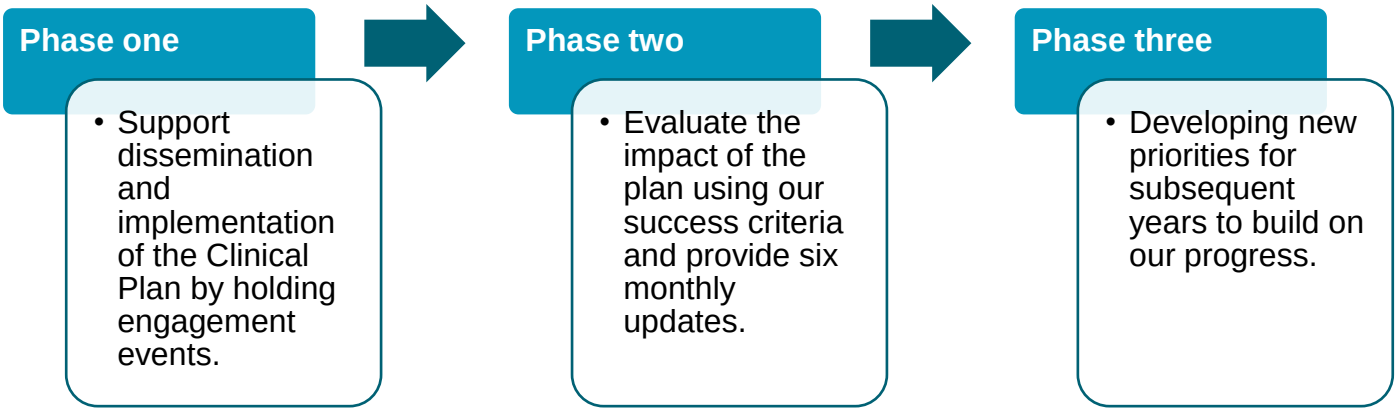
Additionally, we will monitor data including (but not limited to): staff turnover rates, the average length of stay for hospital admissions and the number of missed appointments. We will combine this with patient, carer and staff feedback to achieve a comprehensive reflection of our progress.

This will be supported and evaluated through our WeImproveQ team.

“It is clear that the work undertaken by this team provides critical enabling support to services, in particular local and national clinical audits, monitoring services, QI initiatives, service evaluations and NICE compliance.” – (NED Board Service visit to WeImproveQ 27 June 2025).

Next steps

We will use the Clinical Plan to adapt to current and future challenges by using the following steps.



Conclusion

In conclusion, this Clinical Plan provides an overview of the challenges facing our population, the identified current priorities and the strategies we will use to address these. It is recognised that while some of the priorities listed in our plan may be initiated in the first year, the completion may extend beyond to achieve full realisation of the potential of some initiatives. We are dedicated to the improvement of patient and staff satisfaction and will endeavour to meet these aims by integrating the principles of this plan into all aspects of our work.

Patients are at the centre of our Clinical Plan and we will work towards demonstrating an improvement in clinical care and outcomes, using the principles from our group strategy, ‘Together we Thrive’, to transform services.

L

Leicestershire Partnership NHS Trust

Public Trust Board 30th September

Refreshed Green Plan 2025-2028

Purpose of the Report

This report is being presented to the Trust Board to seek approval of the refreshed LPT Green Plan to meet the requirements set out by NHS England by the deadline of 31st October 2025.

Analysis of the issue

NHS England published the new statutory Green Plan guidance on 4th February 2025. The guidance is designed to support NHS organisations develop robust plans to improve health outcomes, reduce costs, and minimise waste – continuing the NHS' journey to achieving net zero. The NHS has set two targets:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

The updated guidance supports systems and Trusts to refresh their Green Plans for the next 3-year cycle with the aim of:

- prioritising interventions that support world-leading patient care and population health, and reduce inequalities, while tackling climate change and broader sustainability issues
- supporting NHS organisations to plan and make considered investments while increasing efficiencies and delivering value for taxpayers
- ensuring every NHS organisation supports the ambition to reach net zero carbon emissions, reflecting learning from delivery to date

Proposal

Our Green Plan sets out Leicestershire Partnership NHS Trust's (LPT) strategic approach to sustainability for the period 2025/26 to 2027/28, in alignment with the NHS's national commitment to becoming the world's first Net Zero health system. The Plan outlines the Trust's response to the Greener NHS programme, including both actions completed since the previous Green Plan (2022–2025) and the ambitions for the next three years across all areas of focus.

This Green Plan aligns with the seven areas of focus areas detailed in the latest Guidance and outlines specific actions and ambitions under each. Some key achievements in our 2022-2025 journey to highlight include:

- Green Energy - the installation of solar panels at Loughborough hospital, delivering sustainable green energy generation of 200kW. This installation is projected to save the Trust £55,000 annually and a series of further solar panel installation projects, funded by the government's Great British Energy fund are scheduled over 2025-2028.
- Food waste reductions - of 25% have been achieved through a process of food waste monitoring, feedback from patient and staff engagement, menu redesigns and blue-plate crockery trials which not only reduce waste but enhance patient nutrition and recovery outcomes.

Refreshed Green Plans should be approved by the organisation's board or governing body and published in an accessible location on the organisation's website by 31st October 2025. The LPT draft Green plan has been shared with NHS England by the interim deadline of 31st July 2025 and following Trust Board approved, scheduled to be submitted before the 31st October final NHSE deadline.

The refreshed Green plan 2025-2028 demonstrates an increased focus on net zero clinical transformation through minimising single use items and reducing transport related emissions and aims to align with place-based neighbourhood healthcare and Trust clinical strategy. There is also a focus on electrification of fleet and green energy generation in the plan.

In response to CQC Well Led and NHSE Green Plan implementation guidance requirements, sustainability governance has been strengthened by the introduction of a new Sustainability Programme Delivery Group (in common) which launched on 10th September 2025 to oversee the implementation of both LPT and NHFT Green plans and Sustainable leadership approach as a Group and within each Trust.

Sustainability ambitions, framed around the Group THRIVE strategy and mission have been developed to shape and communicate our organisational approach to sustainability.

A dedicated Excel-based action tracker has been developed to monitor progress, and an annual progress report will be produced to inform both internal governance and the public via the Trust's Annual Report. While limitations in staffing, data, and resources currently affect the ability to define SMART* targets across all domains, the Trust is committed to building the infrastructure needed to baseline, track, and report more comprehensively over the life of this plan.

Development of this Green Plan involved engagement with staff across clinical and operational teams, with information gathered through interviews and collaborative input. This inclusive approach ensures the plan reflects the practical realities of the organisation while aligning the Trust THRIVE strategy and national expectations.

LPT's Green Plan represents both a practical response to climate change and a commitment to delivering high-quality, sustainable healthcare for future generations. It will serve as a foundation for continued action, learning, and improvement as the Trust works towards its Net Zero goals.

There are many proposals to develop to take forward the initiatives we need to take in order to meet our Green Plan aspirations and our Net-Zero obligations. We anticipate that many projects will improve efficiency, reduce or remove wastage and make cost savings. Investment will also be needed. Any investment needed will be through available government grants or subject to a Business Case approval in line the Trusts established Governance processes.

Decision required – Please indicate:

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

- The Trust Board is asked to approve of the LPT Green Plan for 2025 to 2028.

Governance table

For Board and Board Committees:	Trust Board – 30th September 2025 (Public)	
Paper sponsored by:	Paul Sheldon – Chief Finance Officer	
Paper authored by:	Amanda Angelescu – Social Value & Sustainability Lead	
Date submitted:	22nd September 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):	Finance & Performance Committee – 21st August 2025 SEB – 12th May 2025	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	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	One Off	
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):*	BAF 5	
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None applicable	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	Supports reduction of health inequalities through enhanced air quality / reduced pollution related health conditions.	

Leicestershire Partnership
NHS Trust

Leicestershire Partnership NHS Trust

Green Plan

2025/26 – 2027/28

Version 2.0 – April 2025

Contents

Executive Summary

This Green Plan sets out Leicestershire Partnership Trust's (LPT) strategic approach to sustainability for the period 2025/26 to 2027/28, in alignment with the NHS's national commitment to becoming the world's first Net Zero health system. The Plan outlines the Trust's response to the Greener NHS programme, including both actions completed since the previous Green Plan (2022–2025) and the ambitions for the next three years across all areas of focus.

The NHS has committed to achieving Net Zero carbon emissions for directly controlled sources (NHS Carbon Footprint) by 2040, and for emissions it can influence (NHS Carbon Footprint Plus) by 2045, with interim targets of 80% reductions by 2028–2032 and 2036–2039, respectively.

This Green Plan aligns with the seven areas of focus detailed in the latest Guidance and outlines specific actions and ambitions under each. Notable achievements include installation of a 200 kW solar array, transition to digital communications, use of robotic dispensing systems and targeted waste reduction efforts in food services and clinical waste streams.

A dedicated Excel-based action tracker has been developed to monitor progress, and an annual progress report will be produced to inform both internal governance and the public via the Trust's Annual Report. While limitations in staffing, data, and resources currently affect the ability to define SMART targets across all domains, the Trust is committed to building the infrastructure needed to baseline, track, and report more comprehensively over the life of this plan.

Development of this Green Plan involved engagement with staff across clinical and operational teams, with information gathered through interviews and collaborative input. This inclusive approach ensures the plan reflects the practical realities of the organisation while aligning with national expectations.

LPT's Green Plan represents both a practical response to climate change and a commitment to delivering high-quality, sustainable healthcare for future generations. It will serve as a foundation for continued action, learning, and improvement as the Trust works towards its Net Zero goals.

1. Background information

1.1. Introduction

The latest Green Plan guidance requires all NHS Trusts have a Board approved Green Plan which sets out their approach for reducing greenhouse gas emissions and supporting the development of a Net Zero National Health Service.

Leicestershire Partnership Trust (LPT) recognises that the health and care system has a responsibility to provide high quality healthcare whilst minimising negative impacts on the environment. Left unabated Climate Change will disrupt care and increase many major diseases that are associated with poor environmental conditions, such as cardiac problems, asthma, and cancer.

1.2. The Net Zero Health Service

The Greener NHS Programme works with staff, hospitals and other partners to lead on NHS sustainability, with a specific focus on Net Zero carbon emissions.

> **"To deliver the World's first Net Zero health service and respond to climate change, improving health now and for future generations."**
>
> **Greener NHS vision statement**

The Delivering a Net Zero National Health Service report was published in October 2020 and set the direction of travel for the NHS with regards to carbon emissions. The report considered the scale of the challenge posed by climate change, the current knowledge, and the available interventions to establish feasible targets for a Net Zero NHS. This analysis produced two key targets:

1. To achieve Net Zero for emissions directly controlled by the NHS by 2040 (NHS carbon footprint). With an interim target of an 80% reduction by 2028 – 2032 when compared to a 1990 baseline.
2. To achieve Net Zero for emissions which can be influenced by the NHS by 2045, known as NHS carbon footprint plus. With an interim target of an 80% reduction by 2036 – 2039 when compared to a 1990 baseline.

The Trust recognises the role it must play in contributing to the achievement of a Net Zero NHS.

1.3. Recent changes

The Trust was previously involved in supporting the national Covid-19 response both in clinical settings and from home. In some respects, this accelerated efforts to reduce the environmental impact of service delivery as the Trust shifted to new ways of working. Conversely, this also increased impacts in other areas such as a spike in waste disposal associated with PPE. The Trust will continue to monitor the environmental, financial, and social impacts from these new ways of working while continuing to deliver the highest standards of service.

1.4. Vision for sustainability

The Trust's vision for sustainability is to provide the highest standards of care while balancing the three key pillars of sustainable development.

1. Environmental impact. Reducing environmental damage resulting from the Trust's operations.
2. Social impact. Helping to reduce health and social inequalities in the communities served by the Trust.
3. Financial impact. Considering the social and environmental impacts of expenditure while also ensuring financial resilience.

1.5. Methodology & limitations

This Green Plan has been developed using the best available data, insight, and capacity within the Trust. To inform the content, a series of online interviews and discussions were conducted with staff across numerous services and departments. These conversations formed the basis for understanding both the actions already completed and the planned ambitions across each of the areas of focus. While every effort has been made to align this document with the NHS Green Plan Guidance, the Trust like all areas of the health & social care sector faces limitations in terms of staffing, resourcing, and data availability. As such, SMART* targets and detailed baseline data are not available for all focus areas currently. Where baselining is incomplete, this Green Plan outlines the Trust's intention to build the necessary data and reporting structures over the plan's life cycle. Additionally, a comprehensive action tracker has been developed to monitor implementation, it is provided as a separate Excel document to maintain usability and readability of this document.

**Specific, Measurable, Achievable, Relevant, Time-bound*

2. Workforce & leadership

LPT has taken several steps to embed sustainability into workforce practices, leadership engagement, and staff communications. A key enabler has been the development of an agile working policy, which existed pre-pandemic but was significantly expanded during and after COVID-19. Staff across the Trust now benefit from flexible and hybrid working arrangements, with hot desk spaces available and many corporate teams continuing to operate in blended formats. This shift has also supported estate rationalisation, including the closure of a large corporate and clinical admin building, with services relocated to a smaller and more efficient facility at County Hall.

Awareness-raising activities are carried out through internal communications channels such as the StaffNet newsletter, Trust-wide posters, and marketing campaigns. These channels have been used to promote energy saving messages, encourage waste reduction, and support wider behavioural change initiatives.

While there is currently no central environmental training programme, sustainability has been promoted informally to staff, and the Trust is aware of national training resources such as the Green NHS Training Hub.

From a leadership perspective, A board level representative has been selected to lead on the Green Plan. Sustainability is often integrated with cost-saving initiatives, most notably through the "Penny

Powers" campaign—an internal programme designed to capture staff ideas for saving money, which naturally aligns with environmentally beneficial actions.

Although LPT does not currently have a formal Green Champions network, there has been experience with similar schemes in the past. There are also ideas from neighbouring organisations such as Northamptonshire Healthcare Foundation Trust (NHFT) which are informing LPT's future planning.

2.1. Actions & ambitions for the coming three years

1. The Trust will seek to recruit volunteer Green Champions from staff and further engage them for suggestions on changes the Trust can make to become more sustainable.
2. The Trust will promote and signpost staff to additional training opportunities available through the Greener NHS training hub.

3. Net zero clinical transformation

As part of its ongoing commitment to sustainability and reducing clinical waste, NHFT has implemented several initiatives aimed at minimising single-use items and reducing transport-related emissions within its clinical settings.

One of the main changes since the Covid-19 pandemic has been the growth of virtual appointments for patients where clinically suitable. The Trust has a large presence within the community which necessitates large amounts of travel, however where suitable some patient appointments can and are held remotely e.g. in the mental health service with therapist appointments.

The Trust is constantly assessing ways to provide high quality, preventative & low carbon care to patients. To this effect the Trust has developed a number of further initiatives which are documented in the Digital Transformation & Medicines sections of this Green Plan.

3.1. Actions & ambitions for the coming three years

1. Identify a clinical lead with oversight of net zero clinical transformation with formal links into board-level leadership & governance.
2. The Trust will focus on reducing emissions and improving quality of care within its mental health service. Steps will be taken to identify improvement in this area which produce measurable reductions in carbon emissions with co-benefits for quality of care and efficiency.

4. Digital transformation

LPT has made substantial progress in leveraging digital technology to improve service delivery while reducing its environmental footprint. One of the most impactful areas has been the consolidation and virtualisation of IT infrastructure, resulting in a reduced number of physical servers. This shift, to increased use of cloud computing, has helped minimise the Trust's direct energy consumption and contributed to lower emissions associated with server maintenance and cooling. To further reduce the Trust's IT-related emissions, LPT has changed its approach to device procurement and management. Laptop specifications have been improved, moving from mechanical hard drives to solid state drives (SSDs), which offer better performance, increased energy efficiency, and lower failure

rates. Devices now come with increased memory, further supporting the Trust's goal of reducing hardware turnover and extending equipment lifespan. The servers still operated by the Trust are targeted to last seven years, while laptops are expected to last approximately five years.

LPT's primary hardware supplier has been Dell, a company committed to achieving carbon neutrality by 2050. Through Dell's design improvements and enhanced support infrastructure, the Trust has reduced the frequency of engineer site visits, further cutting down on transport-related emissions. The Trust also holds a contract with Green World for green disposal of IT equipment. All devices are data-wiped on site, issued with certificates of destruction, and, where possible refurbished and resold, promoting reuse over disposal, in a cost neutral model with the trust.

Digital solutions have also supported a reduction in staff travel. The IT team has prioritised remote support and operates "tech clinics", where staff bring devices to a central location for assistance. In addition, remote access tools and virtual consultations via Microsoft (MS) Teams have reduced unnecessary journeys and paper usage. This long-standing capability has led to significantly lower staff mileage and improved efficiency across clinical and administrative workflows.

Although some operational constraints do exist, such as the inability to power down some devices overnight due to 24/7 service demands and communication screen saver requirements. However, the Trust continues to explore policies and settings to improve energy efficiency, such as sleep mode settings and device throttling via Windows policies.

4.1. Actions & ambitions for the coming three years

1. The Trust will continue to deploy methods of digital communication when it comes to reducing carbon emissions, improving patient care and providing IT support to staff.
2. The Trust will use circular approaches to IT hardware management including extending device lifetimes and continue to utilise disposal routes that prioritise re-use.
3. The Trust will promote good data hygiene among its staff by reducing duplication and investigating long term efficient archiving of historical data.

5. Medicines

LPT has taken several practical steps to improve sustainability within its medicines management and pharmacy services. The Trust does not use desflurane, a high-emission volatile anaesthetic, as it does not operate surgical services requiring this agent. Anaesthetic use is restricted to injectables in specialist services, and nitrous oxide is also not relevant to the Trust due to the absence of piped medical gas systems.

Where medicines are prescribed LPT works with partners across the Integrated Care System (ICS) to reduce the environmental impact of pressurised metered-dose inhalers (pMDIs). As the Trust generally does not initiate inhaler prescriptions, it acts as a pass-through organisation: patients continue to use their GP-issued inhalers during their stay and are discharged with the same product. However, the Trust is represented on the ICS Medicines Optimisation Green Group, contributing to system-wide efforts to reduce the carbon footprint of respiratory care. Additionally, pharmacy and technician teams support inhaler technique education, working with nursing staff where needed.

Within the pharmacy service, several important digital and logistical improvements have reduced the Trust's environmental footprint. The introduction of electronic prescribing allows remote review of medications, reducing the need for pharmacists to travel between sites. Ordering of controlled drugs is now fully digital, eliminating paper forms and the associated vehicle use for document exchange. An innovative robotic medicine dispensing system has been implemented at the Glenfield site, allowing nursing staff to securely access out-of-hours medications without the need for on-call staff to travel. This has significantly reduced staff mileage.

LPT also ensures that expired medications and inhalers are disposed of via licensed pharmaceutical waste routes (e.g. Sanibox). Inhaler recycling has been explored, but no solution has yet been implemented due to cost barriers. Similarly, the Trust has investigated the recycling of blister packs, although the financial cost remains prohibitive at this time.
Internally, the pharmacy service has also worked to Increase recycling across pharmacy departments, installing more bins and ensuring non-confidential waste is disposed of in the recycling stream. The pharmacy has also attempted to reduce the number of pharmaceutical deliveries by consolidating orders and considering route optimisation for daily internal delivery rounds.

Lastly the Trust has already taken steps to reduce unnecessary cannulation, particularly within community hospitals, by promoting decision-making at the clinical level.

5.1. Actions & ambitions for the coming three years

- The Trust will continue to promote correct disposal of inhalers to patients to avoid release of residual propellants.
- Explore cost-effective options for inhaler recycling, including collaborative models with University Hospitals Leicester (UHL) and third-party providers such as Grundon or TerraCycle.
- Reassess the feasibility of blister pack recycling, using updated costings and CO_2 saving estimates to support a future business case.
- Consider expanding the use of robotic dispensing systems to other sites, particularly community hospitals, where this could further reduce on-call travel.

6. Travel & transport

The Trust recognises that reducing carbon emissions from clinician and staff travel is a critical component of its Green Plan. A variety of initiatives are already underway to support this goal, covering staff commuting, fleet management, digital communications, and regional collaboration.

The expansion of hybrid and agile working arrangements has significantly reduced the need for staff to commute. While the Trust's Agile Working policy has been in place since 2017, the Covid-19 pandemic accelerated its adoption, resulting in a substantial shift in working patterns for large numbers of staff. This change has directly contributed to a reduction in daily travel-related emissions.

Regarding the Trusts own fleet, there are currently 42 vehicles within the Estates & Facilities (E&F) department, 21 pool cars and around 80 salary sacrifice vehicles leased to staff. A CO_2 emissions limit of 105g/km is in place for all new salary sacrifice vehicles and many leased vehicles already meet this requirement. All new leased vehicles added in the past 12 months have been plug-in hybrid electric vehicles (PHEVs), driven by staff choice and the benefit in kind tax rules. In support of this transition

to low-emission vehicles, the Trust has begun installing electric vehicle (EV) charging points. There are currently two in place, with plans to expand this infrastructure over the life of this Green Plan. Lastly, the most recent non-emergency transport tender which was held in partnership with University Hospitals of Leicester (UHL) required respondents to have a 70% electric fleet.

To further enhance efficiency and reduce unnecessary travel, the Trust has installed vehicle trackers on fleet vans, which has helped to eradicate use and provide data to optimise routes. There is also an ongoing review of building usage and service delivery patterns across the Trust estate. One anticipated outcome of this review is the reduction of unnecessary deliveries, particularly to locations with low levels of occupancy.

The Trust has significantly reduced its reliance on physical mail. Previously, paper correspondence was collected from various sites and transported to a central location for franking and dispatch by Royal Mail. The adoption of SMS messaging and other digital communication methods has led to a sharp decline in postal volume, along with the reduced use of paper, printing, and toner contributing to both carbon and cost savings.

The Trust also maintains strong regional partnerships through its participation in the local Business Travel Forum, collaborating with neighbouring organisations to inform regional travel planning. This includes ongoing efforts to share best practice with Northamptonshire Foundation Trust (NHFT), particularly in areas such as fleet management and sustainable travel planning, where key roles are shared across both organisations.

6.1. Actions & ambitions for the coming three years

- There is a comprehensive review of travel & transport currently underway which has a focus on reducing costs and improving efficiency. This document will inform a variety of changes such as a reduced reliance on Taxi's for out of hours transport along with a consolidation of storage and improved coordination of distribution.
- Currently, there are 2 EV charging points available across the Trust's estate, there are plans in place to expand this over the coming years, dependent on funding.
- The Trust is investigating the feasibility of transitioning the E&F fleet over to leased vehicles and will consider the viability of EV's as part of this switch.
- The Trust will review the current salary sacrifice scheme with a view to offering only zero emission vehicles for new leases from December 2026.

7. Estates & facilities

Building energy use accounts for approximately 24% of the total carbon footprint of the health and social care system in England, making it a key area for delivering both carbon reductions and financial savings. LPT recognises this and has implemented a range of measures aimed at improving energy efficiency and reducing the environmental impact of its estate.

A key achievement has been the installation of 346 solar photovoltaic (PV) panels at Loughborough Hospital, delivering a total generation capacity of 200 kW. This installation saves the Trust around £55,000 annually in electricity costs. Additional solar PV systems are also in place at Mill Lodge,

Watermead, and The Beacon, further contributing to the generation of renewable energy across the estate. In parallel, a boiler upgrade programme is underway to replace older, less efficient systems with newer, high-efficiency models resulting in reduced gas consumption and lower emissions.

The Trust places a high priority on sustainability when it comes to new builds and major refurbishment projects. For these projects LED lighting is installed as standard, contributing to ongoing energy savings. Improving building insulation has been another area of focus. As part of its capital works programme, LPT has upgraded roof insulation across multiple buildings to meet U-value standards, helping reduce heat loss and lower overall energy demand. Environmental considerations are also embedded into capital project delivery. Contractors working on Trust sites are required to implement waste segregation and recycling of building materials, supporting a more circular approach to construction and refurbishment.

Estates waste management is another priority area. The Trust is currently working in partnership with Biffa to review and reclassify clinical waste, identifying streams that can be safely reclassified as offensive waste. This initiative includes the introduction of tiger stripe bags and is expected to reduce the volume of high-carbon disposal routes such as clinical incineration, while also improving operational efficiency. To further reduce waste and encourage resource re-use, LPT has recently joined the Warp-It furniture reuse platform. Although in its initial stages, this programme is expected to support the redistribution of unwanted furniture internally, minimising unnecessary procurement and extending the life of office and clinical furnishings. Full utilisation of Warp-It is planned over the life of this Green Plan.

Together, these efforts demonstrate the Trust's commitment to low-carbon infrastructure, efficient resource use, and alignment with national Net Zero objectives.

7.1. Actions & ambitions for the coming three years

1. A new PV installation is planned at Hinckley & Bosworth Community Hospital, subject to funding.
2. An investment decision is pending regarding electrification of the white van fleet within E&F.
3. The Trust plans to install ASHPs as the primary heating source for new builds e.g. the P001 project at Glenfield.
4. Upgrades of utility metering and the Building Management Systems (BMS) are scheduled for the coming years to give better control and improved efficiency.

8. Supply chain & procurement

Procurement emissions represent a considerable proportion of the health system's environmental impact. According to the NHS's report Delivering a Net Zero NHS, the supply chain accounts for approximately 63% of the NHS's total carbon footprint. As such, addressing procurement emissions is a clear priority, with a national ambition to reach Net Zero by 2045 for these indirect emissions, and a milestone of an 80% reduction between 2036 and 2039 (against a 1990 baseline).

LPT actively seeks to engage local suppliers where appropriate, helping to reduce transport-related emissions and support regional economies. Environmental sustainability criteria are also incorporated

into the supplier selection process, particularly in locally run tenders, where social value assessments include an environmental component.
To further strengthen its procurement practices, LPT primarily uses NHS-approved national frameworks, such as those offered by the Crown Commercial Service (CCS) and the North of England Commercial Procurement Collaborative (NOE CPC). These frameworks already embed Net Zero and sustainability criteria into the supplier selection process. The Trust also maintains an active relationship with NOE CPC, including regular meetings with their Environmental Manager to seek guidance on how to improve its approach to social value procurement.

In addition, LPT is engaged in a collaborative project with Northamptonshire Foundation Trust (NHFT) to review and align procurement procedures and working practices. This includes an emphasis on embedding sustainability and Net Zero principles across both organisations, drawing on best practices from each to develop a unified approach. The Trust has also committed to reducing its use of virgin materials. A clear example of this is the move to exclusively purchase recycled paper for all written communications, both internally and externally.

8.1. Actions & ambitions for the coming three years

1. Standardisation of procurements practices across both Trusts (LPT & NHFT), drawing on best practice from each.
2. The Trusts aims to embed PPN 06/21 (carbon reduction plans of suppliers) more robustly into future local tenders.
3. Encourage suppliers to go beyond the minimum requirements and engage with the Evergreen Sustainable Supplier Assessment.

9. Food & nutrition

LPT has made notable progress in improving the sustainability of its food services since bringing catering provision back in-house in late 2022. This shift has enabled the Trust to take more control over food waste monitoring, menu planning, and supply chain sustainability.

In June 2024, the Trust began measuring food waste in line with NHS national standards for food & drink. While LPT does not operate production kitchens and instead relies on bulk meals from various NHS Supply chain framework suppliers. the Trust monitors both service and plate waste across its sites with quarterly reporting. Since July 2023, the catering team has delivered a 45-minute training session across wards on how to complete food waste records, helping build staff awareness and ownership of the program. There are also food forums in mental health units, providing a platform for patients to give feedback on meals, which is used to inform future menu development.

In partnership with the Trusts main food supplier, menus have been improved with a focus on nutritional quality and lower carbon options. Menus are coded using nationally recognised dietary symbol system (e.g., heart symbols for healthier meals), and nutritional content is assessed by a dedicated dietitian. The menu is reviewed twice yearly and consistently offers a vegetarian or vegan option at each mealtime. Unpopular dishes are identified through patient questionnaires and meal audits, with results feeding into menu revisions.

Carbon considerations have also been integrated into the suppliers contract management process. The supplier provides carbon footprint data for their meals, and LPT is now working to use this information to shape future menu development, particularly by reducing high carbon foods like pork and beef. This forms part of the contract's key performance indicators (KPIs) and is discussed at the regular contract meetings throughout the year.

On the logistics side, transport emissions have been reduced thanks to changes in supplier location and delivery frequency. Previously, deliveries occurred six days per week; under the new contract, they have been limited to a maximum of two per week per site. Additionally, the suppliers depot is closer than previous suppliers, further lowering the delivery footprint. The introduction of reusable plastic trays has also reduced cardboard waste. Further plastic reduction measures include the elimination of single-use plastic cups and cutlery. Meals are served on reusable metal dishes, and cutlery is reusable, with disposables used only occasionally & wooden.

A trial of blue crockery for patients is currently underway on two wards. Early results suggest a 20–25% reduction in plate waste, and expansion of this initiative is planned. Portion sizes are managed using information from the suppliers portion planners, and meal audits ensure consistency. There is also a process that allows patients to request smaller servings where appropriate.

9.1. Actions & ambitions for the coming three years

1. Set site-specific food waste reduction targets from April 2024, including both weight-based and financial measures.
2. Roll out of the blue plate trial to community wards, following positive waste reduction outcomes.
3. Expand paper-based meal ordering across the Trust in the short term, with a longer-term plan to implement an electronic system Trust-wide to reduce overproduction and end-of-service waste.
4. Evaluate and potentially adopt recycling of plastic meal trays.

10. Adaptation

Over the life of this Green Plan, LPT will continue to assess and implement the adaptations necessary to ensure the ongoing delivery of high-quality care in the face of a changing climate. The Board of Directors recognises the financial, social, and healthcare implications of climate change and fully understands the cost of inaction.

The Trust has a board signed-off Adverse Weather Plan, aligned with the NHS Core Standards and the UK Health Security Agency (UKHSA) national guidance. This plan sets out year-round response actions for a range of severe weather conditions, including extreme heat, cold, flooding, storms, and fog.

Flooding risks are explicitly considered in the Trust's business continuity planning, including pre-populated action cards to guide site-level responses. The Trust also maintains robust command and control mechanisms, with incident response plans that are tested annually to ensure readiness in the event of an emergency.

Communication is also a core element of the Trust's response infrastructure. UKHSA weather alerts (Yellow, Amber, and Red) are cascaded rapidly through internal communications channels, including newsletters and banners on the staff intranet, ensuring staff are aware of risks and prepared to take appropriate action.

The Trust's Adverse Weather Plan also includes tailored risk responses for specific teams, including measures for community nursing services, such as ensuring access to 4x4 vehicles in challenging conditions. Assurance against these standards is reviewed through an annual NHS England and Integrated Care Board (ICB) assurance process, with results publicly reported.

In addition to operational readiness, LPT also addresses the environmental conditions of its buildings. The Trust has a monitoring process for overheating events, aligned with the Estates Returns Information Collection (ERIC) reporting framework. This includes clear mitigation and rectification strategies to reduce the risk of service disruption during high-temperature events.
Furthermore, LPT considers the impact of air-conditioning systems, specifically regarding F-gas emissions. Systems are maintained and repaired promptly to minimise leakage and associated environmental harm, supporting both patient comfort and the Trust's wider sustainability goals.

10.1. Actions & ambitions for the coming three years

1. The Business Continuity Policy will be updated to include specific wording for climate change.
2. Over the life cycle of this Green Plan the Trust will review and strengthen climate change risk assessments using the NHS Futures Climate Change Risk Assessment Tool.
3. Emergency Preparedness Resilience & Response (EPRR) involvement in future infrastructure decisions, such as green spaces and drainage systems, is planned to ensure resilience against adverse weather and climate-related risks.

11. Tracking & reporting progress

To support effective delivery and transparency, a dedicated action tracker has been developed in Excel to monitor progress against the actions and ambitions set out in this Green Plan. This tool will be used to track and report progress.

The Trust will provide an annual progress report, which will be shared both internally with Board-level representatives overseeing this plan and publicly via the Trust's Annual Report. This reporting will include:

- Narrative updates on key achievements and progress to date.
- Identification of risks and challenges to future delivery.
- A quantitative assessment of performance against defined targets & ambitions.

In addition to this Green Plan reporting, the Trust will continue to calculate and publish its annual carbon footprint, offering a transparent, year-on-year view of its emissions performance. Together, these measures will ensure that progress remains visible, measurable, and aligned with both local priorities and the wider NHS Net Zero goals.

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Leicestershire Partnership NHS Trust

TRUST BOARD – 30 SEPTEMBER 2025

Winter Plan Progress and Timeline

Purpose of the Report

Both ICBs and NHS Trusts have been asked to develop winter plans during the summer period, covering both preparatory actions that need to be taken now (e.g., vaccination programmes and capacity planning) as well as detail on the operational response during winter itself.

This Report outlines progress to date and the sign off process required.

Analysis of the issue

NHSE ask of all NHS Trusts is to:

- Develop an organisational winter plan, completing a draft by end August 2025.
- Ensure preparatory actions, including staff vaccination programmes, are in progress now.

NHSE ask of ICBs is to:

- Develop the ICB plan with appropriate levels of engagement across all system partners, including primary care, 111 providers, community, acute and specialist trusts, mental health, ambulance services, local authorities, and social care provider colleagues.
- Lead on the system-wide preventative measures which can be put in place now, including a focus on vaccination strategies and proactive identification of patient groups who will be more vulnerable to winter viruses and cold weather.

NHSE ask of all ICBs and Trusts:

- Stress test draft winter plans by participating in an NHS England-hosted exercise in September (Regional teams will arrange these events).
- Following the exercise, sign off plans using the below Board Assurance Statement.

Board Assurance Framework

- BAF Shared at Confidential Trust Board progress as of 29.7.25.
- LPT Winter plan shared at EMB 5.8.25.
- LPT Winter plan shared at SEB 12.8.25.
- LPT Winter plan shared at System 20.8.25 UEC Operational group.
- Below updated progress as of 23.8.25

Section A: Board Assurance Statement

Checklist	***Confirmed (Yes / No)***	***Additional comments or qualifications (optional)***
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	TBC	
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	Completed by DON and MD
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	UEC Operational Group
The Board has tested the plan during a regionally led winter exercise, reviewed the outcome, and incorporated lessons learned.	In Progress	Due 17th September 2025 Any significant changes will be shared with Board
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Sam Leak (Operational) Jean Knight (Collaborative) Use of Board Flash reports as required
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	TBC	
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	Managed by the system control Centre through 3x daily system escalation calls linked to system and organisational OPEL levels and actions.
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against trajectories already signed off and returned to NHS England in April 2025.	NA	

Provider CEO name	**Date**	**Provider Chair name**	**Date**

Section B: 25/26 Winter Plan checklist

Checklist	**Confirmed (Yes / No)**	**Additional comments or qualifications (optional)**
Prevention		
There is a plan in place to achieve at least a 5-percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	Last year's vaccination numbers were above national average. Outlined in LPT winter plan
Capacity		

The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	System bed modelling has incorporated Community capacity. LPT CHS boarding SOP linked to OPEL and Surge
Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	Will be planned (6 weeks in advance) to ensure clinical capacity and skill mix is appropriate
Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	Discharge numbers agreed across the system and predictive numbers reported through the System Control Centre (SCC)
Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	NA	
Infection Prevention and Control (IPC)		
IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	LPT IPC developed the LPT plan and feedback into the system plan Plan to EMB on 5 August 2025 Strategic Flu group mobilised
Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Yes	Fit testing training available and monitored through AFM. Process for stock ordering and management in place.
A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	Boarding SOP for CHS agreed across the system. IPC process in place for this
Leadership		
On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	On call rota for DOC and Directorate silvers. Induction and training in place
Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	SHREWD Real time reporting to system escalation meetings linked to OPEL actions
Specific actions for Mental Health Trusts		
A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	Yes	Can increase call handling and clinical capacity within the Central Access Point (111,2) at times of high demand to prevent escalation of urgent MH. Can step up system unscheduled care coordination hub which allows trained MHPs to support EMAS colleagues to divert MH cases from the stack and avoid use of blue services. MH Response Vehicle which is available to support assessment in the community and telephone support to system partners. We provide a professional's advice and guidance line in the CAP to support primary care with queries around treatment options, crisis management and medication advice.
Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	yes	Plans in place in DMH to deliver over summer 2025

Provider CEO name	Date	Provider Chair name	Date

Completed Board Assurance Statements are to be submitted by **30 September 2025.**

Trust Board Assurance Statements do not need to be assured by the ICB before submission, however we would expect partnership working during the development process.

Proposal

- The LPT winter plan is completed and will be stress tested in an NHSE event on the 17.9.25. There may be additions / alterations required following the stress test.
- Share the current plan with the board for early sight noting there may be additions / alterations, outline the sign off timescales.
- Submit the final LPT winter plan to the board 22.9.25 for virtual sign off by the 25.9.25.
- CEO and Chair sign off 26.9.25.
- Final submission of the plan to NHSE by 30.9.25.

Decision required – Please indicate:

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

Governance table

For Board and Board Committees:	Trust Board 30.09.25	
Paper sponsored by:	Jean Knight	
Paper authored by:	Sam Leak	
Date submitted:	23.09.25	
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):	Confidential Trust Board 29.7.25 EMB 5.7.25	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	NA	
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	September	
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):*		
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:	Considered	

NHS
Leicestershire Partnership
NHS Trust

T H R I V E

LPT Winter Plan (V3 - 31.7.25)
2025 / 2026

Introduction

Each winter, the health service faces significant challenges due to increased pressures across all parts of the system. Every day, over 140,000 people access UEC services across the country, including more than 11,000 who are so unwell they need to be admitted to hospital for a day or more, and 20,700 people who are seen by the ambulance service. Since 2010/11, the number accessing UEC services has risen by 90%, and the number seen by the ambulance service has risen by 61%. This huge increase in reliance on UEC services has only in part been fuelled by an ageing population and an increase in multiple long-term conditions and mental health needs.

Effective and comprehensive planning is essential to maintain resilience and ensure continuity of care during these demanding times.

System National requirements

Commit to developing and testing collective winter plans, which will be signed off by every board and chief executive within each system by summer 2025. Regions will work with systems and providers on an exercise to stress-test and refine the plans in September 2025 and will continue to oversee improvement support to the most challenged organisations in the run up to and throughout this winter. As a minimum, each plan should show how, by this winter, systems will:

- Improve vaccination rates.
- Increase the number of patients receiving care in primary, community and mental health settings.
- Meet the maximum 45-minute ambulance handover time standard.
- Improve flow through hospitals with a particular focus on patients waiting over 12 hours and eliminate corridor care.
- Set local performance targets by pathway to improve patient discharge times and eliminate internal discharge delays of more than 48 hours in all settings.

National Urgent and emergency care plan 2025/26 published in June 2025

Mental health teams leading from the front.

An emergency department is seldom the most appropriate setting for people experiencing a mental health crisis, yet too often, service users find themselves with no local alternative. As a result, too many patients wait for 24 hours or more in emergency departments. Systems that invested in crisis assessment centres or specialist alternatives to emergency departments can evidence both a positive impact for service users in crisis and a broader impact on improving UEC provision in their areas. Those systems that haven't yet been able to invest in crisis assessment centres have seen benefits from ensuring community assertive outreach and crisis intervention teams are working with acute providers to support patients who attend an emergency department with mental health-related issues.

Requirements

- £26 million capital available to support systems that can demonstrate they can invest in crisis assessment centres in-year, ahead of winter offering rapid assessment and short-term support to ensure people in mental health crisis have timely access to specialist support and are directed to the right care pathway. All areas will have an opportunity to apply for this funding.

- £75 million to be invested to eliminate inappropriate out-of-area placements by delivering additional capacity to improve local mental health inpatient provision. The new capacity will be available by the end of this financial year.
- System winter plans need to demonstrate how local mental health providers can evidence that mental health inpatient stays will be as short as possible.

Plans should set out:
- How the number of patients in out-of-area placements will be reduced.
- How mental health providers will proactively identify and reduce the re-admissions of high intensity users of crisis pathways and provide a percentage reduction target of re-admissions for the highest intensity users.
- How they will ensure fewer patients who need a mental health admission wait over 24 hours. This will include the consistent and systematic use of the mental health UEC Action Cards in all relevant settings (acutes) and delivery of the 10 high-impact actions for mental health discharges to support flow through all mental health (including child and adolescent mental health) and learning disability and autism pathways.

From hospital to community: increasing the number of patients receiving care in community settings
At least 1 in 5 people who attend the emergency department don't need urgent or emergency care. An even larger number of attendees could be more efficiently managed by growing community capacity.

The neighbourhood health guidelines published in January 2025 set out the 6 core components of neighbourhood health that all local health and care systems will start to implement systematically this year. This will help people stay independent for as long as possible, reduce avoidable exacerbations of ill health and minimise the time people need to spend in hospital or in long-term residential or nursing home care.

System winter plans should clearly set out how local partners are working together to identify patients who are most vulnerable during the winter period and co-ordinate proactive care for them. As part of the system winter plan submission, ICBs will need to evidence how NHS providers and local authorities will improve discharge and admissions avoidance. Plans should set out how systems intend to expand access to urgent care services at home and in the community, so patients don't need to attend hospitals unnecessarily. This includes understanding the actual volume and optimising the use of urgent community response and virtual ward capacity in each ICS as well as planning with the ambulance service and 111 how to use this capacity most effectively.

Every patient living with frailty should be identified early in their journey and a comprehensive geriatric assessment initiated or amended. This assessment and early involvement of a frailty team is proven to reduce admissions and length of stay and improve the patient's chance of maintaining independent living.

We need to use UTCs effectively, as well as children and young people's specific services, and standards need to be refined. ICBs should also consider commissioning means of local advice and guidance (such as Healthier Together) so parents can navigate their local systems and care provisions more effectively.

A whole-system approach to improving patient discharge.
In some trusts, 1 in 4 bed days are lost due to delayed discharges. Acute trusts and local authorities should set local performance targets for pathway 1, 2 and 3 patients. Patients should be discharged as soon as possible to appropriate rehabilitation, reablement or recovery support, based on the

"Home First" principle. ICBs should work with local authorities to ensure that BCF capacity plans include appropriate capacity for surges over winter.

The discharge rates of people who are ready to leave community beds are low, with 1 in 5 beds occupied by people with no criteria to reside in the service. Reviewing bed usage and returning people to home-based care where possible will reduce long stays and increase capacity for those who need it. As well as providing surge capacity, additional beds have the potential to support acute admission avoidance for respiratory and flu cases, alongside IPC cohorting where it is appropriate to do so.

Falls place a significant burden on UEC services, costing the NHS more than £2.3 billion a year. Falls in social care, home and community settings make up around 75% of this cost. Care technology in these settings can support people to live independently and avoid falling; for example, remote monitoring technology in care homes has been found to halve falls and prevent "long lies", strongly associated with hospital admissions.

Bed Modelling UHL

To establish the size of the gap and the mitigations required as a system a bed model is produced every year and a plan to bridge the gap as a system through efficiency schemes is developed. This is a theoretical model and used as a guide only and its validity will be measured monthly retrospectively against actuals.

Assumptions

- Beds required based on emergency demand as per activity plan (0% growth)
- Beds available excludes day case and critical care beds.
- 92% Elective and Emergency bed occupancy

Scenarios

Best Assumes 85% of mitigations are delivered.
Most likely Assumes 75% of mitigations are delivered.
Worst Assumes 50% of mitigations are delivered.

Fig 1 – UHL bed gap

Base

		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
UHL Bed Model output - April 2025	Beds Required	1777	1768	1748	1723	1693	1745	1803	1830	1777	1852	1813	1770
	Beds Available	1671	1671	1671	1671	1671	1671	1671	1671	1671	1671	1671	1671
	Initial Bed Gap	**-106**	**-97**	**-77**	**-52**	**-22**	**-74**	**-132**	**-159**	**-106**	**-181**	**-142**	**-99**

Fig 2 – UHL bed gap with removal of 'bad beds' (bad bed = patients waiitng in the wrong location)

Additional negative requirements	Patients waiting in ED for beds at 08:00	47	52	47	37	41	51	59	59	54	75	70	70
	Patients waiting in CDU for beds at 08:00	33	32	25	24	24	37	36	35	44	51	34	35
	Patients waiting in GPAU	14	14	14	14	14	14	18	18	18	18	18	18
	Patients in escalation beds (Rapid Flow & Boarding)	10	10	10	10	20	10	15	20	20	25	25	25
	Relocation of Ashton				24	24	24	24	24	24	24	24	24
	Total additional beds required	**104**	**108**	**96**	**109**	**123**	**136**	**152**	**156**	**160**	**193**	**171**	**172**
Unmitigated gap (Initial bed gap with additional impact)		**-210**	**-205**	**-173**	**-161**	**-145**	**-210**	**-284**	**-315**	**-266**	**-374**	**-313**	**-271**

Fig 3 – UHL mitigation scenarios

Unmitigated gap (Initial bed gap with additional impact)		**-210**	**-205**	**-173**	**-161**	**-145**	**-210**	**-284**	**-315**	**-266**	**-374**	**-313**	**-271**
Scenarios													
Best													
		Apr-25	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**
Negative impact	Equivalent of 1 UHL ward closed due to staffing/infection (28 beds)	28	28	28	28	28	28	28	28	28	28	28	28
Mitigations	Assumes 85% of mitigations are delivered	47	57	67	87	96	96	98	121	121	121	121	121
Mitigated gap (Base scenario following ward closures and mitigations applied)		**-191**	**-176**	**-134**	**-102**	**-77**	**-142**	**-214**	**-222**	**-173**	**-281**	**-220**	**-178**
Most likely													
		Apr-25	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**
Negative impact	Equivalent of 2 UHL wards closed due to staffing/infection (56 beds)	56	56	56	56	56	56	56	56	56	56	56	56
Mitigations	Assumes 75% of mitigations are delivered	41	50	59	77	85	85	86	106	106	106	106	106
Mitigated gap (Base scenario following ward closures and mitigations applied)		**-225**	**-211**	**-170**	**-140**	**-116**	**-181**	**-254**	**-265**	**-216**	**-324**	**-263**	**-221**
Worst													
		Apr-25	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**
Negative impact	Equivalent of 3 UHL wards closed due to staffing/infection (74 beds)	74	74	74	74	74	74	74	74	74	74	74	74
Mitigations	Assumes 50% of mitigations are delivered	27	33	39	51	56	56	57	71	71	71	71	71
Mitigated gap (Base scenario following ward closures and mitigations applied)		**-257**	**-246**	**-208**	**-184**	**-163**	**-228**	**-301**	**-318**	**-269**	**-377**	**-316**	**-274**

Using the most likely scenario the largest bed gap is in January 2026 with minus 324 beds. Add bad beds back in +193 and increase occupancy to 98% +100 = bed gap of 31 *this will not support flow and will result in handover delays*)

LPT Winter plan

General

- EQIA completed by LPT DON and MD
- Plan has been shared with system partners and reflects the System winter plan.
- LPT winter plan has been through system UEC Operational Committee, UEC Transformation Board, LPT Strategic Executive Board.
- The plan will be tested through the regionally led winter exercise and any learning will be incorporated into the plan
- The Executive Operational Lead for Winter is Sam Leak (Executive Director Community Health services) and Jean Knight (MD and DCEO)
- A Director on call rota is in place 24/7

Community Health Services

CHS Priority

- Increase opportunity for step up into Frailty Virtual Ward and Community Hospital from Primary Care and ED (reduce Flow In)
- Improve discharge performance on inpatient wards including learning from LPT MADE events (improve Flow through)
- Improve inpatient transfer from UHL to LPT including learning from UHL MADE events (increase Flow out)
- Increase bed capacity – additional ward, funding dependent (increase Flow out)

CHS Plan

1. Ensure patients stay well at home and avoid unnecessary admissions by:
   - Care home education and intervention to decrease admissions.
   - Falls prevention work.
   - Maximise appropriate use of UCR attendance and follow up.
2. To support improved flow
   - Pilot in July with system support and via System transport Transformation programme focusing on CHS discharges before 12. The aim is to increase flow and capacity for UHL earlier in the day which will support decreasing delays in UHL.

- Boarding SOP
- Length of stay (LOS) reduction (where appropriate ie decreased LOS may result in increased Packages of care POC)
- Medically optimised for discharge (MOFD) delayed discharge opportunities with ASC support / capacity

3. CHS Boarding SOP updated and agreed by the system.
   To be used in periods of surge
4. Protected beds for ED direct admissions.
   Pilot taking place over summer to test the benefits.
5. Continued partnership working
   To ensure patients are managed in the right place at the right time.
6. 1x/52 long LOS meeting to review top long waiters including those 21days+ MOFD.
7. Using data to demonstrate benefit.
   Data shows increased numbers of patients discharged home form CHS with decreased POC.
8. Aim to exceed last year's vaccination numbers which were above national average.
9. Maximise urgent community response provision.
10. Step Up (from primary care) to community hospital beds being explored over summer.
11. Current pilot with DHU to facilitate earlier transcribing and transcribing to ensure there will be decreased / no delays in periods of surge and super surge.

Adult Mental Health Priority

- Optimising flow through mental health inpatient settings
- Raising profile of all age 24/7 urgent mental health helpline (Central Access Point) via 111 options
- Increased capacity within the 24/7 urgent mental health telephone services
- Bring online additional 5 beds to support trend in demand seen Jan/Feb time.
- Liaison coordinator role to be introduced within EDU to support management MH cases.
- Enhance availability of hours worked of the MH Response Vehicle
- Enhanced reviews of patients considered for informal admission out of hours.
- MH winter budget agreed as part of commissioning plan.
- Continue to maximise flow through MH beds to enable availability. Increased capacity of MHP's in liaison service to increase reviews. New Link Worker role to support patients in ED.
- MH Urgent Care Hub in place, provides direct access for patients, EMAS, GP referrals or other professional referrals.
- Patients who frequently access urgent care services and all high-risk patients are being reviewed over summer to ensure they have a tailored crisis and relapse plan in place ahead of winter.

Families, Young People, Children, Learning Disabilities, and Autism Services Priority

- Increase the uptake of flu vaccinations in CYP and vulnerable adults across LLR, as well as maximising uptake of front-line staff entering patients' homes (reduced flow in)
- Support prevention of CYP and vulnerable adults across LLR being admitted to hospital or accessing ED (reduced flow in)
- Support expediated and timely discharge from hospital of CYP and vulnerable adults across LLR (increased flow out)
- Ensure improved access to information and advice, including digital healthcare, for families on minor illness and ailments, ensuring inclusivity for LD patients (reduced flow in)

LPT IPC Plan

The Infection Prevention and Control (IPC) team implement safe systems of working during winter using the IPC hierarchy of controls and measures to implement effective controls and reduce the spread of respiratory pathogens (Covid-19, Flu and RSV) in health and care settings.

There is a robust outbreak policy in place that has incorporated national UKSA and IPC guidance and learning from local infection incidence. The policy and winter plan has a balanced approach to assessment of patient and staff risk, minimising service disruption and flow to beds with scalable response plans working in conjunction with system partners to assess the patient risk across services and providers.

Robust IPC outbreak management plans going into OOH periods are documented and communicated to clinical teams and in the on-call pack to manage any escalation or de-scalation as appropriate and to allow for rapid re-opening of capacity if there have been bed restrictions. There is also a risk assessment to admit into an outbreak area if the system patient safety risk is greater.
Respiratory Protective Equipment (FFP3 masks) must be considered when a patient is admitted with a known/suspected infectious agents/disease spread wholly or partly by the airborne and when carrying out aerosol generating procedures (AGP's) on patients with a known/suspected infectious agent spread wholly or partly by the airborne route.

Guidance published in the National Infection Prevention and Control manual for England clearly sets out the level of preparedness for the use of FFP3 within staff groups and the importance of using risk assessments for staff/service groups which have not been identified. In May 2025 following review with clinical directorates a prioritisation model was applied and LPT staff identified for mask fit testing in line with their role, responsibilities, and clinical environment. To note mask fit testing is required every 2 years.

Scalable response plans include use of universal mask use (risk proportionate) across wards or sites to maximise workforce resilience, increased cleaning and decontamination, review of patient placement during infection surges for operational continuity. All winter/high consequence infection action cards are up to date and available as staff resource, alongside testing protocols.

LPT Vaccination plan
The Trust clinical lead for staff and covid-19 flu vaccination has implemented a programme delivery model to enable all frontline staff to easily access the vaccine, utilising peer vaccinators and a roving vaccination team to maximise opportunity and ensure flexibility for our workforce. As a result, the Trust achieved an above national average of staff uptake at 42% last year and have been asked to increase this uptake to 47% this year. The programme has executive sponsorship by the Executive Director of Nursing, AHPs and Quality and delivery of the programme is monitored through the Strategic Flu and Covid-19 group, through to the Trust Quality Forum, the Strategic Flu group commenced early planning in June 2025.

The flu delivery plan incorporates The UKHSA frontline healthcare workers flu vaccination key components of developing an effective flu vaccination programme.

- committed leadership.
- communications plan
- flexible accessibility
- incentives
- using performance data to inform actions.

The Trust will continue to utilise a hybrid delivery plan with local peer vaccinators and a roving team to maximise opportunity, including an offer to all clinical teams for the vaccinator team to attend team

meetings, staff induction, training events and to maximise uptake and demonstrate leadership and commitment to the staff flu campaign.

The Trust is looking to increase the number of peer flu vaccinators in clinical teams to support the increased uptake. Peer vaccinators and IPC link staff act as flu champions to promote the need for flu vaccinations. The Trust Communications team have engaged with LPT staff networks to work with representatives from low uptake groups to discuss concerns round vaccine hesitancy and vaccine overload to support key messaging and to reduce hesitancy and improve uptake.

School Aged Immunisation Service

The School Aged Immunisation Service (SAIS) Flu Programme will start on the 15th of September 2025 with an expected completion date of the 12th December 2025, delivering vaccinations to all eligible children and young people across primary, secondary, special schools and home educated in LLR

The NHSE target for SAIS for 2025/25 is:
60% flu uptake target for children in reception to year 6
50% flu uptake for young people in Year 7 – Year 11.

SAIS plans to deliver target:

- Offer vaccination to all eligible CYP with a first opportunity in school with a second opportunity in community clinics.
- After school clinic / weekend clinics to be made available to increase second opportunity offer
- Invitation letter to consent available in multiple languages.
- Social Media toolkit, flu animations for primary and secondary schools to share with parents/carers in support of the flu programme.
- Injectable Flu video to compliment the nasal flu video.
- MAVIS – New Digital consent system for 2025/2026, developed by NHSE to improve vaccination and consent uptake.
- Injectable flu vaccination offers where nasal flu is not acceptable.
- Providing the option of self-consent to all eligible young persons, from year 8 (13yrs and above)
- Strong links developed with system stakeholders, local authority, ICB and Public Health including with community leads.
- Targeted second opportunities in schools where vaccination rate is low.
- Targeted community clinics across LLR
- Work force resilience
- Logistics co-ordinator to ensure clinical and administrative staff availability and workforce rota.
- In the likely increase in flu consents due to social media and our new consent model our surge workforce model will comprise of the following:
- Majority of workforce are on annualised hours to ensure availability during the flu programme.
- Bank staff known to the service, skilled and trained to respond to a surge.
- Student nurses on placement within the SAIS in administering vaccine and supporting in sessions.
- Schedule for the flu programme delivery in place

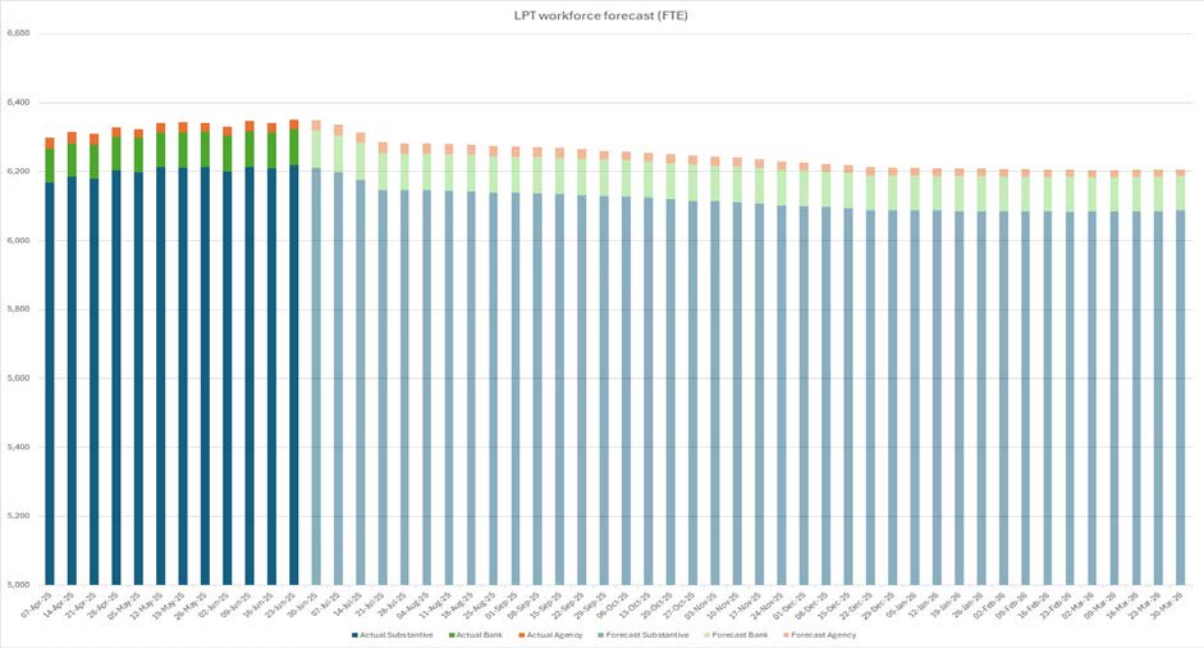
LPT Workforce plan

LPT anticipates that our overall staffing levels will remain the same in a baseline, surge, and super surge scenario. In 2024-25 we saw no notable increase in use of temporary staffing during Winter. The workforce plan is based on the no additional bed capacity to be opened in LPT and workforce utilisation must fit within existing budgets.

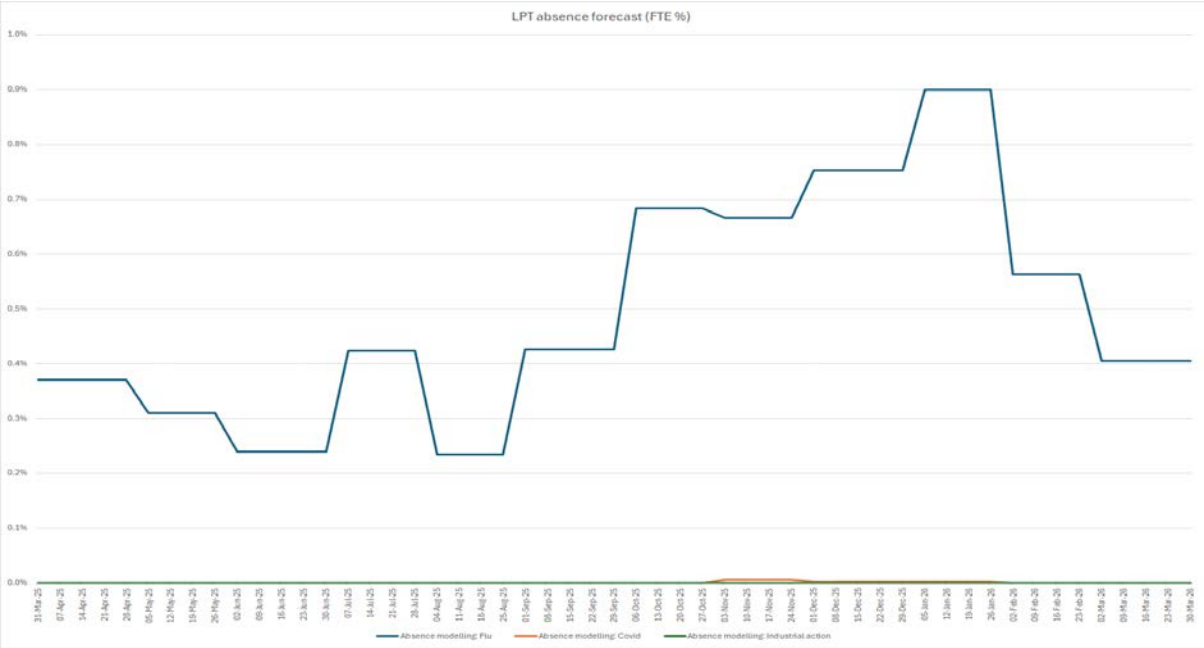
If the availability of substantive staff reduces (for example due to higher-than-expected absence) we will look to our own internal resources to bridge the gap. This would include consideration of:

- standing down meetings to release capacity.
- cancelling attendance at non-essential training and other personal development activities
- postponing planned annual leave
- reducing/standing down services to enable internal redeployment of staff (particularly those in non-patient facing roles such as education, research, and corporate nursing)

LPT workforce forecast.



LPT absence forecast.



LPT workforce mitigations

- Sickness absence levels to be closely monitored by the executive team through the winter period, with well-established routes in place for escalating risks including concerns about staffing levels.
- Monthly reporting already in place to support adherence to rostering KPIs. This includes rosters being published 12 weeks ahead of when they are due to be worked.
- Monthly reporting in place to support annual leave planning.
- As per policy all annual leave should be planned/booked by 30 September.
- LPT Strategic Flu and Covid Vaccination Meeting meets each month and is currently planning for the 25/26 staff vaccination campaign.
- Enhanced Therapeutic Observations and Care (ETOC) group/lead monitoring use of temporary staffing for ETOC reasons.
- Our well establishment health and wellbeing offer to continue throughout the winter period.
- Ongoing monitoring of potential/planned industrial action and assessment of the likely impact on the Trust.

LPT Communication plan

- We will work with system and Group partners to design and implement a full winter communication activity plan.
- This activity will focus on specific communications that will help the system and each Trust to deliver the priorities within our Winter Plan e.g. patient flow.
- We will focus on high priority areas specific to our Trust and make use of data and analysis to adapt focus and reprioritise where necessary.
- A specific named communications lead will be provided for each directorate as their main contact.
- We will deliver a communications campaign to support the winter vaccinations programme for staff and service users, and the general public. We will share good practice and coordinate as a system communications community across LLR and the Group.
- The specific communications priorities will include:
    - Attending and admission avoidance in ED, including signposting through 'right care, right place', supporting UHL LLR campaign.
    - Targeted comms as a system in geographical areas where ED attendance is high.
    - Specific focussed communication for vulnerable groups outlined in the LPT plan:
        - frail older patients, specifically around falls prevention, preparing to go home from hospital/speeding up discharge support, remote monitoring technology and winter wellness.
        - those requiring care in the community, profiling our virtual wards, urgent community response and community Home First offer for example.
        - support for families with children aged under five, promoting our Healthy Together Helpline and extensive digital offer.
        - Promotion of the Healthy Living toolkit for people with learning disabilities. Potential for a winter version.
    - Prevention measures, self-care, and winter wellness tips in regular communications, using clinicians where possible, delivered through inclusive accessible communications such as subtitles and different languages where possible.
    - Mental health, signposting to 111 option 2, neighbourhood mental health cafes and other community support.
    - Promotion of Joy website to enable local population to find support close to them.
    - Supporting frontline colleagues with related urgent or emerging issues, including the production of leaflets and other support materials where required and stakeholder communications to improve system communications flow (including care homes).

- Supporting frontline colleagues with their health and wellbeing, e.g. vaccinations and details of comprehensive health and wellbeing offer.
- Regular updates to staff to show what's working, including examples of great practice to share learning and raise morale. We could have a winter themed Spotlight Talk for example and SLF agenda.
- Media profiling of high impact success, to raise general public awareness of our efforts including the Frail Virtual Ward, mental health response vehicle, the urgent mental health care hub, digital healthcare innovations, urgent community health response.

Conclusion

LPT is committed to ensure we work in partnership to deliver the system plan and take responsibility for delivering the LPT plan to ensure the best possible winter for patients of LLR over winter 2025 2026.

Appendix 1 - System highlights

Strategic Assurance

Key question and points to consider	Response
How the system is planning to ensure a resilient winter workforce, including overnight and out-of-hours cover, minimising reliance on agency staff, and pre-emptively managing known high-risk gaps across UEC, community, and social care services	• Winter Workforce Group to understand workforce issues and implement workforce actions. • Workforce sharing agreement, volunteer sharing agreement. • Increased Volunteer roles across providers • Work is underway to support ASC (Home First) Service and Community Health Services workforce issues understanding gaps, implementing solutions, streamline processes etc. • Monitoring agency staff usage in line with set expectations. • CYP – supporting the upskilling of parents and Primary Care Colleagues to support <5yos.
Identify, monitor, and mitigate risks of disproportionate impact on high-need, high-risk or underserved populations, including those with mental health needs, learning disabilities, or from minoritised communities	• Our PHM tool enables each practice to identify, segment, and risk stratify high-risk/complex patients including specific filters for SMI, LD, Core 20, and AHD cohorts. • General Practice resourced through a LES to provide longer proactive assessment and care planning appointments for such patients, evidence showing that this reduces unplanned secondary care use. • General practices whose allocations are least well matched to population need are additionally funded by the LLR ICB Health Equity payment model. • BCF additional support for homelessness and community MH support, and for city centre Safespace/SJA offer in city centre on weekends. • Weekly MDT for inclusion HFUs. • Call before convey (PTCDA) service • EMAS can mitigate the risk to patients waiting for a response in the community through the oversight of patients waiting by senior clinicians
How insights from Winter 2024/25 and other recent surge events have been embedded into current winter plan, and mechanisms in place to iteratively test, evaluate, and adapt schemes in real time during Winter 2025/26	• Learning from the LLR Winter 2024/25 Summary Report has been reviewed at UEC Operational mtgs, UEC Collaborative Transformation mtgs and Health & Care System Dynamic Risk Assessment Workshop in April 2025. • Exercise Pressure Point 1 (June 2025) has tested updated action cards for further review at the follow up Exercise Pressure Point 2 in September 2025. • Weekly mtgs commencing 30/06/2025 will take a forward view of risk across all health and care providers. • Established weekly system governance mtgs will review progress and support iterative changes.

Quality

Key question and points to consider	Response

Policies and measures in place to mitigate the risk of avoidable harm from long waits for treatment, delayed ambulance handovers and use of temporary escalation spaces	• Rapid Flow and Boarding Policy at UHL & LPT • Release to respond protocol introduced. Operating against 45 min target. • Daily Escalation calls at system level provide space to support management of risk through mutual aid and other interventions. • Daily Huddles to review patients, capacity and safety issues . • Temporary escalation spaces in use in UHL. • EMAS will use the actions within the Capacity Management Plan to mitigate the risk of patients waiting for a response in the community.
Ensuring negative impact of long waits on Mental Health patients is assessed and support is available to patients with high acuity risk presenting at UEC. Alternative arrangements for mental health crisis attending UEC for support	• Increased capacity of the MHPs within the liaison service to ensure that patients with longer waits are reviewed regularly and review any negative impact. • We have created a new role for a link worker to support patients waiting for both assessment and MH admission in ED. • Alternatives to ED, include LPT Urgent MH hub which can accept referrals from EMAS, GPs and other professionals
Using learning from patient safety harm reviews, incidents (including embedding the learning from mental health related PSIRF incidents) and audits to drive quality improvements including management of the deteriorating patient and recognition / management of sepsis.	• Use of incident reporting to capture data and identify harm. • Harm reviews and report findings through established governance routes i.e. intraorganizational /System Quality Group and Quality and Safety Committee. • Mental Health Matron in UEC to liaise with LPT and ensure subject matter experts are close to the patients to help mitigate risk . • Introduction of Release to Respond to ensure improved use of EMAS back into the community.
Policies and measures in place to mitigate the risk of avoidable harm from long waits for treatment, delayed ambulance handovers and use of temporary escalation spaces	• Rapid Flow and Boarding Policy available at UHL & LPT • Release to respond protocol introduced. Operating against 45 min target. • System Daily Escalation calls support management of risk through mutual aid • Daily Huddles to review patients, capacity, and safety issues. • Temporary escalation spaces in use in UHL. • EMAS use actions in the Capacity Management Plan to mitigate risk of patients waiting for a response in the community.

Infection Prevention & Control

Key question and points to consider	**Response**
Plans in place for 7-day IPC cover over the winter/periods of high IPC demand to support patient safety, capacity, flow, and management of outbreaks.	• UHL has 5-day IPC and 24/7 out-of-hours Microbiology and IDU service available. 2025-26 winter plan includes IPC team request to re-establish 7-day service during winter pressures. • LPT has 5-day IPC and 24/7 out-of-hours Microbiology and IDU service available. • Community NHS Services (including GPs) have 5-day IPC and 24/7 out-of-hours Microbiology and IDU service available. • In addition, the local UKHSA Health Protection Team is available 24/7 for urgent IPC guidance.
Cohorting, isolation and surge plan updated with learning from last winter. Risk assessments for patient placements and appropriate cleaning protocols to support local teams when patients are discharged, or isolations precautions have been stepped down	• UHL and LPT have reviewed and updated 2025-26 winter plans, including cohorting, isolation and surge protocols. Plans include risk assessments for discharged/isolated patients with associated cleaning protocols. • The East Midlands Region will have the 45 mins handover protocol implemented and embedded in all hospitals across the region.

Staff vaccination plans reviewed with the learning from the last campaign, ensuing access to vaccination through onsite services, bookable and walk in appointments. Vaccination offer to include vulnerable patients who are inpatients.	• specific vaccination Key Lines of Enquiry submitted on 4th July. • Vaccination offer for vulnerable inpatients. • Plans stress-tested on 10th July 2025.
Point of care or rapid testing in place for respiratory viruses during the winter period across hospital settings, including admission pathways.	• UHL have testing protocols in place for respiratory viruses as per winter planning. • This includes escalation of testing for admission and discharge pathways depending on local infection rates.

System Working

Key question and points to consider	**Response**
Sharing understanding and acting on decisions across system partners during winter operational pressures, and accountability for decisions across executive and operational levels	• System Coordination Centre leadership, oversight and escalation across seven days. • All partners have access to SHREWD, with SHREWD Action now in mobilisation phase. • 24/7 two-tier Director On Call process across providers. • Daily System Flow Calls at 09:45 with escalation SOPs embedded, and flexibility to stand up afternoon calls as necessary. • Mental Health escalation calls twice weekly as a minimum. • Escalation themes reviewed at cadence of usual operational, clinical, and executive mtgs.
Effectively manage clinical risk. Arrangements for clinical leadership, accountability, governance, and processes	• Established cadence of clinically-led mtgs across every month with clinical membership. This includes the Clinical Executive and the Clinical Responsibility Group which reports into the UEC Collaborative Transformation Group. • Clinical Executive By Exception mtgs to be responsive to surge demand. • The monthly System Quality Group mtg has oversight of all identified clinical risk. • The SCC escalation process includes direct liaison with clinical leads where appropriate.
Evidence that shows proactive system coordination (e.g. joint planning, mutual aid, surge agreements) in place and has been tested or used effectively outside of crisis periods	• Exercise Pressure Point 1 held on 19/06/2025 was the first exercise in a series of surge and escalation exercises across Q1 & Q2 2025/26 for LLR health and care providers. • The SCC SOP is subject to monthly review, as are the associated action cards. • Recent testing in June 2025 to support UHL whilst Nervecentre was offline for 48hrs during their Patient Administration Service ("PAS") software replacement.
Contingency plans for rapid scaling of capacity in response to unforeseen external factors	• The SCC and EPRR teams work together daily as per the national SOP issued in March 2025. • System-wide exercises, 'lunch & learn' sessions and regular review of SOPs underpin our processes for any rapid response for support.

Escalation

Key question and points to consider	Response
In the event of sustained system pressure or deterioration, how the decision to move from local to regional oversight is triggered, and the agreed operational pathway to escalate support or enact contingency measures	• LLR Surge and Escalation Plan sets out the escalation routes and decision points that are undertaken by the LLR ICB Strategic Director. • LLR SHREWD is used as the system operational pressure insight tool. • The SCC has daily connectivity with the Regional Operations Centre (ROC) to discuss escalations in operational pressure and articulate high-level actions to deliver a direct impact.

Ensuring that OPEL declarations and escalation triggers are applied consistently across all acute, community, ambulance, and mental health providers and actions are linked to system-level interventions, not just provider-level responses	• The LLR SCC owns the LLR Surge and Escalation plan the sets out all system providers actions at OPEL Levels. These are overlayed with ICB / Regional / Multi Provider / National mitigations. • This Plan is reviewed twice yearly (H1/H2) and tested through system exercises; post-exercise reports share learning across ICS partners and is presented through the ICB Governance Structure.
Process for real-time dynamic risk assessment and escalation during winter, and how this informs tactical decisions (e.g. system calls, cohorting, mutual aid, ambulance diverts)?	• LLR use the SHREWD platform as an insight operational pressure, this will be discussed at the daily UEC System Flow Calls with meaningful actions set and driven through by the SCC. • There is a separate weekly system predictive risk meeting in place for system collaboration and forward look regarding potential future risks, this allows the tactical element to apply early planning and preparedness actions. The LLR meeting cadence allows for extraordinary meetings to be stood up in times of extreme pressure.

UEC

Key question and points to consider	Response
Prevent/ED avoidance or alternatives to ED with focus on the homeless and those considered vulnerable (Frail/Elderly) or at risk throughout the winter period.	• Call Before Convey service operates daily from 08:00 to 18:00, with a plan to extend its operational hours until 20:00. • Implementation of Community antimicrobials for moderate to severe infection in the context of significant frailty, or other complex co-morbidities • Virtual Care scheme detecting early deterioration in patients within PNGs 9, 10 and 11. The pilot takes a population health management approach by selecting patients in the most need of proactive care and monitoring. • virtual digital monitoring platform, to support clinical observations and a questionnaire designed to detect other medical considerations for the detection of deterioration. • Delirium pathway for early identification of delirium and early recognition of those with an episode of delirium to prioritise admission avoidance
Enhanced MH crisis pathways, for those acute patients considered non-complex but require intervention from physical and MH teams	Urgent mental health hub which will support those with crisis mental health needs and very minor assessed physical health issues but do not provide a physical health intervention.
Plans to enhance or implement connected care records to help inform first responders and avoid unnecessary transportations or attendances at healthcare settings or hospital.	• The LLR Care Record (LLRCR) is directly connected to the East Midlands Ambulance Service Unified Care Record, allowing EMAS staff to access information about a patient's broader health and care services within their own system. • Progress is also being made on enabling NHS111 and out-of-hours services to access the LLRCR.

Discharge Services

Key question and points to consider	**Response**
System coming together at place/locality level to improve efficiency and productivity with complex discharge, reducing/driving down cost and increasing capacity to help manage the surges in activity associated with inclement weather	• System Discharge Working Group in place to support timely discharge. • Improved flow through CHS to support system - boarding SOP, LOS reduction, predicted risk system reviews, MOFD delayed discharge opportunities, system pathway transformation. • Discharge data governance daily via SCC and SHREWD data sets in place across system. Daily system SCC calls as planned to support surges and escalations. • Reducing LOS planned as priority metric across the system with collaboration across acute, CHS and ASC teams (monitoring of the BCF for discharge).

Drive down the average length of stay throughout the winter period of the proposed .4 of a day (2024/25 vs 2025/26) as outlined in the 2025/26 UEC plan	• Acute Emergency LoS is 7.4d in March 2025. • UHL Ward improvement plan is being developed in line with I&I PA Consulting work. Plan to be signed off through UHL UEC TG in July. • Data deep dive underway to identify detail of delays inc. incomplete discharge audits and subsequent actions being put in place. PDSA in SM to reduce time from DRD to time of discharge • IDT working group and Strategic System discharge groups in place to improve demand and capacity mismatch to reduce delays.
Agreed targets/timelines for pathway 1, pathway 2 and pathway 3 complex/noncomplex discharges and patients requiring RRR, as outlined in the 2025/26 UEC plan	• 2025/26 Winter Plan metrics shared with system organisations and being implemented for assurance via the system Discharge Working Group. • Transparency of data relating to patient discharge pathways being managed across the system. Increasing usage of LLR Care Record enables faster/safer discharge by being able to see patient wider health and care provision. • New System Dx WG metrics to support P0, P1, P2 - P0 target 85% , needs to be 100% same or next day, P1 24hrs, P2 48hrs and P3 within 7 working days.

Mental Health

Key question and points to consider	Response
Improve patient flow through Mental Health inpatient beds, especially joint work with partners around clinically ready for discharge patients	• ten high impact actions to support improved mental health inpatient flow. • As part of this system approach, we have adopted a Housing Enablement Team which supports patients with accommodation needs as soon as admitted. • daily escalation calls to support heads up and CRFD management and a weekly mini MaDE event with senior partner reps for escalation of complex and long cases.
Elements of crisis offer (both crisis alternatives and CRHT capacity) that can be bolstered at the times of highest pressure	• Able to increase call handling and clinical capacity within the Central Access Point (111,2) at times of high demand to prevent escalation of urgent MH • System unscheduled care coordination hub which allows trained MHPs to support EMAS colleagues to divert MH cases from the stack and avoid use of blue services. • MH Response Vehicle available to support assessment in the community and telephone support to system partners. • Professional's advice and guidance line in the CAP to support primary care with queries around treatment options, crisis management and medication advice.
Minimise the numbers of MH patients in EDs and the length of their waiting times to give the best patient experience and to support acute services	• Neighbourhood crisis cafes have been increased over the last 12 months and operate 7 days a week across multiple locations for adults. • VCS providers support with cascade of diversion information for our diverse communities. • JOY app which hosts information around local services in an accessible environment. • MH texting service which operates 24/7. • TELLMI app provides chat function to support self-help. • Provide a link worker on the ED floor to support diversion from ED to our urgent mental health hub where possible and no complex physical health needs are indicated.

Children and Young People

Key question and points to consider	Response
Working with system and regional partners (including to: UEC, Primary Care, EMAS/WMAS, social care, Public Health, Community and Neighbourhood teams, Virtual Wards, Same Day Emergency Care) to ensure your local winter plans meet the needs of CYP.	• CYP UEC working group reporting into the UEC Transformation Group. Meetings are held monthly with representatives from UHL (Children's ED and Children's Hospital), LPT, DHU (out of hours provider), Primary Care, Public Health and local authority as well as regional CYP NHSE attendance. • Close links with the LLR training hub for provision of primary care education and are providing universal and targeted education sessions on management of acutely ill children and local pathways.

Key local challenges (including workforce capacity/sickness) in terms of CYP, along with your plans to address those challenges and meet demand in response to any other factors such as seasonal influenza, RSV or measles	Paediatric Consultant workforce has 8.5WTE shortfall according to national guidance and modelling. The impact of this includes: o Absence of paediatric SDEC. o Absence of paediatric advice and guidance (potential to start Autumn 2025). Increasing numbers of children with medical complexity and complex needs requiring a specialised medical workforce and MDT approach (including additional challenges as they transition into adulthood with lack of commissioned adult services). Fragile services: Immunology, dermatology, and neurology. o 69% reduction in national funding for immunisation services. o Maternal RSV vaccination rate in LLR is 33%.
Plans to support messaging and alternative pathways for CYP presenting to emergency care with the lowest acuity (particularly those under the age of 5 years), including primary care, community and neighbourhood offers, and any specific communications planned.	• Local digital offer for health information is Health for Under 5s, Health for Kids and Health for Teens. • Primary care triage appropriate children into Pharmacy First, and this is being explored for use in the Children's Emergency Department. • UHL CED triages children into the co-located UTC at LRI and community based UTCs.
Ensure that young people presenting to ED in mental health crisis will be cared for in the most appropriate setting in a timely manner. Are there know local challenges around this? If so, please detail your local approach to solving these challenges.	• CYP presenting to CED in MH crisis are seen by CAMHS Crisis Plus practitioners. CYP without medical needs may also be diverted at the ED front door to the Mental Health Hub and the Bradgate Mental Health Unit. • Joint escalation process for children with emotional dysregulation and complex needs involving UHL, LPT and local authority.

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Leicestershire Partnership NHS Trust

3As Highlight Report
Meeting Name: Quality and Safety Committee
Meeting Chair & Report Author: Josie Spencer Non-Executive Director
Meeting Date: 19th August 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 (AFM) AAA report	Item 7	Jean Knight	The alert around the number of waits over 52 weeks continues to be a major concern. This is being worked through by the Access Delivery Group, with a focus on waits not relating to ADHD, which is known to be a systemic issue, to get a greater understanding of all our waiting patients. A deep dive is to be undertaken at the next AFM to explore this.	3.2		
Quality Assurance and CQC update Report (June and July 2025)	Item 10 Verbal update	Emma Wallis	Following the CQC assessment of our community based mental health services for adults of working age on 13 – 15 May 2025, the trust received a Section 29A notice identifying four key areas for improvement. A letter of representation was submitted and on the 11 August 2025 the Trust received an outcome letter from the CQC who concluded that the legal test has been met in respect of the need to make significant improvements to the waiting times for service users to access outpatient appointments, the other three areas did not meet the legal test.	3.2		
ADVISE: Advise the Board of areas subject to on-going monitoring or development or where there is negative assurance						
Executive Environmental Scan – Director of Nursing Update	Item 5		A review of the new quality and safety forums has been completed and presented to Strategic Executive Board (SEB) on 12 August 2025. A short survey will be used with group members and clinical directorate executives, as well as Quality and Safety Committee to gather feedback for analysis and the outcomes will inform recommendations going forward.	3.3		

Accountability Framework Meeting (AFM) AAA report	Item 7	Jean Knight	There is an escalating concern around access to ICE and the impact on LPT clinical teams in CHS particularly, arising from delays in accessing results from blood tests and other medical interventions. ICE is hosted by UHL, and the issue is being escalated through system meetings. All known clinical risks are being mitigated within Directorates.	3.2		
Level 2 Quality Forum AAA reports (June and July 2025)	Item 9	Emma Wallis	Waits for Paediatric Phlebotomy for routine and urgent requests had increased, due to increased GP referrals. There was a change in commissioning arrangements 18 months ago. The matter is being escalated through the ICB to resolve	3.2 3.3		
Level 2 Safety Forum AAA Reports (May, June & July)	Item 14	Dr Samantha Hamer	The Committee received an update on the Suicide and self-harm prevention post, which is still under review through the workforce control route. Some work is being picked up temporarily within the Directorates and there are aims to explore opportunities for a joint post with NHFT prior to achieving a sustainable plan. Concerns around capacity to complete investigations and actions have been escalated by Patient Safety Implementation group and Incident Oversight group. A further update will be received at the next QSC.	3.3		
Safety Assurance report	Item 16	Emma Wallis	The Committee received an update on the continuing work on Co-Occurring Mental Health and Substance Use (COMHAD). Following a deep dive into historical homicides involving patients previously under LPT care, and in response to findings from both national and local reviews, a Quality Summit was commissioned. A self-assessment was undertaken against the Royal College of Psychiatrists report, Co-occurring Substance Use and Mental Health Disorders, which was published in May 2025. A number of recommendations were made and a follow up COMHAD meeting is scheduled for 14 August 2025.	3.3		
Level 2 Safeguarding Group AAA (July)	Item 18	Emma Wallis	The Committee were advised of the Safeguarding Reforms Bill and the potential impact to Childrens Services. Assurance was received that the ICB is fully sighted on the significant change in process. There is now confirmed representation from all parties and a Health Reform group has been set up to take forward this work and a Lead identified.			

			A report on Section 42 audits has identified some themes of neglect and patient on patient abuse, which are being actioned in directorate and followed up by the Safeguarding Team. There has been a relaunch of the Whole Family workstream and this is being led by the Childrens Safeguarding Lead. The Committee was made aware that the Safeguarding Assurance Report Q4 2024-25 was submitted to NHS England, with the final action relating to accessible information having been completed.			
ASSURE: Inform the Board where positive assurance has been received						
Policies approved/ extensions granted:			Nil			
Quality Improvement Report	Item 11	Emma Wallis	The Committee received a briefing paper on progress against the four key deliverables of the trusts Quality Improvement (QI) Programme as reported to the Transformation and QI Delivery Group. The Transformation and Quality Improvement group receives significant assurance of the outcomes and benefits of quality improvement and the positive impact on our patients, which has resulted from the clinical teams being empowered to deliver these improvements.			
Safeguarding Assurance report	Item 17	Emma Wallis	The Committee received the report on behalf of the Trust Board. They were advised that the substantive Trust Head of Safeguarding has now commenced in post. The report highlighted a reduced number of Children's Practice Reviews/Rapid Reviews due to a caseload data cleanse with the Safeguarding Board officer.. An increase in numbers of domestic homicides in Q1 2025-26 is being explored in detail across the system and an update on this will be provided in the next report. There has been an increase in activity around Safeguarding advice requests and children's strategy calls , data is discussed with the Children's Local Authority leads monthly to explore themes and trends. It was noted that all areas of core and clinical mandatory safeguarding training, for both substantive and bank staff are compliant. The Safeguarding Quality Improvement Plan implemented in January 2025 is on track with just four outstanding actions remaining from the original 17.	3.3		
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding						

Accountability Framework Meeting (AFM) AAA report	Item 7	Jean Knight	There were a number of areas of excellence indicated in the report. It was agreed to highlight the following to Trust Board; DMH Neighbourhood Lead and Voluntary Action South Leicestershire (VASL) have been delivering Rural Roadshows in remote villages across Harborough District as part of a Prevention & Resilience project; and the Waterlily team has been shortlisted for the HSJ for 'Community Care Initiative of the Year' and 'Virtual Care of the Year' both in the patient safety area.			
Quality Assurance Report & CQC Update (June & July)	Item 10	Emma Wallis	Welford Ward has received a Silver Valuing High Standards accreditation; Heather Ward has been shortlisted for the HSJ Awards for the nursing led Patient Safety initiative for their reduction in deliberate self-harm and research dissemination.	3.3 3.1		

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Leicestershire Partnership NHS Trust

Trust Board – 30 September 2025

Safe Staffing Monthly Report – July 2025

Purpose of the Report

This report provides a full overview of nursing safe staffing during the month of July 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 increased this month by 0.42% reported at 25.05% overall and Trust wide agency usage decreased this month by 0.20% to 1.36% overall.
- Registered Nurses
  - Vacancy position is at 262.4 Whole Time Equivalent (WTE) with a 13.1% vacancy rate, a decrease of 0.7% since June 2025.
  - Turnover for nurses is at 5.8% which is below the trusts target of 10%.
  - Sickness reported at 5.6%. a decrease of 0.4% since June 2025.
  - A total of 8.3 WTE nursing staff (bands 5 to 8a) were appointed in July 2025.
- HCSW
  - Vacancy position is at 127.1 WTE with an 12.1% vacancy rate, decrease of 2.3% since June 2025.
  - Turnover rate is at 7.2 %. which is below our internal target of no more than 10% turnover.
  - Sickness reported at 8.3% an increase of 0.7% since June 2025.
  - A total of 9.8 WTE HCSW were appointed in July 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 at 11.8 CHPPD (national average 10.8) for July 2025 consistent with June 2025.

July 2025 scorecard is presented below.

July 2025

Ward Group	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%						
DMH Bradgate	Ashby	14	14	91.8%	124.7%	100.1%	123.6%		100.0%	36.2%	32.2%	4.0%	9.0	1↓	0↓	0→		
	Aston	17	17	92.9%	80.6%	104.8%	96.8%		100.0%	24.5%	23.1%	1.4%	7.1	1↓	0↓	0→		
	Beaumont	23	22	86.9%	95.3%	100.1%	100.9%		100.0%	26.0%	23.2%	2.8%	7.1	1↑	0→	1↑		
	Belvoir Unit	11	10	102.5%	104.4%	101.1%	101.2%		100.0%	26.4%	23.7%	2.8%	17.6	0→	0↓	0→		
	Bosworth	14	14	89.2%	213.9%	104.7%	205.4%		100.0%	44.1%	43.3%	0.9%	12.3	1↑	2→	0→		
	Heather	18	18	92.7%	145.9%	96.2%	149.4%		100.0%	34.7%	29.0%	5.8%	9.1	2↑	11↑	1↑		
	Watermead	20	19	101.8%	103.3%	98.4%	105.3%		100.0%	35.6%	33.3%	2.3%	7.5	2↑	1→	0↓		
	Griffin - Herschel Prins	6	6	98.3%	97.4%	98.4%	112.9%		100.0%	26.3%	24.7%	1.6%	26.8	0→	1→	0→		
DMH Other	Phoenix - Herschel Prins	12	12	92.0%	95.0%	103.2%	97.8%		100.0%	20.6%	20.3%	0.3%	11.3	2↑	0→	0→		
	Skye Wing - Stewart House	29	25	101.9%	94.5%	100.4%	103.1%		100.0%	17.7%	17.3%	0.4%	6.0	1↑	0↓	0→		
	Willows	10	8	97.1%	116.2%	99.6%	107.0%		100.0%	15.1%	14.0%	1.1%	12.7	2↑	3↑	0→		
	Mill Lodge	14	8	94.6%	93.3%	96.4%	129.5%		100.0%	33.7%	26.7%	7.1%	20.2	0→	1→	0→		
	Kirby	23	22	90.3%	150.4%	98.5%	177.9%	100.0%	100.0%	37.2%	37.2%	0.0%	10.2	1↑	22↑	0↓		
	Langley (MHSOP)	20	16	92.0%	187.7%	95.3%	197.3%			45.4%	44.4%	1.0%	11.6	0↓	13↑	0→		
	Coleman	18	17	95.1%	127.8%	100.1%	187.2%	100.0%	100.0%	36.3%	35.2%	1.1%	19.2	1↓	15↑	0→		
	Gwendolen	19	18	78.9%	136.4%	100.4%	160.3%		100.0%	40.8%	38.6%	2.1%	14.6	0↓	22↑	0→		
CHS City	Beechwood Ward - BC03	24	24	99.7%	101.5%	100.3%	99.8%	100.0%	100.0%	16.1%	15.8%	0.3%	8.6	2↑	4↑	0→	0→	0→
	Clarendon Ward - CW01	22	20	80.9%	98.9%	100.0%	100.0%	100.0%	100.0%	9.1%	8.7%	0.4%	8.8	1↓	1↓	0→	1↓	0→
CHS East	Dalgleish Ward - MMDW	3	2	25.9%	15.6%	22.6%	15.0%	100.0%	100.0%	10.3%	9.7%	0.7%	24.1	0→	0↓	0→	0↓	0→
	Rutland Ward - RURW	18	17	99.8%	116.8%	100.0%	145.6%	100.0%	100.0%	17.4%	17.0%	0.4%	8.8	2↑	4↑	0→	2↑	0→
	Ward 1 - SL1	20	18	97.3%	105.2%	100.0%	102.3%	100.0%	100.0%	24.6%	24.6%	0.0%	11.3	0↓	2↓	1↑	0→	0→
	Ward 3 - SL3	14	13	105.4%	115.0%	100.0%	130.6%	100.0%	100.0%	19.7%	19.0%	0.6%	10.2	0↓	2↓	0→	0↓	0→
CHS West	Ellistown Ward - CVEL	18	17	95.0%	99.5%	100.0%	100.8%	100.0%	100.0%	7.2%	7.2%	0.0%	11.3	1↓	2↑	0→	1↑	0→
	Snibston Ward - CVSN	19	17	108.6%	104.4%	100.0%	102.2%	100.0%	100.0%	22.6%	22.4%	0.2%	10.0	4↓	3↓	0→	0↓	0→
	Ward 4 - CVW4	15	13	99.4%	103.1%	100.1%	120.2%	100.0%	100.0%	14.8%	14.6%	0.2%	12.1	3↑	0↓	0→	0→	0→
	East Ward - HSEW	23	22	80.9%	95.9%	102.7%	100.0%	100.0%	100.0%	16.3%	16.0%	0.3%	8.9	2↑	8↑	0→	0→	0→
	North Ward - HSNW	19	18	101.7%	92.1%	100.0%	100.0%	100.0%	100.0%	17.8%	17.3%	0.5%	8.6	0→	1↓	0↓	0→	0→
	Charnwood Ward - LBCW	18	17	96.4%	97.6%	100.0%	108.6%	100.0%	100.0%	0.0%	0.0%	0.0%	10.5	0→	1↓	0→	0→	0→
	Swithland Ward - LBSW	20	20	101.1%	103.0%	101.6%	113.8%	100.0%	100.0%	16.6%	16.5%	0.2%	9.3	1↑	1↓	0→	1→	0→
FYPC	Welford (ED)	15	10	99.6%	162.6%	99.6%	158.1%	100.0%	100.0%	24.6%	23.8%	0.8%	18.4	3↑	1→	0→		
	CAMHS Beacon Ward	17	4	93.4%	141.7%	100.0%	128.5%			47.8%	43.4%	4.4%	61.2	1↓	1→	2↑		
LD	Agnes Unit	1	1	74.4%	89.8%	70.3%	79.7%			19.5%	17.9%	1.6%	65.4	1↓	4↑	0→		
	Gillivers	4	2	109.4%	62.9%	116.5%	91.9%			9.2%	9.2%	0.0%	41.3	0→	0→	0→		
	1 The Grange	2	1	67.7%	74.1%	40.2%	83.1%			8.8%	8.8%	0.0%	49.8	0→	0→	0→		

THRIVE

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** Key areas to note - Ward 1 St Lukes 24.6% and Snibston 22.6% temporary workforce.	**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. Temporary workforce to meet planned staffing has reduced significantly across all wards due to continued recruitment drives. Utilisation of temporary workforce was due to high levels of sickness and vacancies.	**Amber**
	Fill rate: Fill rate below 80% of RN and HCA Day shifts and night shifts on – Dalgleish Fill rate above 110% of HCA day shifts on Rutland and ward 3 St Lukes and night shifts on – Rutland, Ward 3 St Lukes, Ward 4 (Coalville) and Swithland This is a significant reduction in the number of wards from 6 in January to 2 in July 2025. No wards have had a fill rate of above 110% for RN shift on either day or nights in July 2025.	**Fill rate:** Dalgleish ward closed 11 July 2025 for estates work. For wards using over 110% fill rate this is due to increased acuity and dependency, increased one to one supervision with patients requiring enhanced care and impact of patient transfers from acute providers.	
	Nurse Sensitive Indicators A review of the NSIs has identified a decrease in the number of falls incidents from 37 in June to 29 in July 2025. Ward areas to note with the highest number of falls is East, Beechwood, Rutland and Snibson. The number of medication incidents has decreased from 21 in June to 16 in July 2025. Ward area to note with the highest number of medication incidents is Snibston.	**Nurse Sensitive Indicators** **<u>Falls</u>** 29 reported falls incidents occurring across 11 wards, multifactorial with the majority resulting in low or no harm and one patient fall resulted in moderate harm. The weekly falls meeting continues across all areas discussing themes and improvements in care. Falls link training days are planned to include themes recognised across all wards which the patient safety team will be assisting. **<u>Medication errors</u>** The main theme is medication unavailable due to late patient transfers from acute providers and medication unavailable on admission. The medication incidents are across 8 wards 14 of the incidents reported as no harm, and 2 incidents reported as low harm. Wards continue to use safety crosses, whilst carrying out senior conversations and reflections. A daily report is shared with all leads reflecting omissions,	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
	The number of category 2 pressure ulcers developed or deteriorated in our care has decreased from 7 in June to 5 July 2025. No Category 4 pressure ulcers have developed or deteriorated in LPT inpatient care since March 2024.	which is showing improvement. Focus work has also commenced on controlled medication and will be captured in the new CHS medication group. **<u>Pressure Ulcers</u>** Pressure Ulcers category 2 developed in our care across 4 wards. 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. A new project to reduce moisture damage in care to patients continues working closely with our continence specialist teams. **<u>Staffing Related Incidents</u>** The number of safe staffing related incidents has decreased from 9 in June to 5 in July 2025 across 4 wards, due to reduced planned staffing. **<u>To be Noted</u>** In June 2025 the monthly safe staffing report identified that Clarendon was an area to note for falls, medication and category 2 pressure ulcer incidents. Clarendon does not feature as an outlier for July 2025 following monitoring by ward matron.	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
DMH In-patients	**Staffing:** High percentage of temporary workforce to meet planned staffing for Langley 45.4%, Bosworth 44.1%, and Gwendolen at 40.8%. Kirby, Coleman, Ashby and Watermead all above 35%.	**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. Utilisation of temporary workforce was due to a number of factors including increased patient acuity, high rates of patients with violent and aggressive behaviours requiring high levels of care interventions, increased therapeutic observations to manage both mental and physical health care needs, patient and hospital escorts due to deterioration in patients' physical health. High levels of sickness and last-minute short notice absence of substantive staff alongside bank cancellations.	
	Fill rate: Fill rate RN on day shifts below 80% on Gwendolen. Fill rate HCA day shifts above 110% on Ashby, Bosworth, Heather, Willows, Kirby, Langley, Coleman and Gwendolen Fill rate HCA night shifts above 110% on Ashby, Bosworth, Heather, Griffin, Mill Lodge, Kirby, Langley, Coleman and Gwendolen.	**Fill rate:** On Gwendolen there were 12 days with 2 RNs (safe staffing levels were maintained and mitigated by Medicines Administration Technician or an Assistant Practitioner) and 7 days with 2 RNs, supported by deputy ward sisters. Additional HCSWs are also utilised when there are 2 RNs on shift. HCA fill rate above 110% was due to increased patient acuity and dependency requiring increased therapeutic observations to manage mental and physical health needs, patient escorts and transfers to acute hospital, long term patient requiring 2 to 1 continuous observation and additional staffing due to sickness across a number of wards requiring additional backfill.	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
	Nurse Sensitive Indicators: A review of the NSI's has identified an increase in the number of falls incidents from 69 in June to 91 in July 2025. There is no change in the number of medication incidents from 13 in June to July 2025. 2 complaints were received in July 2025.	**Nurse Sensitive Indicators:** **<u>Falls</u>** **AFPICU –** 18 reported falls incidents occurred in Acute, Forensic and PICU services (AFPICU) in July 2025. There were no falls in this period reported as moderate harm. **Rehabilitation** – 3 falls incidents reported and none of moderate harm. **MHSOP** – 73 falls incidents were reported in July 2025. Highest falls on Gwendolen and kirby (22) Langley (13) and Coleman (15). It is noted an increased number of patients placing themselves on the floor due to behaviours, (as well as sliding onto the floor) as opposed to falls and a high number of repeat unwitnessed falls. All incidents reported consistently. 2 falls were reported as moderate harm, both patients transferred to acute services for review. All other falls reported in this period as no moderate harm. Falls huddles are in place and physiotherapy reviews for patients with sustained falls and increased risk of falling, where themes and trends in falls are being discussed to share, learn and support safe care. **<u>Medication errors</u>** 11 no harm medication incidents were reported for AFPICU.	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
FYPC. LDA in-patient	**Staffing:** High Percentage of temporary workforce, key area to note – Beacon at 47.8% and Welford at 24.6%.	**Staffing:** Beacon unit continue with reliance on high temporary workforce usage with a block booking approach to meet safe planned staffing due to increased patient complexity and acuity levels. High rates of violence and aggression incidents requiring high levels of interventions with subsequent increase in patient observation. Welford ED temporary workforce usage due to increase in patient acuity, increased patients requiring support with naso-gastric feeding and patient complexity, staffing levels reviewed and adjusted accordingly.	
	Fill Rate: Fill rate below 80% for RNs on day and night shifts – Agnes Unit and the Grange. Fill rate below 80% for HCA on day shifts at the Gillivers and the Grange and on nights at Agnes. Fill rate above 110% for RN on nights at the Gillivers. Fill rate above 110% for HCA on days and nights on Welford ED and Beacon.	**Fill rate:** Agnes unit operating on 3 pods. Safe staffing is reviewed daily by charge nurse and matron and staffing amended accordingly due to fluctuations in patient acuity. Violence and aggression incidents towards staff reported in July 2025. Grange & 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 in both services, that also provide cross cover. Beacon unit staffing levels were reviewed and adjusted according to patient acuity and bed occupancy. Welford ED has high patient acuity and a number of patients requiring additional staff to provide increased therapeutic observations, supervision at mealtimes and Naso-gastric feeding.	
	Nurse Sensitive Indicators: A review of the NSIs has identified an increase in the number of falls from 4 in June to 6 in July 2025.	**Nurse Sensitive Indicators:** Analysis has shown that 4 of the 6 patient falls on the Agnes unit mainly due to a patient placing themselves on the floor. There was 1 fall on Welford ED and on the Beacon unit. All falls were reported as low or no harm.	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
	The number of medication related incidents decreased from 6 in June to 5 in July 2025.	**Medication errors** 6 medication incidents were reported there was no harm reported to any patients.	
CHS Community	No change to Key areas to note - City West, City East, and East South, due to high patient acuity. All hubs currently welcoming new staff and have new staff in the pipeline, resulting in backfill whilst staff are inducted. Overall community nursing Service OPEL has been level 2, 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. Induction of new staff continues across all hubs. 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 – Melton and Rutland CMHT, Northwest Leicestershire CMHT, Assertive Outreach and Perinatal Mental Health service also experiencing significant senior nurse sickness and vacancies. Recruitment challenges within Crisis Resolution Home Team (CRHT) for registered clinicians working to OPEL level 3 and older adults Mental Health Liaison Service (MHLS)	**CMHT** **Planned Care** The CMHT leadership team review staffing daily and request additional staff via bank and agency, mitigation includes staff movement across the service, potential risks are closely monitored within the Directorate Quality and Safety meetings or escalated via the daily Community Assurance Huddle. Quality Improvement plan continues via the transformation programme. Case load reviews continue, introduction of alternative and skill mix of roles to support service need. **Urgent Care** CRHT remain challenged over the summer with reduced availability of competent temporary workforce. OPEL level 3 enacted and team leads stepping into planned staffing to support safe staffing. Two clinical fellows now recruited into MHLS 'older adults' team and once onboarded will support safe staffing. Recruitment challenges continue into Mental Health Practitioner posts however successful recruitment to 3 posts made in MHLS. **MHSOP Community** No change this month, temporary workforce being used across MHSOP community services to manage long term	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
		sickness, absence, and vacancies across community teams. Vacancies are being filled and awaiting recruitment checks to be completed.	
FYPC. LDA Community	No change to key areas to note. Improved position continues 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 now recruited to and awaiting confirmation of start date for October/November 2025. Recent challenge due to recruitment to Children's Wellbeing Practitioner roles (nationally driven), however the British Association for Behavioural and Cognitive Psychotherapies (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. Work continues at pace to ensure that the route of referral into the service is widened to include self-referral and direct referrals from other stakeholders. These referrals will go via Triage and Navigation, the impact of this will be assessed. 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 July 2025 staffing challenges continue to improve with a slight decrease in agency usage and significant reduction in temporary workforce usage overall.
- CNSST II Pilot Report to be presented to CHS DMT in August and EMB in September 2025. Revised implementation to start in 2 Community Nursing Hubs in September 2025.
- Annual Establishment Review and data collection to commence 1-30 October 2025.

Proposal

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

Decision required – Please indicate:

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

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 30 September 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	
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	

P

Leicestershire Partnership NHS Trust

Public Trust Board - September 2025

Patient Safety & Learning Assurance Report for July/August 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 July and August 2025, there were 3269 patient safety incidents reported that were classified as "incidents attributable to LPT" and "Incidents affecting patients". The top five reported incidents account for 61.91% of all patient incidents reported during this period and are explored in order and in more detail below. This equates to an average of 1634.5 incidents per month during July and August 2025.

Top 5 reported patient safety incidents July and August 2025

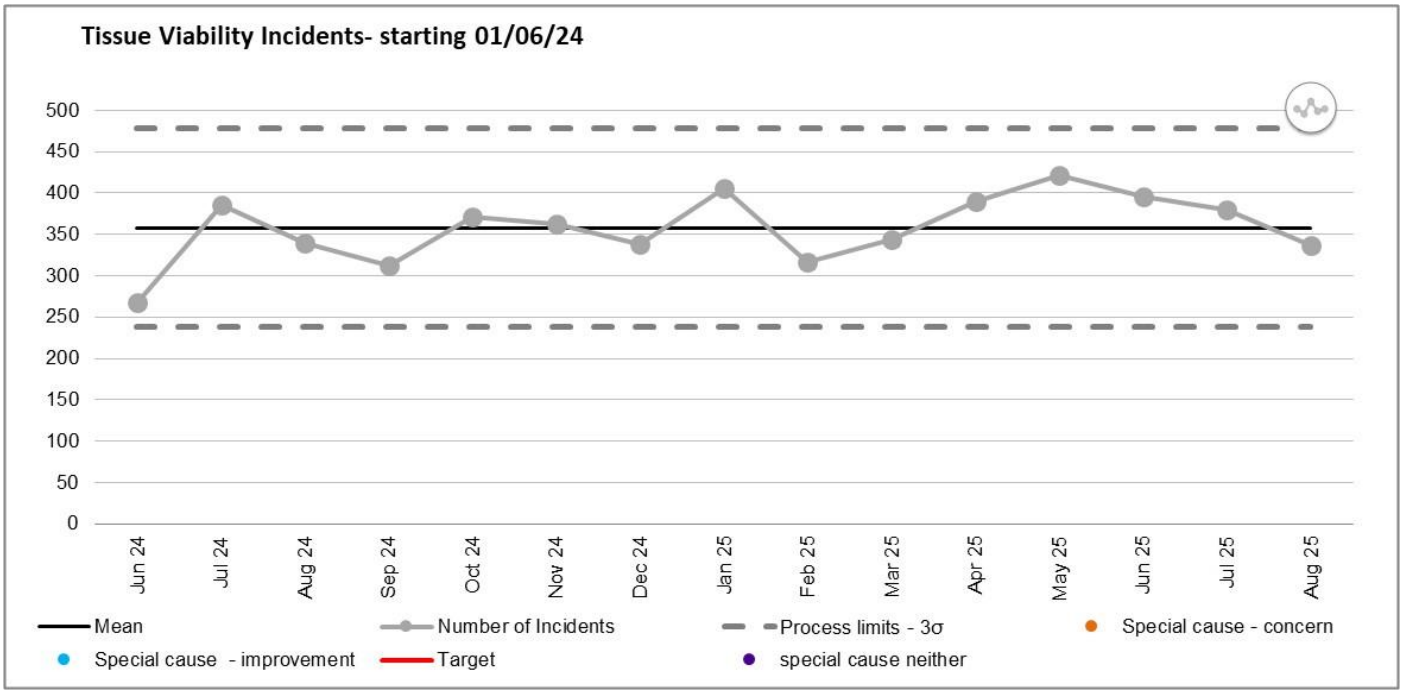
Category	Number of incidents	Directorate with highest % of the total reported
1. Tissue Viability	717	CHS (98.88%)
2. Self-Harm	470	DMH (75.96%)
3. Violence and Assault	305	DMH (89.51%)
4. Care/Treatment Under Restraint	270	DMH (52.96%)
5. Falls	262	DMH (62.60%)

Degree of harm recorded for all patient safety incidents for July and August 2025

Reported degree of harm	Number	% of total incidents reported
No Harm	1733	53.01%
Minor/Low Harm	1444	44.17%
Moderate Harm	56	1.71%
Severe Harm	7	0.21%
Death	29	0.89%

NB: these incidents were reported in July and August 2025 and will be being reviewed through local and corporate governance structures and the degree of harm may change. Since moving to the national NHSE Learning from Patient Safety Events (LFPSE), there is a requirement to report incidents by 'harm' to the patient even if it does not involve care delivered in your organisation's care. This accounts for the increase in number of deaths reported compared to the same reporting period in 2024. Work has been undertaken with teams to report expected deaths clearly. All expected deaths are reviewed by a senior manager to be classified or reclassified as required.

1. Tissue Viability this includes Burns/Scalds/Moisture Lesions/Medical Device Injury/Podiatry Pressure Ulcer



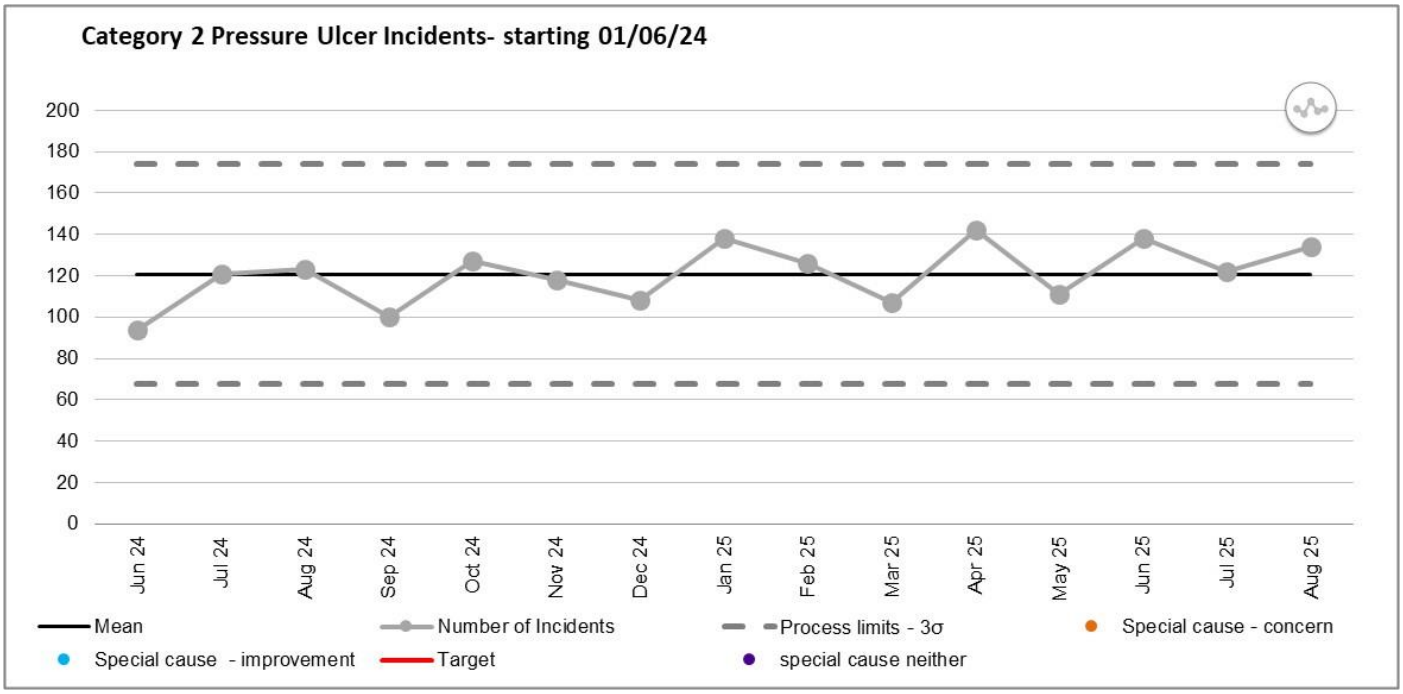
21.93% of all patient safety incidents reported relate to 'Tissue Viability' during July and August 2025; this equates to 717 incidents. This category includes pressure ulcers on admission, developed or deteriorated in our care, skin tears, scalds, wounds, and moisture associated skin damage. As Pressure ulcers (category 2,3,4 and unstageable) represent 70.99% of these, we will focus on this aspect of patient harm.

In July and August 2025, there were 509 reported incidents whereby 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 8.29% decrease in pressure ulcers reported in comparison to the previous 2 months reporting.

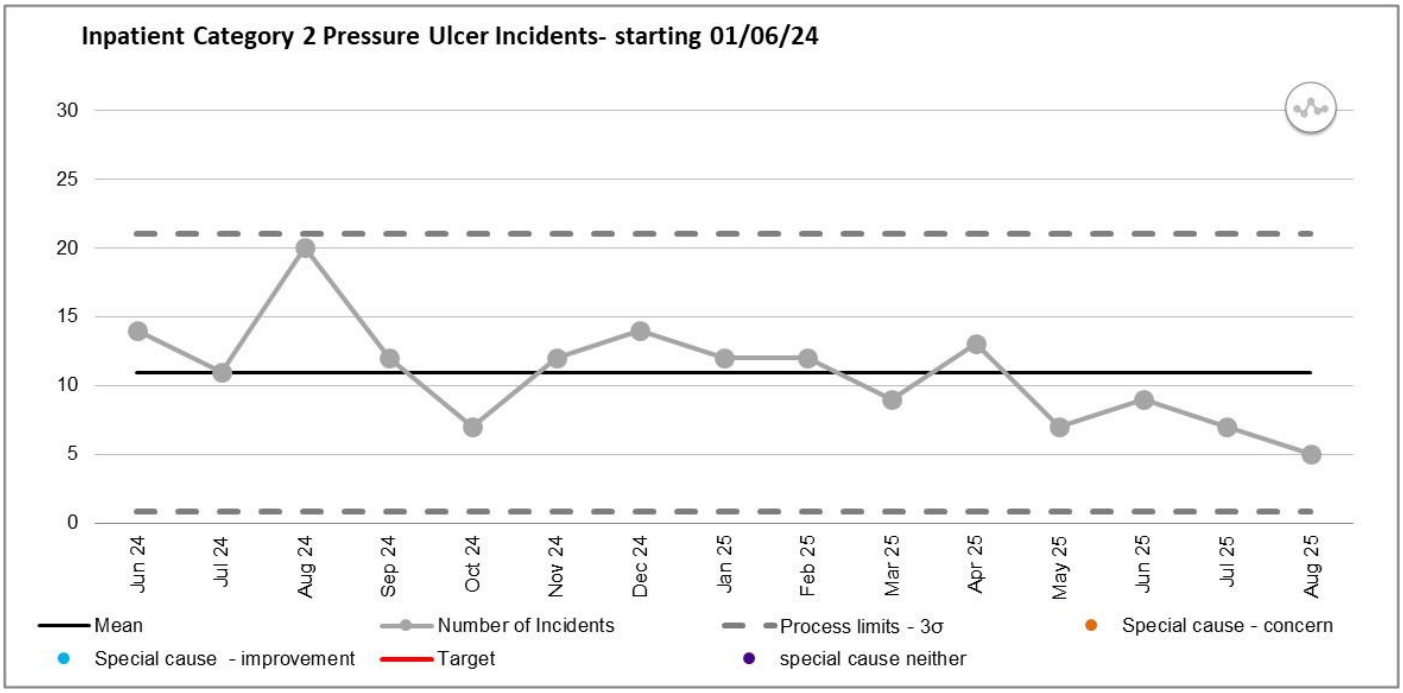
During this period, 491 (96.46%) were reported in CHS community nursing services and 14 (2.75%) were reported in community hospitals (inpatients).

Of the remaining 4 incidents (0.79%), 3 were reported in DMH, which had two Category 2 Pressure Ulcers; one on Mill Lodge and one on Langley (Mixed) Ward, and one Unstageable Pressure Ulcer on Gwendolen Ward. FYPC-LDA had one Category 2 Pressure Ulcer reported by the Diana Service.

Category 2 pressure ulcers developed or deteriorated in LPT care – Trust wide.



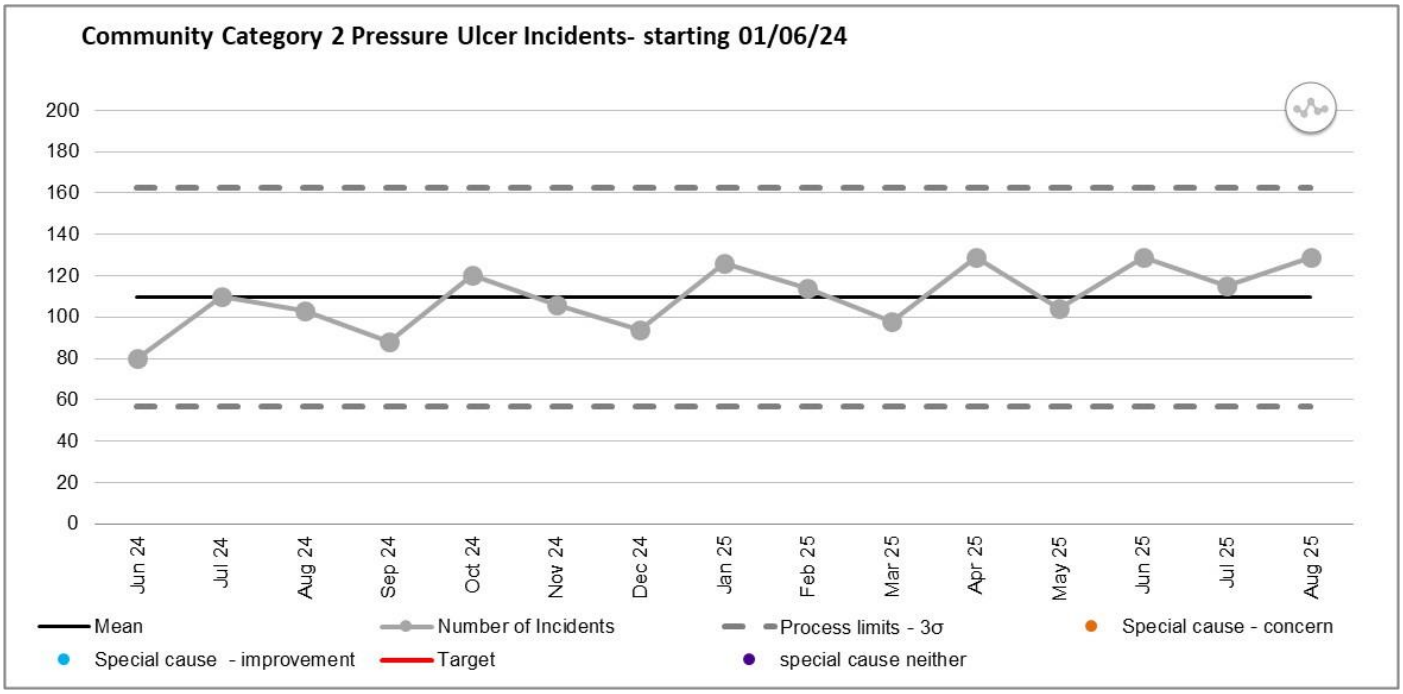
In-patient Category 2 pressure ulcers developed in LPT care.



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

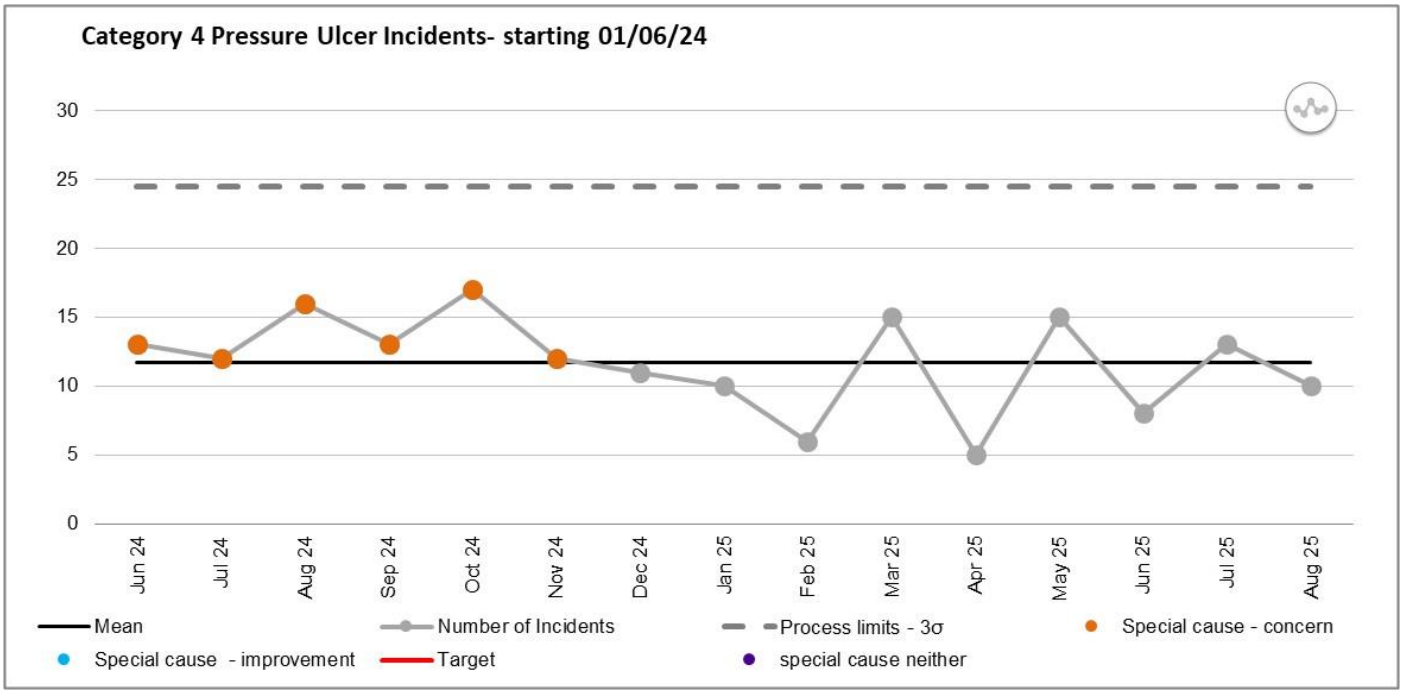
Community Hospital Category 2 pressure ulcers developed in our care.

CHS Community Hospital pressure ulcer improvement work continues and there is a pressure ulcer validation meeting held weekly led by the senior nursing team. There is a downward trend of four data points which is too early to be statistically significant, however, is encouraging.



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.



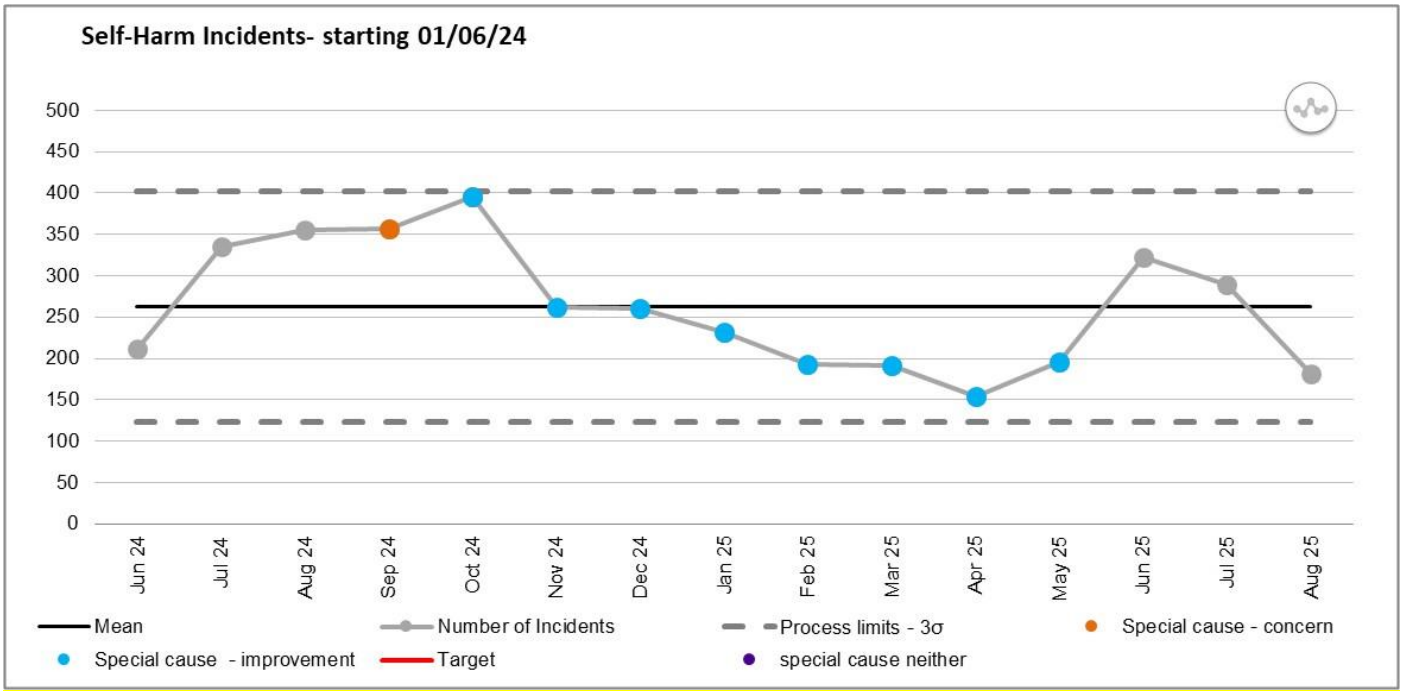
To note there have been no patients who have developed a category 4 pressure ulcer whilst in LPT in-patient care for 16 months since March 2024.

High level themes are noted to relate to an increase in fragile and frailer patients, patients nearing the end of life, the impact of maximum packages of care (four times per day) including access to carers beyond those packages of care in their own home and meeting patients care needs when they prefer to remain seated in a chair for extended periods of time. The full analysis of these reviews will be reviewed at both the pressure ulcer group and the end-of-life steering group.

There is a community nursing pressure ulcer workshop planned for September to review the impact of the current and previous workstreams, reporting processes and to identify future workplans, taking learning from a recent National Conference: *Standardising measures, definitions, and reporting for nursing specific quality indicators.*

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 by the Trust Board. Joint visits are planned in Q2 commencing around building relationships between the nursing and continence teams on the wards, reviewing PU and continence products, identifying the equipment available on the wards, and also scoping teams' knowledge to inform learning packages.

2. Self-Harm – inpatient and community



There were 470 patient self-harm incidents reported during July and August 2025, this equates to 14.38% of all reported patient safety incidents during this period. During the previous reporting period, there were 517 self-harm incidents reported across both inpatient and community settings, this shows a decrease of 9.09% during the current reporting period. The number of incidents has

been analysed and over the reporting period there are 3 areas with a significant number of self-harm incidents reported relative to the total number (470) of such incidents reported:

- Heather Ward – 62 incidents (13.19%) this is an increase from 43 incidents in the previous reporting period.
- Sycamore Ward – 56 incidents (11.91%) this is an increase from 1 incident reported in the previous reporting period.
- Ashby Ward – 51 incidents (10.85%) this is an increase from 12 incidents reported in the previous reporting period.
- For this reporting period, both Heather and Ashby ward experienced higher acuity based on the patient cohort being both significantly unwell along with self-harm risks. This is also reported in the safe staffing report, noting a high temporary workforce and have an increased fill rate for HCA on long days and long night shifts due to high acuity.

Sycamore ward saw an increase due to a cluster of patients transferred where the transfer had unsettled them and affected their coping skills.

Harm Levels

Within the 3 areas of Heather Ward, Sycamore Ward, and Ashby Ward, there has been 1 incident reported as moderate harm. Of the 62 incidents reported by Heather Ward, 39 (62.90%) were recorded as minor/low harm with the remaining 23 (37.10%) being reported as no harm. Of the 56 incidents reported by Sycamore Ward, 34 (60.71%) have been recorded as minor/low harm, with the remaining 22 (39.29%) being recorded as no harm. Of the 51 incidents reported by Ashby Ward, 1 (1.96%) has been reported as moderate harm, 15 (29.41%) as being minor/low harm, with the remaining 35 (68.63%) being recorded as no harm.

Overall, of the 470 total reported self-harm incidents, one (0.21%) had been reported as catastrophic/death however on review is now re-categorised as suspected suicide, six (1.28%) have been reported as severe harm, ten (2.12%) have been reported as moderate harm and 251 (53.40%) have been reported as minor/low harm, with the remaining 202 (42.98%) incident being reported as no harm.

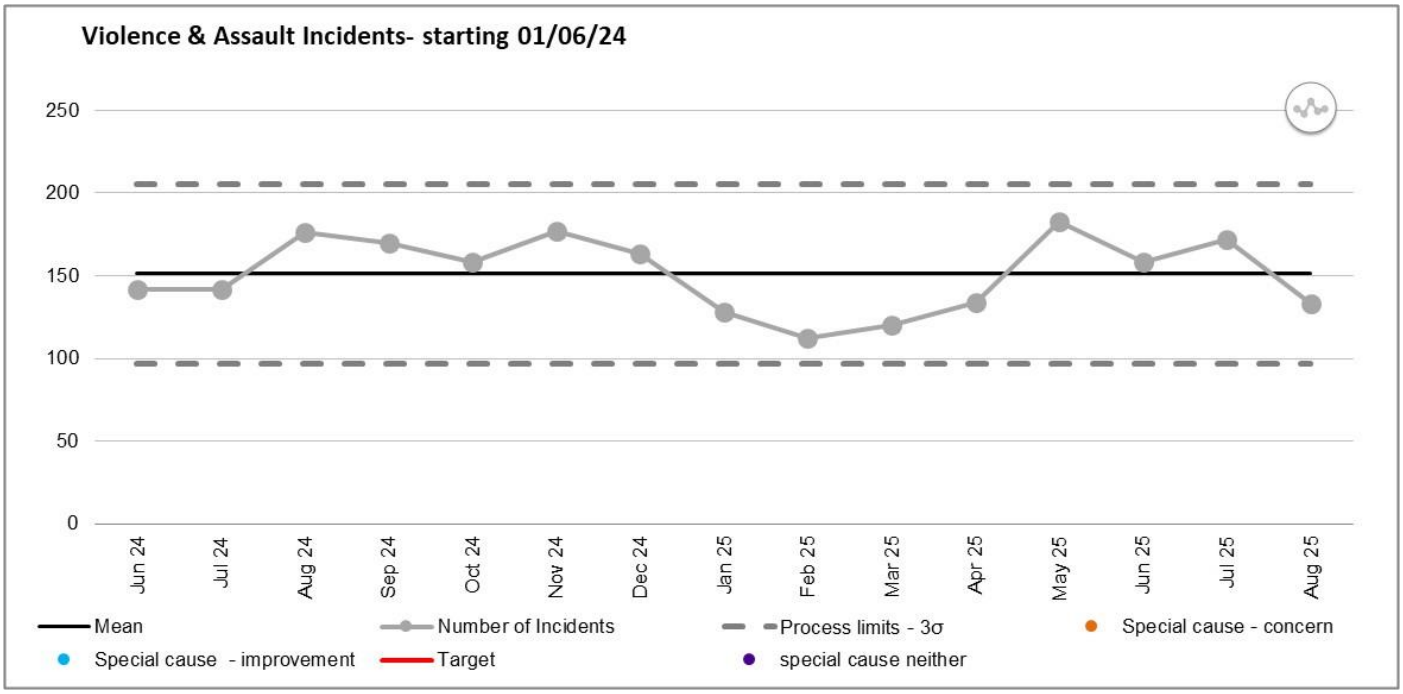
The data shows a decrease in the number of incidents reported, however, there is an increase in incidents reported as resulting in moderate or severe harm on the last reporting period. All six reported as severe harm, were patients in the community. Of the ten moderate incidents, two patients were inpatients and the remaining eight had not all had their managers review at the time of this report.

The self-harm and suicide prevention group have previously undertaken a deep dive to review community suicides which has led to trust wide actions (such as medicines amnesty). However, the

Interim CNO and Medical Director have instructed the group to do a further deep dive to report to safety forum to maintain oversight and learning from self-harm and suicide incidents.

The self-harm and suicide prevention group organised a conference in July 2025 with NCISH (National Confidential Inquiry for suicide and safety in mental health.). NCISH agreed to review the suicide data for LPT with a view to advising on the need for a thematic review. The outcome of the thematic review will be reported to a future trust board.

3. Violence/Assault



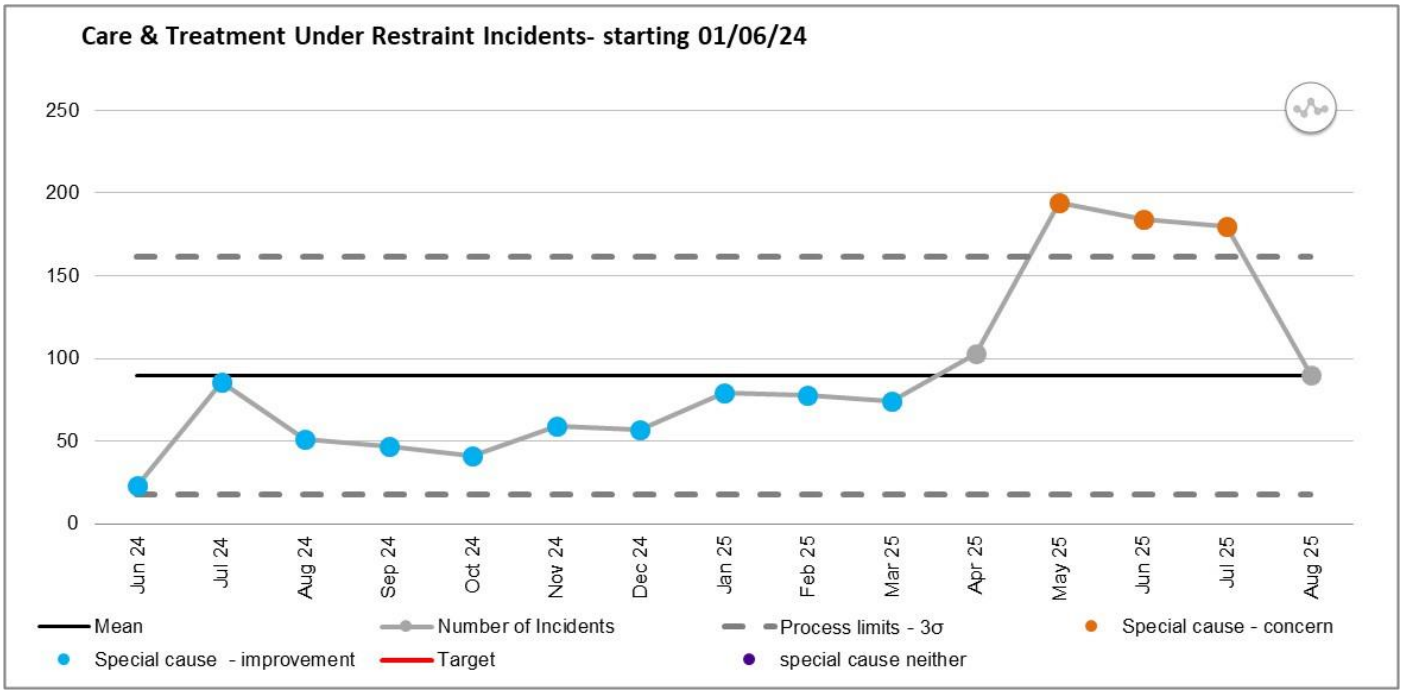
There were 305 incidents of violence and assault reported during July and August 2025. These incidents are reported under the category's patient violence towards other patients, people not employed by the trust and incidents of disruptive behaviour towards others. This represents 9.33% of all reported patient safety incidents. During the previous reporting period, there were 339 violence and assault incidents reported, this shows a decrease of 10.03% during the current reporting period.

The numbers of violence and assault incidents has been analysed and over the reporting period, there are two areas with the highest number of incidents reported relative to the total number (305) of violence and assault incidents, those being Aston Ward with 34 (11.15%) incidents, and Heather Ward with 31 (10.16%) incidents. Of these 305 incidents, 148 (48.5%) were reported as physical disruptive behaviour.

Of the 305 incidents reported as Violence and Assault, 3 (0.98%) were reported as moderate harm, 101 (33.11%) were reported as minor/low harm, and 201 (65.90%) were recorded as no harm.

There were 0 incidents of violence and assault requiring review at IRLM during this reporting period.

4. Use of Restraint for Care and Treatment



There were 270 incidents of Use of Restraint to deliver Care during July and August 2025, representing 8.26% of all reported patient safety incidents during this period. During the previous reporting period, there were 378 incidents reported where restraint was utilised, therefore this shows a decrease of 28.57% 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 to deliver care shows that over the reporting period, there have been 2 areas with the highest number of incidents reported relative to the total number (270) incidents; those being CAMHS Beacon with 97 (35.93%) incidents, and Mill Lodge with 91 (33.70%) incidents.

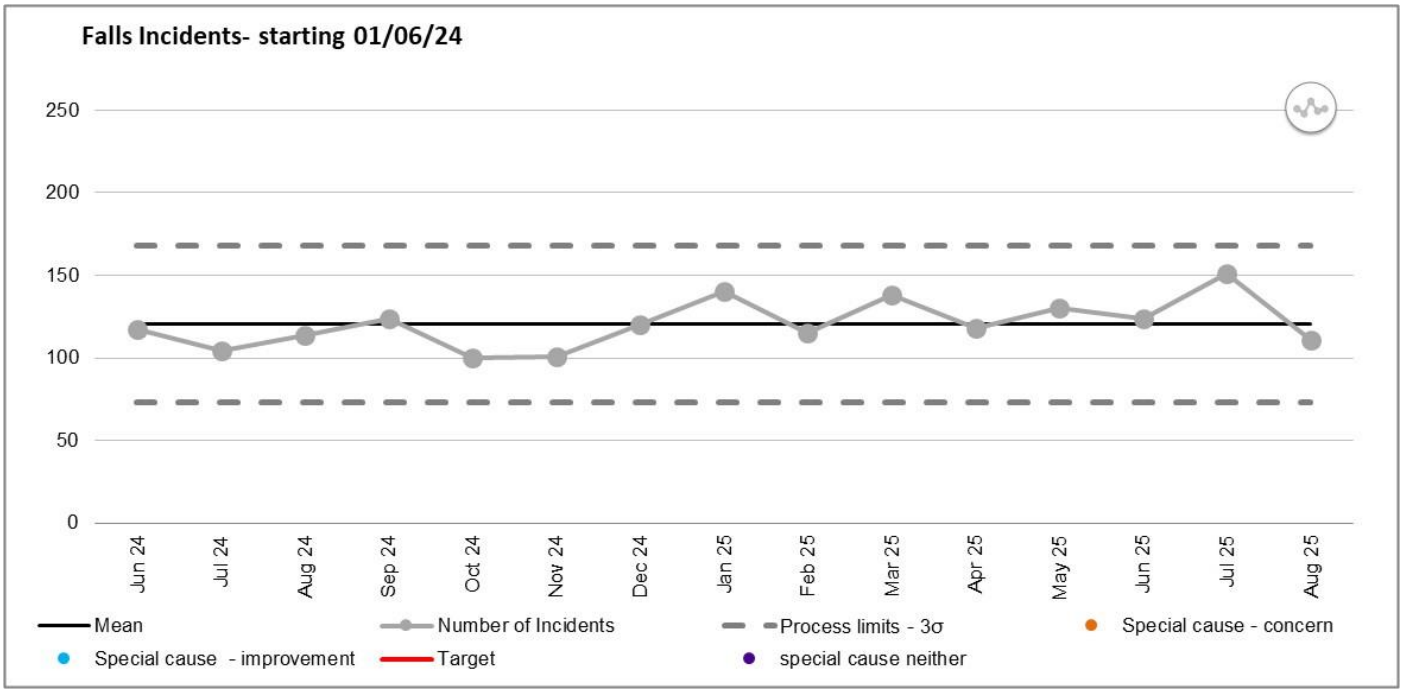
CAMHS Beacon

During August there has been an overall reduction in incidents.

Mill Lodge

The restraint in Mill lodge is relating to the safe care and management using safeholds during personal care interventions to maintain the safety of the patients and staff delivering care – this is care planned and reviewed regularly with senior staff and the wider multidisciplinary team. Overall, of the 270 incidents reported where restraint was utilised, 91 (33.70%) were reported as minor/low harm, and 179 (66.30%) were reported as no harm.

5. Patient Falls, Slips and Trips

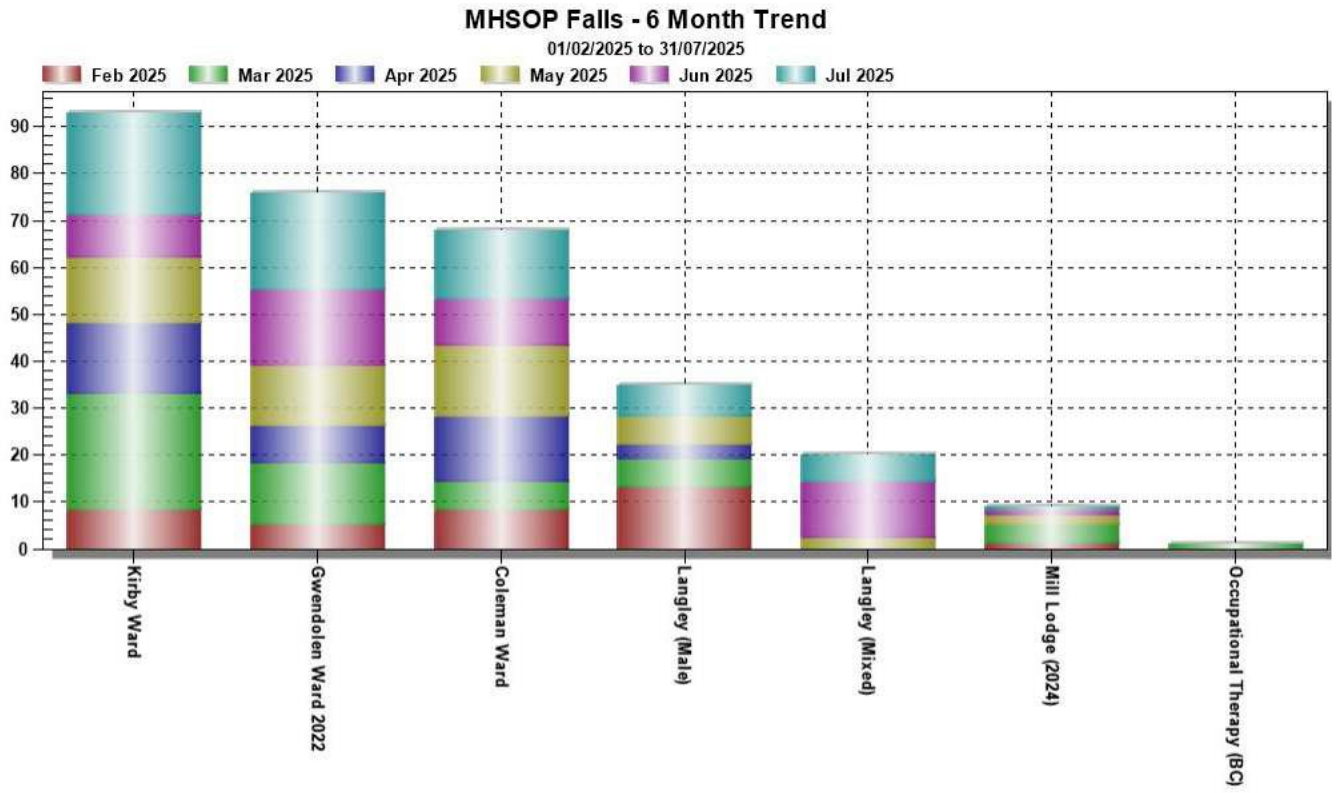


There were 262 falls during July and August 2025 representing 8.01% of all reported patient safety incidents. During the previous reporting period there were 254 Falls incidents reported, this shows an increase of 3.15% during the current reporting period.

DMH

Numbers of falls have been analysed and over the reporting period, out of the 262 reported falls incidents, Kirby Ward at the Bennion Centre reported 34 (12.98%) incidents, Gwendolen Ward at the Evington Centre reported 33 (12.60%) incidents, and Coleman Ward at the Evington Centre reported 29 (11.07%) incidents.

Of the 262 reported Falls incidents, 140 (53.44%) were recorded as ‘no harm’, 112 (42.75%) were recorded as ‘minor/low harm’, 9 (3.44%) were recorded as ‘moderate harm’ and 1 (0.38%) was recorded as ‘severe harm’ and relate to a patient fracture.



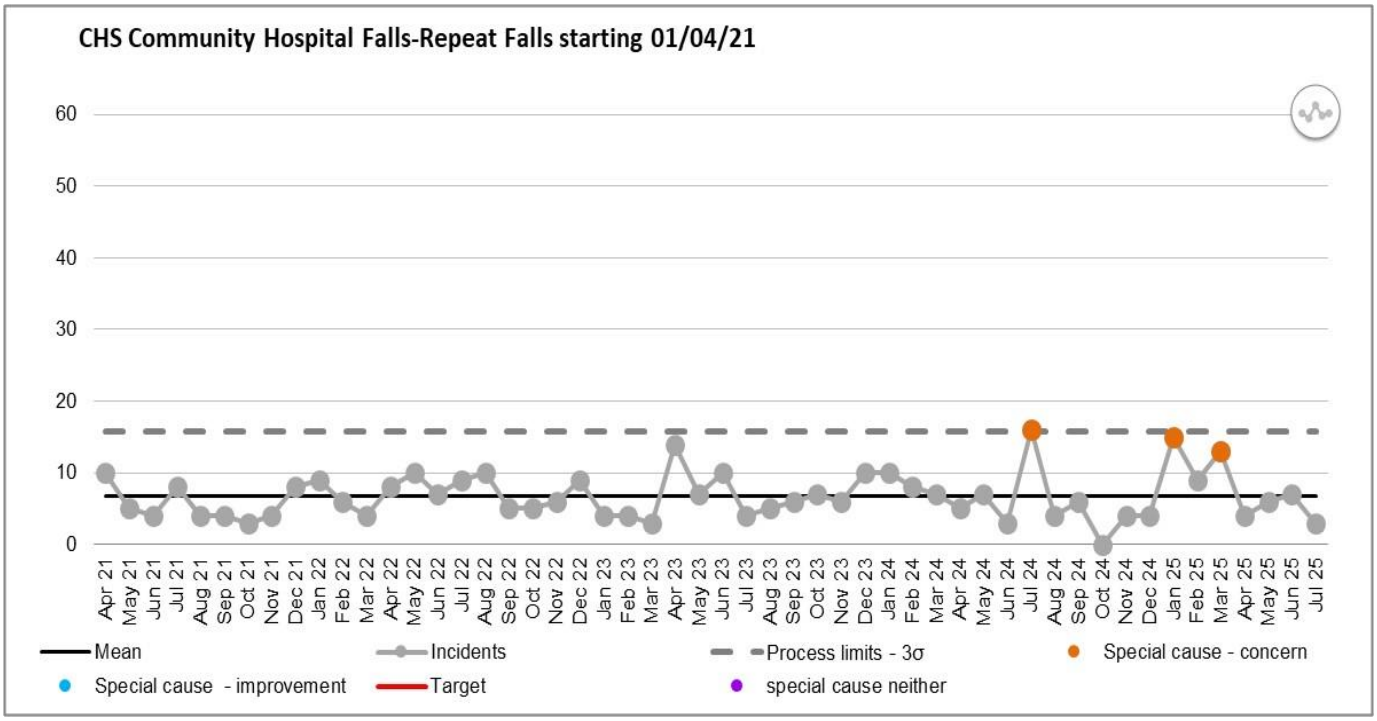
Department							
Feb 2025	8	5	8	13	0	1	0
Mar 2025	25	13	6	6	0	4	1
Apr 2025	15	8	14	3	0	0	0
May 2025	14	13	15	6	2	2	0
Jun 2025	9	16	10	0	12	1	0
Jul 2025	22	21	15	7	6	1	0

Data from July showed a trend across MHSOP of increased numbers of falls, particularly Kirby and Gwendolen wards and the DMH Falls Group are reviewing themes. Of the 72 falls incidents reported, there were 16 first falls, 49 repeat falls and 7 where patients placed themselves on the floor. It was also recognised that Heather ward had an increase in repeat falls in July.

DMH continue to improve in the audit of falls documentation, but the group are doing a deeper dive into the quality of the documentation and engaging with staff on the effectiveness of the assessment tools and falls education.

Community Health Services (CHS)

A rise in falls on East ward was noted in July. There were 8 falls incidents involving 7 patients, with no immediate themes and CHS team are reviewing. Compliance with post falls huddles is an improving picture and is the opportunity for staff to update the patients care plan to reduce further risk.



FYPC/LDA provide an overview report quarterly to the Falls Steering Group due to low number of falls in the directorate but still attend the group monthly to contribute and share any issues.

Behavioural Falls

Within the organisation, incidents are regularly described as a “behavioural fall,” generally describing a fall where someone had put themselves on the floor but sometimes related to other incidents. Following discussion in the Falls Steering Group, it was recognised there is no formal definition of a behavioural fall so a small group was commissioned to undertake a literature search to develop commonality in the use of the term, but also to understand how it can be better managed, to reduce any risk to patients. The first draft of the paper was shared at the July Falls Steering Group which promoted significant discussion across all the directorate teams, and it was agreed to finalise the paper for sharing and then to develop an action plan from this.

Review of External Prevention of Future Deaths Reports

The Falls Steering Group review the External Prevention of Future Deaths Reports available at each meeting. To date no initial learning has been identified beyond the areas we are already focussing on.

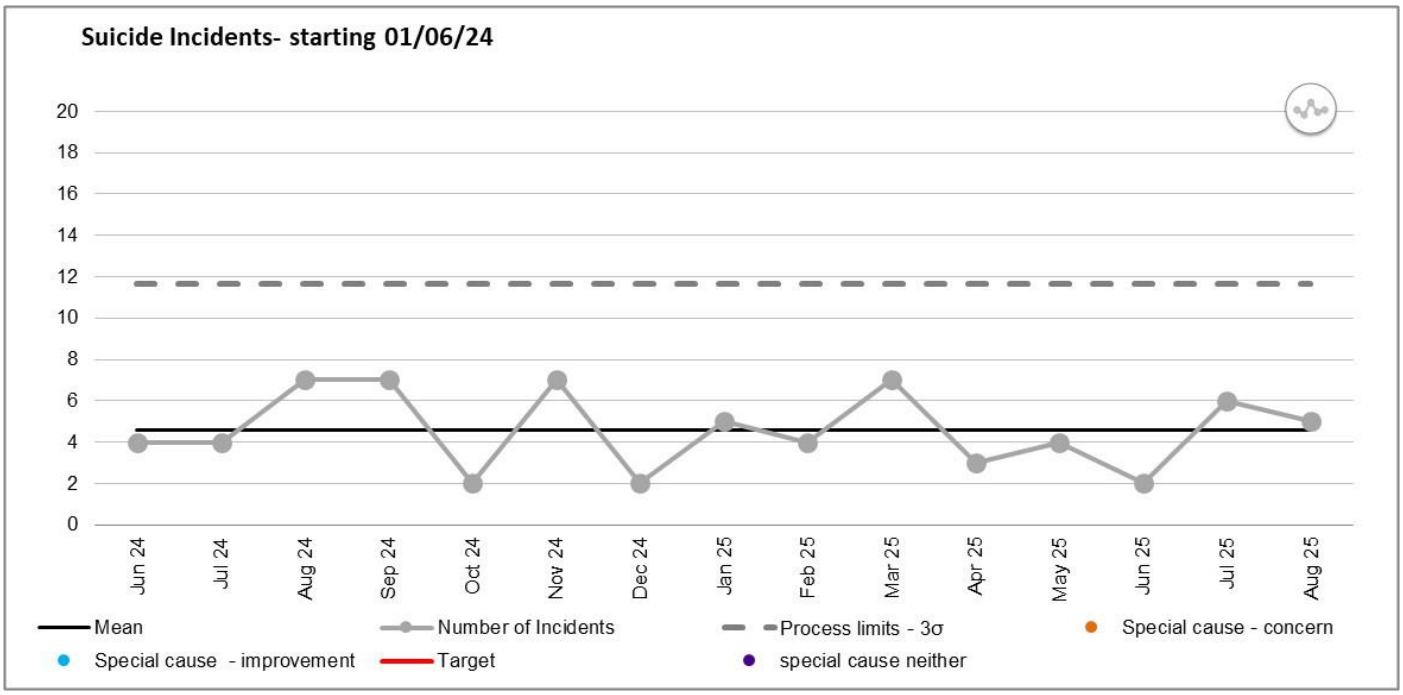
Review of National guidance changes related to falls prevention.

The directorates are taking the recommendations from the two national documents which have been

published recently; Royal College of Physicians (RCP) *National Audit for Inpatient Falls 2024*, and *creating improvement plans* which were shared at the Falls Steering Group in September.

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 (NCISH)



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

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 assurance.

LeDeR

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

- There were 6 notifications made by LPT staff to LeDeR related to patients with a known learning disability and who have died for July (1) 2025 and Aug (5) 2025.
- For city and countywide reviews, there were 5 patient death notifications in July 2025 and 4 patient death notifications in Aug 2025.
- Of those notifications, 6 are focused and 9 are initial reviews.

Outstanding patient safety reviews: As of end of August 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	14	14	7	(17 are DMH) 22
Overdue PSII	0	0	0	8
Overdue SEIPs	1	2	3	7
Overdue AAR	0	0	0	0
Overdue Other Learning Response	0	0	0	0
Overdue STEIS	0	1	0	(external investigator) 1
Grand Total Overdue	**1**	**3**	**3**	**16**
Percentage Overdue	7%	21%	43%	73%

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, and this is in final drafting stages. The other report is complete and was undertaken by an external investigator and there has been a delay in agreeing the final report. Several of the overdue reports are in the final stages of sign off and being managed by the directorates and patient safety team.

The Interim Chief Nurse chairs a weekly PSII tracker meeting with the patient safety team and directorates in order to manage the overdue reports and those in the full pipeline.

Duty of Candour

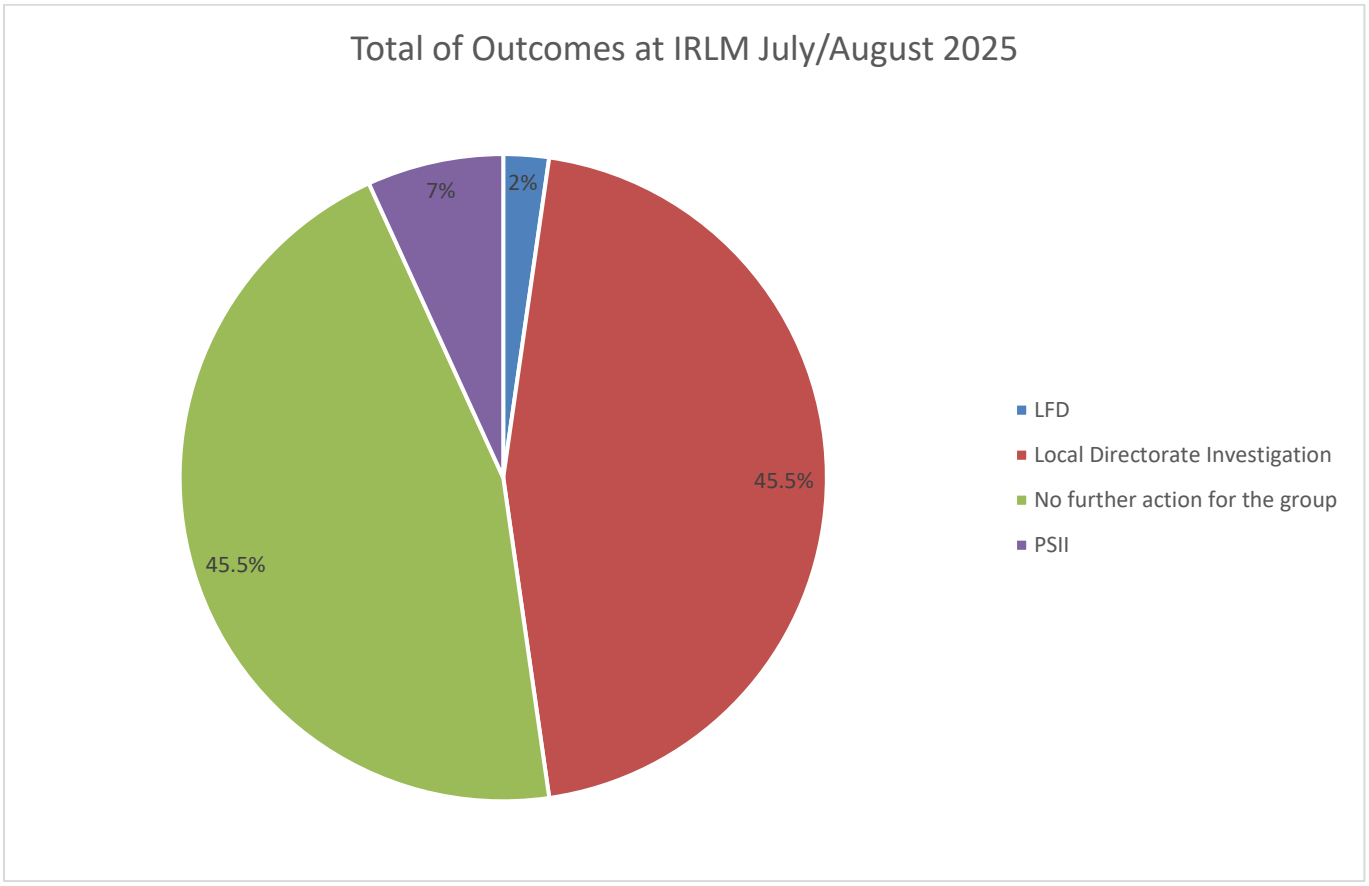
There was no statutory duty of candour breaches during this period. We continue to follow 'being open' which is inbuilt in PSIRF principles of compassionate and positive engagement with patients/families.

Never Events

No Never Events were reported during this period. We are awaiting NHSE outcome of the review of the 'Never Event' Framework.

Incident Review & Learning Meeting (IRLM)

44 cases were reviewed at IRLM during July and August 2025. Three (7%) Patient Safety Incident Investigations (PSIIs) were declared during this reporting period. Twenty (45.5%) were identified as having already identified any learning and actions put in place. There were 20 (45.5%) Local Directorate reviews requested to explore appropriate actions, one (2 %) initial service managers reviews (ISMR's) were shared with Learning from Deaths (LfD) for the themes to be aligned with their own.



Queries Raised by Commissioners / Coroner / CQC 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.

The CQC are reviewing patient safety incidents reported by LPT and requesting additional information for some incidents as part of their oversight process.

Patient Safety Strategy

Training: SEIPS approach to investigation training.

During July and August 2025 14 staff had been trained bringing the total so far 138 members of staff. There are further dates available throughout 2025/26.

This 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	73	71
CHS	33	27
FYPC/LDA	31	22
Enabling	1	0
TOTAL	**138**	**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 below figures 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 the 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
Jul-2025	347	8	355
Aug-2025	207	6	213
Total	7133	162	7295

Decision Required

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

Governance Table

For Board and Board Committees: Paper sponsored by:	Trust Board James Mullins, Interim Executive Director of Nursing, AHP's & Quality
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	Corporate Patient Safety Team 23 September 2025 N/A N/A Bimonthly – November 2025
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:	
Positive confirmation that the content does not risk the safety of patients or the public	
Equality considerations:	

Q

Leicestershire Partnership NHS Trust

Annual Complaints and Concerns Report for 2024-25

Trust Board – September 2025

Introduction

Leicestershire Partnership NHS Trust welcomes all feedback from patients, families, and carers about their experience of our services and view this information as invaluable in enabling us to learn and improve our patients experience, as well as determining whether changes could be made to the services we provide.

The report includes feedback received by the Trust between 1 April 2024 and 31 March 2025, including an overview of complaints, concerns, and compliments. The report outlines the Trust's overall regulatory performance, as well as the learning and changes made to process throughout the year. This year's annual report also includes feedback received through the Trust's Friends and Family Test (FFT) to provide a complete picture of all feedback received in 2024/25.

Executive Summary

In accordance with Regulation 18 of the NHS Complaints Regulations (2009), this report sets out a detailed analysis of the number and nature of complaints received by Leicestershire Partnership NHS Trust in 2024/25. The report also records other support provided by the Trust's PALS & Complaints Team during the year, including Friends and Family Test Feedback (FFT) and compliments.

In summary:

- In 2024-25, the Trust received 22,027 individual pieces of feedback in relation to complaints, concerns, compliments, and FFT. This represents a 16% decrease on the previous year.
- The number of complaints received increased by 9% from 239 to 262 in this reporting year.
- In 2024-25, the Complaints and PALS Team compliance to acknowledge complaints within three working days remained at 96%, this exceeds the 90% target set by the Trust.
- In 2024/25, the Trust had five complaints referred to the Parliamentary and Health Service Ombudsman (PHSO), compared with the two cases referred the previous year. In respect of two of the cases investigated, no fault was found, with the remaining three cases still awaiting a final outcome from the PHSO.
- 262 complaints were responded to via the formal complaints process in 2024/25 and 53.8% of these were responded to within the agreed timescale, this is below our expected performance. In response, a comprehensive review has been undertaken to understand the multi-factorial reasons for not achieving our performance, with a complaint improvement programme in place to support us achieving our Trust agreed timescales of 90% by December 2025. To note the current position on 1 September 2025 is 73% overall Trust wide.
- The PALS Team received a total of 725 contacts including concerns, comments, signposting, and enquiries.

- Concerns and comments remained consistent with the last three years with a total of 509 received by the Trust's Patient Advice and Liaison (PALS) Service.
- Fourteen PALS concerns were escalated to a formal complaint.
- Fourteen complaints were reopened during the year, this is a significant improved position in comparison to the previous years. The reduced number of reopened complaints demonstrates improved complainant satisfaction with investigation and final responses provided by the Trust.
- The Trust continues to deal with a higher proportion of complaints via the informal process and PALS concerns, which means that these issues are resolved as quickly as possible and by the specialty managers responsible for the service involved in the interest of the patient.
- Twelve percent of all those who were eligible to receive a FFT survey responded, which is an increase in response rates of 3% from 2023-24.
- During 2024-25, 18,778 ratings received, and 14,789 individual comments, both shows an 18% reduction on the previous year, and this is due to the fall in number of eligible patients who receive a FFT survey when compared to 2023-24.
- The overall score of satisfaction, either very good or good for services increased from 87% to 90% during the year, with 5% responses reporting a negative experience which is a decrease of 3% compared to 2023-24. The number of responses is broken down below per month and by rating.

Complaints Management

The corporate Complaints and Patient Advice and Liaison Service (PALS) Team oversee the management of concerns and complaints across the Trust. Complaint investigation and responses are managed within directorates and performance is overseen by the directorate management and governance teams.

A Level 3 Complaints Review Group meets bi-monthly and is chaired by the Deputy Director of Nursing & Quality and is attended by directorate governance leads. This feeds into Quality Forum and to Quality and Safety Committee.

2024-25 Complaints Performance

During the period from 1 April 2024 to 31 March 2025, the Trust registered 262 formal complaints which is a 9% increase from 239 registered in the previous year.

Complaint numbers have risen, but this trend aligns with other Trusts across Leicester, Leicestershire, and Rutland (LLR), including Northamptonshire Healthcare Foundation Trust (NHFT).

The Complaints and PALS Team continues to collaborate closely with departments such as Patient Safety, Safeguarding, Legal, and Human Resources to ensure complaints are triaged effectively. This joint approach supports both patients and staff, ensuring investigations are handled with care and consistency.

262 The number of complaints formally registered.

The percentage of complaints responded to in the agreed timeframe. 54%

The percentage of complaints registered against the number of patients that attended and were seen by the Trust. 0.014%

14 The number of reopened complaints received.

96% The Percentage of complaints acknowledged within 3 working days.

The percentage of complaints we upheld or partly upheld. 64%

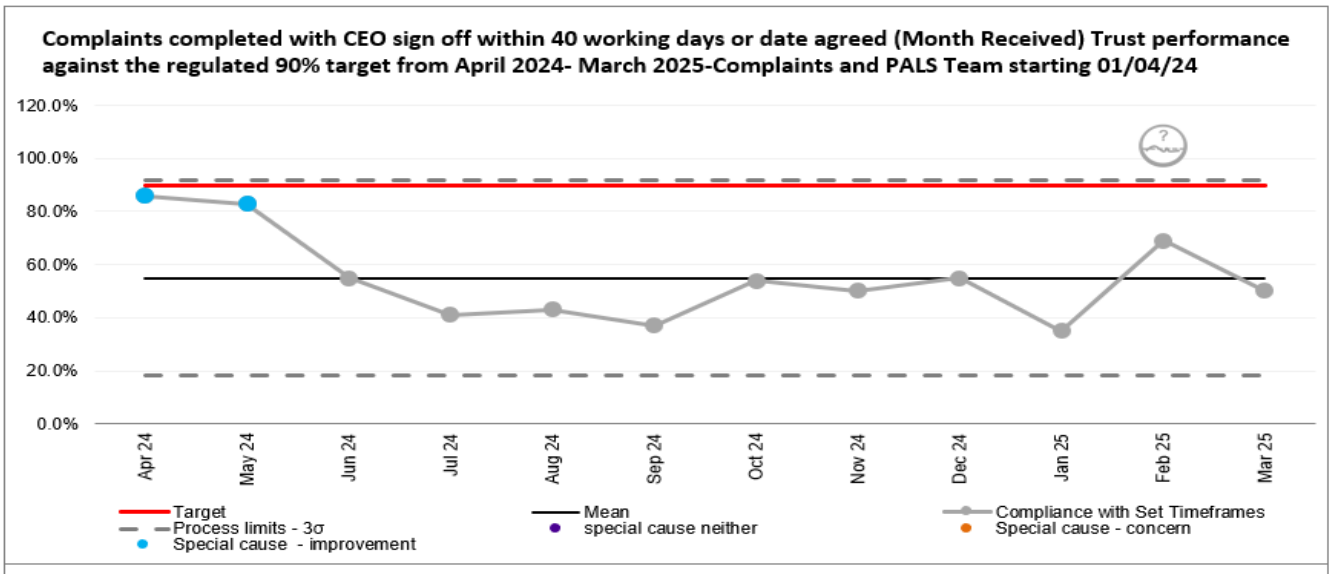
The number of complaints we resolved in 40 working days. 127

5 The number of complaints that were formally investigated by the Parliamentary & Health Service Ombudsman.

The Trust is committed to a patient-focused approach, encouraging open communication, and collaboration across all directorates through regular meetings. Staff investigating complaints receive formal and tailored training, helping them feel confident and prepared. Weekly virtual drop-in sessions offer additional support, and feedback has been overwhelmingly positive. Staff report feeling empowered to address concerns at the first point of contact, which enhances the overall patient experience and improves the efficiency of the complaints process.

In 2024-25, the Complaints and PALS Team compliance to acknowledge complaints within three working days remained at 96%, this exceeds the 90% target set by the Trust.

The Trust has an agreed a forty working day response period for all complaints, both new and reopened, with shorter or longer timeframes agreed with the complainant, where appropriate.



During this time there have been several improvements made in relation to the complaints management process, aimed at improving the quality of complaint investigations.

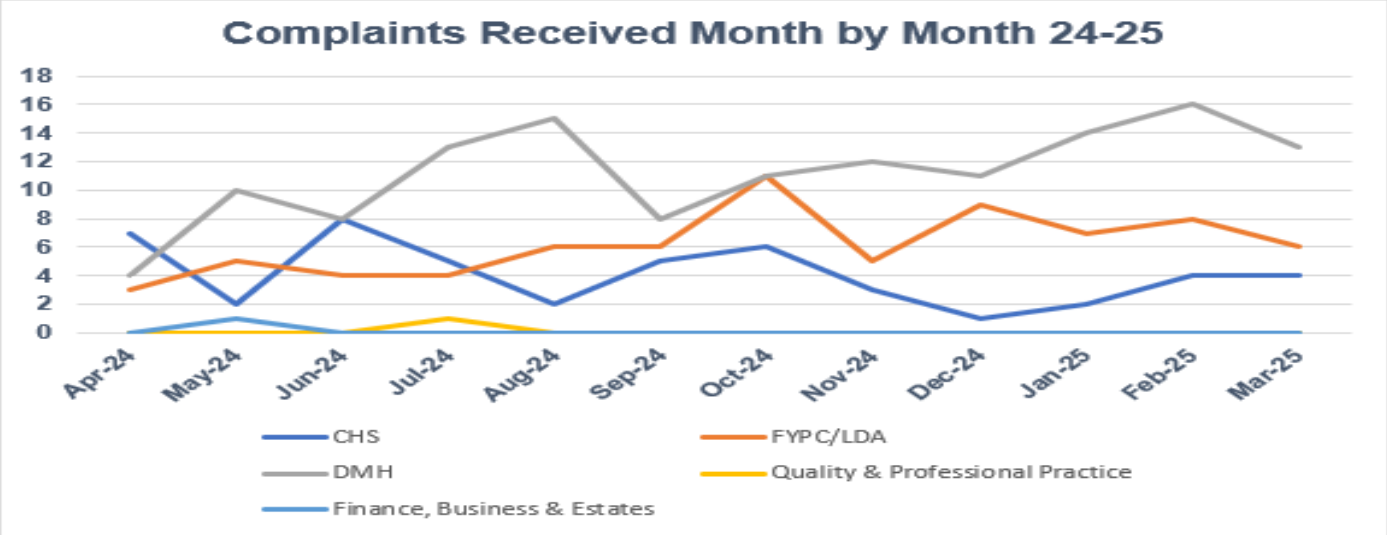
These include:

- Improved triage on receipt of a concern/complaint.
- Comprehensive staff training programme on complaint management.
- Customer service staff training refresh and relaunch.
- Complaints peer review programme, leading to improvements in complaints management. documentation; complaints letters and triaging of complaints.

In response to our complaint performance, a comprehensive review has been undertaken to understand the multi-factorial reasons for not achieving our performance, this includes an increase in case complexity i.e., the number of services and organisations involved in someone's care leading to multi-agency complaint management and delays in obtaining information from other services or agencies, increased demand and waiting for community paediatrics and neurodiverse services and assessments, and staffing issues.

A complaint improvement programme in place to support us achieving our Trust agreed timescales of 90% by December 2025. The current position on 1 September 2025 is 73% overall Trust wide.

Below is a breakdown of complaints received by month per Directorate 2024-2025:



The table below shows the complaints by directorate over the last three years.

	24-25	23-24	22-23
Total Complaints Registered	**262**	**239**	**198**

Directorate of Mental Health	139	124	101
Community Health Services	46	55	36
Families, Young People & Children &Learning Disabilities & Autism	75	60	60
Other	2	0	1

As was the trend last year, the Trust continued to receive most complaints via email. The Complaints Team have noticed a considerable uptake from patients, families, and carers to our offer of having consent forms, acknowledgement letters, and final response letters shared digitally. This ensures that complainants can communicate with the Trust through their preferred method of contact. This approach also helps the Trust move forward in terms of the wider NHSE aim to go paperless. However, the Trust will continue to ensure the most accessible method of communication is offered to those who contact us.

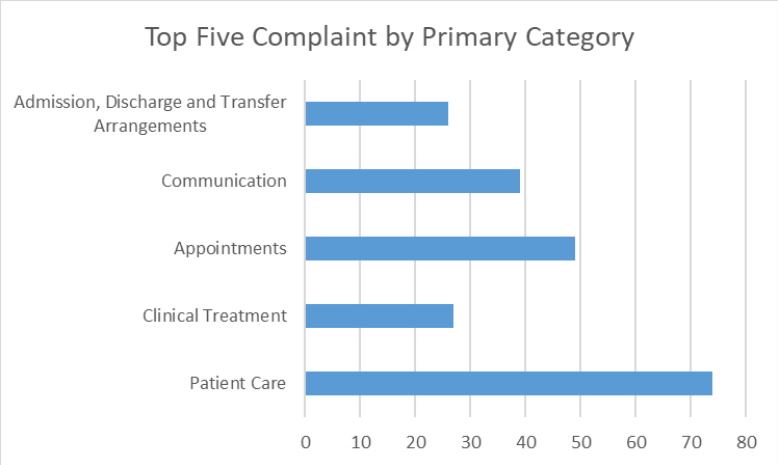
Improving Complaint Categorisation

Following discussion at the Complaints Review Group, it was identified that the recording of complaints did not always accurately reflect the issues being raised by complainants.

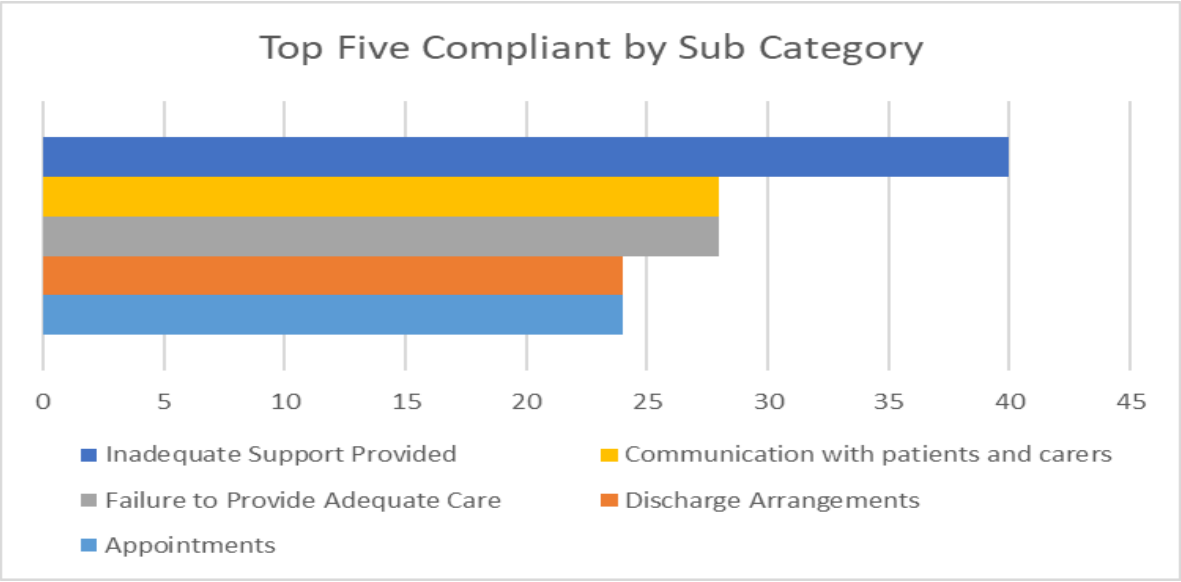
To address this, the Complaints Management Document (CMD) has been updated to allow a retrospective review of the complaint category following closure of a complaint and training for staff to ensure robust category decision making and consistent logging. This has resulted in an improvement to the logging of categories within complaints, ensuring this is as accurate as possible, especially in respect of the subcategory, which is reportable to NHSE through the annual KO41a return.

This work has allowed the Trust to provide the most accurate and up to date information and supports thematic analysis of complaints and responsive learning and actions to our complaints.

Complaints Themes



In the last 5 years, Patient Care, Communication, and Appointments have been the top three complaint themes across the Trust. At the time of writing this report, national comparator figures were not available, however, looking at comparable Trusts and their complaint themes, our themes are consistent; access to services and waiting times, clinical care, and communication.



In June 2024, the Trust's Peoples Council completed a review of complaints in relation to communication, using a model of 'Receive, Review, and Recommend', the findings were presented to the Complaints Review Group in June 2024 and Quality and Safety Committee in August 2024. In response to the People's Council recommendations actions were developed and monitored through the Complaints Review Group, recommendations included:

- Strengthening the lived experience/partner voice at Directorate Patient and Carer Experience Group (PCEG) meetings in embedding learning.
- Mapping of complaint themes against quality improvement projects, for example the CRISIS continuity of care project, which demonstrates after complaint learning.
- Review of the Valuing High Standards Accreditation tool to identify further opportunities or evidence of learning following complaints.
- Update the Complaint Management Document to add an EDI section with drop down boxes to start to collate wider complainant demographic data.
- Review complaint demographic data through the Patient and Carer Race Equality Framework (PCREF) metric reporting.

Training

We continue to deliver our Customer Service training programme for our staff. The programme is available via Ulearn or face-to-face sessions, the training was co-designed with staff and patients (see infographic page 6) and specialist training on Complaints and PALS management.

Customer Service Training numbers 2025/25:

- 337 staff members attended Customer Service training via Ulearn modules and a taught session:
- Ulearn – Customer care, collecting and learning from patient feedback.
- Ulearn – Customer care for everyone.

Feedback:

- "*Thank you it's been really helpful."*
- *"Thank you for this detailed session, very much appreciated."*
- *"Developing Customer care and customer/staff satisfaction has become important to me and as an expert by experience in Mental Health I'm always learning. Thanks for the training."*

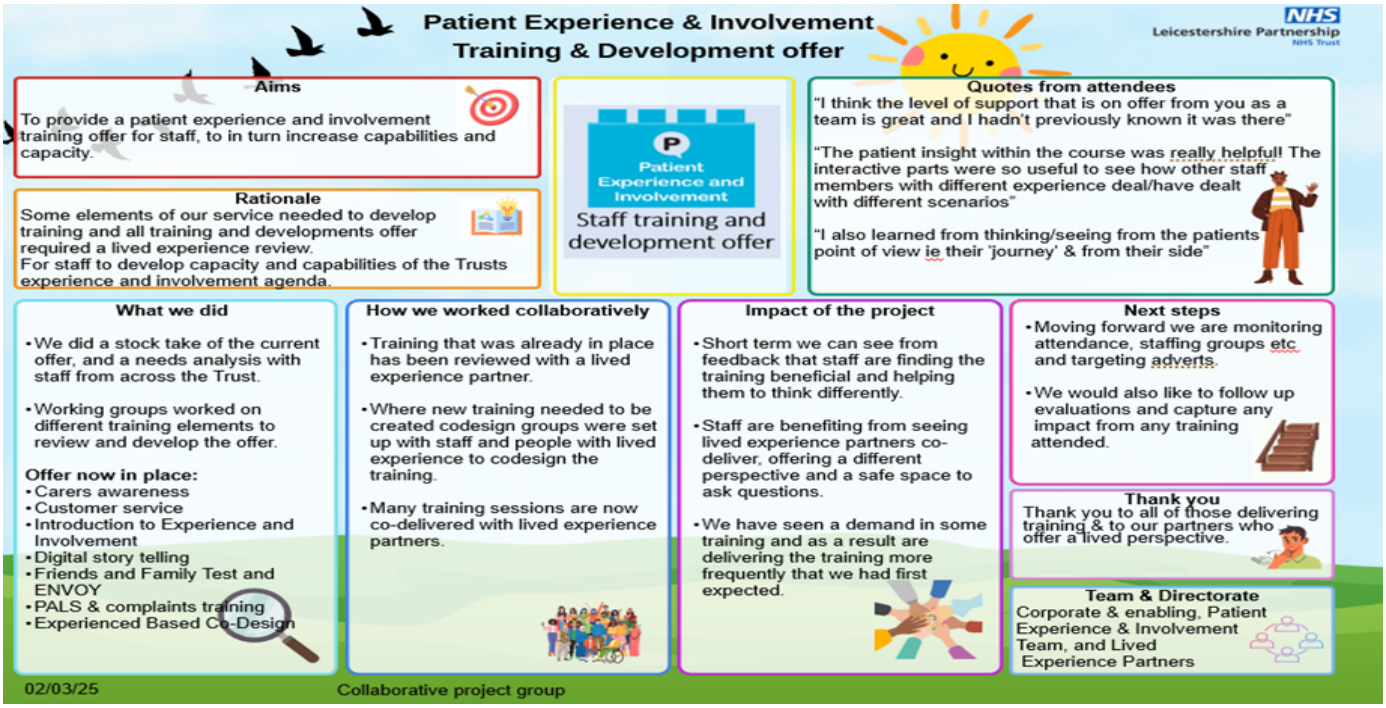
Complaints and PALS Management training

The aim of the training programme is to provide staff with tools and approaches to support effective communication, this will result in a decrease in concerns and complaints relating to poor communication between staff, patients, and carers. During 2024-25 training has been delivered by area:

- 3 training sessions held in 2024 with 50 attendees.
- Ulearn – Investigating and responding to PALS and complaints - 20 staff completed.
- Bespoke sessions held with Podiatry, and Community Paediatric clinicians.

Feedback

- "*Excellent session well explained and time to answer questions".*
- *"I think the level of support that is on offer from you as a team is great and I hadn't previously known it was there".*
- *"I found it informative and answered all the questions I wanted answering".*
- *"Mary and Kirsty did a great job presenting. The session was informative but also light enough to be able to retain the information given, it was also a nice change from most training sessions with having some interactive moments between the slides. Thank you"*



Outcomes of Complaints

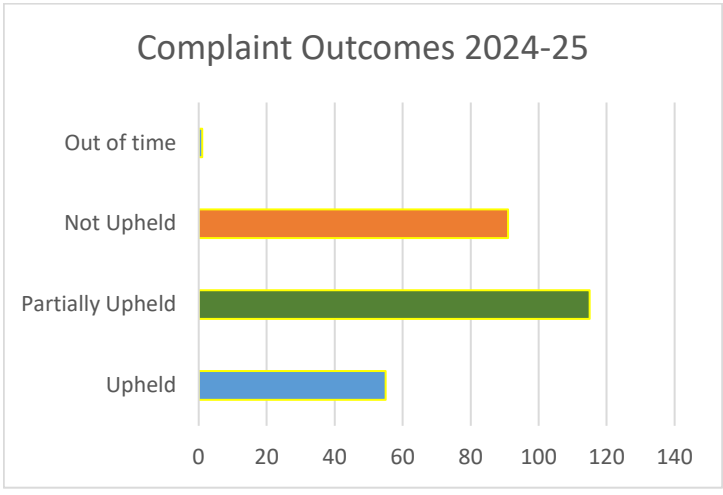
The outcome of a complaint is categorised in line with the KO41a national return requirements set out by NHS England with the outcomes noted below:

Upheld	All issues of the complaint are fully substantiated and that there are shortcomings in the care and treatment provided
Partly Upheld	Some of the issues of the complaint are substantiated.
Not Upheld	The issues of the complaint are not substantiated, and the care was appropriate and according to process or guidelines.
Ongoing	The complaint is under investigation.
Withdrawn	The complainant no longer wishes to progress their complaint or require a response.

Between 1 April 2024 and 31 March 2025, the Trust upheld or partly upheld 78% of our complaints (205 of 262 received), which is an increase of 10% compared to 2023-24.

Out of Time (OOT) cases are not reportable to NHSE, it is helpful to note this data due to the strict parameters with which complaints can be raised (12 months from the date of the event or 12 months from the knowledge of the event).

As with the previous two years, the Trust had no complaints withdrawn.



Further Local Resolution/Reopened Complaints

Between 1 April 2024 and 31 March 2025, 14 complainants got back in touch, as they were unhappy with their initial response; this is an improving trend; 56% reduction on the previous year (32) and a 63% reduction from 2022-23 (38).

The table below provides a breakdown of why people were unhappy with their response and why the complaint was reopened for further investigation.

Reason	
Response did not address all issues	11
Disputed Information	1
Unresolved issues	2

The theme of reducing the number of reopened complaints throughout the year demonstrates that complainants are increasingly happy with the complaint investigation and its findings and therefore indicates improved complaint investigation and final responses provided by the Trust.

Learning from Complaints

It is important that the Trust recognises when something has gone wrong and to use this feedback to learn and make improvements. Complaints are a valuable source of feedback and an opportunity to bring about positive change. In addition to sharing complaints directly with the staff involved in the care, complaints are shared at directorate governance meetings, which feed into Complaints Review Group and Quality Forum, the Quality Assurance Committee, and Trust Board.

Below are examples of actions taken across the Trust in response to complaint feedback in 2024/25:

- Directorate of Mental Health reported that from an urgent care perspective, patients experience, and communication seem to be highlighted as top themes. In response to this, several Quality Improvement Projects were introduced including a Continuity of Care project which has seen a significant improvement in patient experience and staff feedback, and it is hoped that there will be a reduction in concerns and complaints around this theme.
- Following a review of complaints and concerns for CHS, Community Hospital wards, the directorate have increased ‘clinics’ with families and patients and matron, Ward Sister/Charge nurse ‘ward walk rounds’ to proactively de-escalate and respond to issues raised. Wards have reported a decrease in concerns and complaints raised.
- Following a complaint raised on a community ward in relation to a verbal handover which led to a communication error when booking an ambulance with one crew member and a wheelchair being requested rather than two crew members and the use of a carry chair, the Trust has implemented an electronic task system that will allow therapy teams to clearly handover ambulance booking requests to the ward clerk for booking. The therapy team have shared the learning from this incident to ensure all discharge needs and rationale are clearly documented.
- In response to a complaint received in relation to community nursing services in the patients last days of life, the service has worked to ensure all community nurses attend specialist palliative care training provided by LOROS. The therapy team are taking steps to ensure equipment orders are timely placed and followed up.
- Following a complaint raised regarding catheter care and advice given to a patient following the removal of the catheter, the directorate communicated to all community staff members the importance of providing clear communication and advice including information resources to inform patients about their treatment and to offer appropriate safety netting advice to minimise the risk of hospital admission.
- Following an investigation into communication to a family member regarding missing controlled drugs, the service has introduced additional processes to ensure that staff follow the correct protocol when managing medication discrepancies, including involving a second checker before informing family members and reiterating that clear, compassionate, and timely communication is essential, especially in sensitive situations involving end-of-life care.
- Following recent complaints received by our Adult Eating Disorder Ward, Welford

Ward, in relation to meals being incorrect and not matching the relevant plan for the patient, a review was undertaken It was found that meal plans being stored in various locations (kitchen / nursing office) were different to the one given to the patient. As a result of this, the ward has amended the way in which meal plans are drafted and have also worked on a Nutrition & Hydration Standard Operating Procedure.

- The Trust has introduced a new Family Liaison Officer role. The role supports families in relation to complex complaint and incident investigations and provides a single of point of contact, if needed, to support families and patients to contribute to investigations if they wish to do so. The aim of the role is to make sure patients, families and carer experiences are central to the findings, and any potential learning we may identify as a Trust.

Looking towards 2025-26

The focus into 2025-26 will be to continue to improve on the Complaints Performance across the Trust, working towards our 90% trajectory and to continue to ensure that the Trust acts, learns and improves on what our patients, carers, and their families tell us. Our complaints improvement implementation plan will focus on:

Key performance indicators for complaints management include:

- Ninety percent of all complaints acknowledged within three working days.
- Ninety percent (reported quarterly) for investigation and complaint closure – 40 working days (or timescale agreed with complainant), note complaint timescales were increased from twenty-five working days to forty working days during the Covid pandemic and have remained in place.
- Target of below 10% per quarter of the number of breached complaints (with supplementary commentary on directorate performance).
- Target of below 10% per quarter of complaints referred to PHSO (with supplementary commentary on directorate performance).
- Number of PALS concerns resulting in a formal complaint – quarterly target set at zero.
- 100% MP concerns closed within internal timescale (10 working days).
- Target of below 5% per quarter of reopened complaints (with supplementary commentary on directorate performance.

Create a pool of best practice examples of complaint responses / peer review of final response letter sign off process:

- Undertake a peer review of complaint sign off. Review a closed complaint from each directorate to peer review with People's Council.

- Working with Peoples Council to develop best practice templates for complaint final response letters.

Spread approach and introduction of local resolution meetings (LRM's):

- Review the current use of LRM's across each clinical directorate.
- Where LRM's are being used, benchmark the impact of these against a formal investigation.
- Where LRM's are not being used, scope with directorate/service opportunities for introducing LRM's into the complaints process.
- Using current successful processes for LRM's, develop a Standing Operating Procedure for use of LRM's across the Trust and implement as key phase of complaints process.

Design and implement a Standard Operating Procedure (SOP) for repeat complainants/vexatious complainants:

- Using PHSO best practice recommendations, develop and implement a standard operating procedure (SOP) for managing repeat/vexatious complainants using recent cases to inform our approach.
- Undertake engagement on the SOP with senior leaders, CEO and DCEO to inform the SOP and processes for escalation and management.
- Ensure that the SOP is aligned to the allegations policy.

Staff training – extend the complaints element of the Ashton Compassionate Leadership Development Programme for Nurses and Allied Health Professionals (AHPs):

- Review current training package for Module 5 of the programme and lengthen the complaints element of the module with a focus on responsibilities and complaints management.

Scope introduction of signposting and information to support alternative approaches to responding to concerns in relation to waiting times and referrals:

- To review information on how other Trusts manage similar national/regional issues such as Community Paediatric; ADHD Service and CAMHS complaints (including what NHFT have done in relation to right to choose to offer) and consider any areas to adopt.
- To review the standardised complaints response information and all other information/ signposting to ensure it contains all relevant information for families, including the criteria for expediate requests, Healthwatch support offer, and the service digital offer (when live).
- To also consider how we can involve Lived Experience individuals in reviewing the information/signposting to ensure it has patient/carer/family feedback.

Explore opportunities within the Ulysses System to improve complaints process management.

Review all current reporting requirements to establish core data sets for reports to include:

- Assurance Framework Meeting.
- Complaints KPIs.
- Board and Directorate Performance Report.
- Quality and Safety Metrics Report.
- Directorate Governance Reports.
- Meet with the QI Team regarding assurance reports to Quality Forum and Accountability Framework Meeting.
- Meeting with Ulysses Manager to review and consider Ulysses opportunities.
- Develop a specific Ulysses module for PALS and Complaints

Alignment of complaint management pathway across the Trust

- Initial meeting with Heads of Nursing to identify areas of concern and opportunities to reduce variation in approach.
- Undertake a mapping process on all directorate complaints management processes.
- Present findings to Heads of Nurisng and Governance leads to develop a single process for the management of complaints in directorates.
- Undertake mapping of complaints sign off process including regional Trust processes.
- Present findings to Heads of Nursing and Governance leads to develop one process for the signing off of complaint responses for consistency.

Review Transferring Care Safely (TCS) data alongside complaints data to identify trends and themes and identify improvement in triangulation of data.

Decision required – Please indicate:

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

The Trust Board as asked to accept and approve the 2024-25 Complaints and Concerns Annual report.

Governance table

For Board and Board Committees: Paper sponsored by:	Trust Board James Mullins, Interim Director of Nursing, Quality and AHPs

Paper authored by:	Alison Kirk, Head of Participation Coproduction and Patient and Carer Experience	
Date submitted:	18.09.2025	
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 Report	
LPT strategic alignment:	**T** - **T**echnology	
	H – **H**ealthy Communities	
	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):*	Risk 6062 Due to challenges in the investigation and sign off process complaints are not consistently being completed with agreed timescales	
Is the decision required consistent with LPT's risk appetite:	Y	
False and misleading information (FOMI) considerations:	N	
Positive confirmation that the content does not risk the safety of patients or the public	Y	
Equality considerations:	n/a	

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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: 21 August 2025 Quorate: Yes

Agenda Item:	Minute Reference:	Lead:	Description:	BAF Ref:
ALERT:				
IM&T Committee Triple A Report	FPC/25/098	Group Chief Digital Information Officer	UHL's migration to the Nervecentre Patient Administration System had resulted in a large number of erroneous records being entered onto the system. LPT's CCIO and CSO were now working with their counterparts at UHL to resolve the issue.	BAF 1.2
ADVISE:				
Finance Report Month 4 2025/26	FPC/25/094	Director of Finance	FPC agreed that Trust Board would be advised of the level of risk in achieving a break even financial position for 2025/26. The key points to note were; • The current best case forecast was a break even position at year end, the likely stretch case forecast was a £4m deficit but this included £2.5m of the plan gap being closed for which no schemes had been identified. • Capital expenditure was where it was expected to be at this time of the year but urgent decisions on strategic estate moves needed to be made as delays in capital projects were being seen. • Discussions were taking place at system level to agree how the pay award was allocated and on the detrimental impact it was likely to have on LPT. A deep dive on CIP schemes was carried out, FPC noted the detail of some schemes was still being established at month 4; • £1m was outstanding for estates' schemes that was being treated as a control total. • c£4.5m worth of assumptions had been included for corporate schemes when the plan was submitted and were still without a specific scheme. • Work was taking place to mitigate the impact of only £540k being allocated to the LHIS capital rolling replacement programme for 2025/26 when actual requirement was c£2.4m.	BAF 6.3 BAF 6.4

Agenda Item:	Minute Reference:	Lead:	Description:	BAF Ref:
Accountability Framework Meeting	FPC/25/101	Director of Finance	The upward trend of over 52 week waiters remained largely unaltered. The total number was now reported at 15,707 and almost half of those had been waiting over 104 weeks. Focus was being given to waiting list management to ensure the Access Policy was being applied correctly.	BAF 3.2
Board Performance Report M4 2025/26	FPC/25/102	Director of Finance	• Generally KPIs were consistent with previous months although they were trending lower in CINSS, Community Paediatrics and Memory Services. • The normalised workforce turnover rate had been static for a number of months which was a concern as workforce reduction was one of the key elements of delivering the financial plan. • Out of area placements had gone up again this month and there had also been an increase in the average length of stay in acute mental health beds.	BAF 3.2
Joint Collaborative, Commissioning and Contracting Group	FPC/25.104	Director of Strategy and Partnerships	FPC was advised of the quality concerns identified at St Andrews Healthcare by the CQC and the restriction placed on admissions across the St Andrews site in Northamptonshire. LLR had seven patients at St Andrews and close monitoring of the patients was being carried out. The ICB was aware of the challenges.	N/A
ASSURE:				
Procurement Legislation Update	FPC/25/095	Group Head of Procurement	FPC received an update on the new Provider Selection Scheme (PSR) and the new Procurement legislation and were assured by LPT's response and progress in implementing the necessary changes. The Committee noted the continuing drive to improve the supplier social value contract commitments and management and the contribution this could make to addressing health inequalities.	N/A
FPC Green Plan 2025/26 to 2027/28	FPC/25/106	Partnerships Manager	FPC approved the Green Plan and acknowledged the huge amount of work that was taking place in the Trust across all elements of the plan, giving significant assurance against BAF risk 6.2 (*sustainability*). The emphasis of the Green Plan was on; embedding sustainability into workforce practices; net zero clinical transformation; reduction of carbon emissions from clinician and staff travel; sustainability in terms of new builds and major refurbishment projects; and improving the sustainability of food services.	BAF 6.2

Agenda Item:	Minute Reference:	Lead:	Description:	BAF Ref:
CELEBRATING OUTSTANDING:				
Thriving Through Transformation / T&QI Delivery Group Triple A Report	FPC/25/091 FPC/25/102	Director of Governance and Risk	FPC received the June update of the Quality Improvement & Transformation report to highlight some of the quality improvement areas of work taking place and the good news stories from directorates. In particular, the Committee noted: • Community nursing teams had been utilising Isla Health's digital pathway platform for some time now which enabled remote monitoring of patients through patient submitted images and videos. It was particularly helpful in the management of growing complex caseloads. • The SALT Team had introduced a digital questionnaire to screen children and young people on the waiting list which had enabled the discharge of fifty four CYP and a reduction of 108 hours of clinical time.	N/A

Leicestershire Partnership NHS Trust

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Trust Finance Report for the period ended **31 August 2025**

For presentation at the **TRUST BOARD MEETING 30 September 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	A	The Trust is reporting a YTD deficit of £1.8m at the end of August (in line with plan). The forecast year end position is currently a surplus of £0.3m, also in line with plan, but with £6.7m likely net risks	APPENDIX A
2. Remain within Capital Resource Limit (CRL).	G	G	The YTD capital spend for August is £3.15m, 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 August is in line with plan, as is the forecast year end surplus (but with £6.7m likely net risks)	SUMMARY REPORT
5. Achieve Efficiency Savings targets.	G	A	Savings at 31st August are £8.6m, 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 August is £5.04m, which is lower (£371k) than planned YTD spend. Forecast year end spend is £10m, £1.1m 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 also achieved 2 of the 4 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 £24.8m at the end of August. This is £8.2m above 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. August's cash level of £24.8m was 21 days.	APPENDIX F
10. Deliver capital investment in line with plan	G	G	YTD capital expenditure is £3.15m - compared with planned levels of £2.81m, this is £0.34m (12%) above plan. See 'Capital Section' in summary report.	APPENDIX E

Summary report – financial position as at 31 August 2025

OVERVIEW AND KEY ISSUES

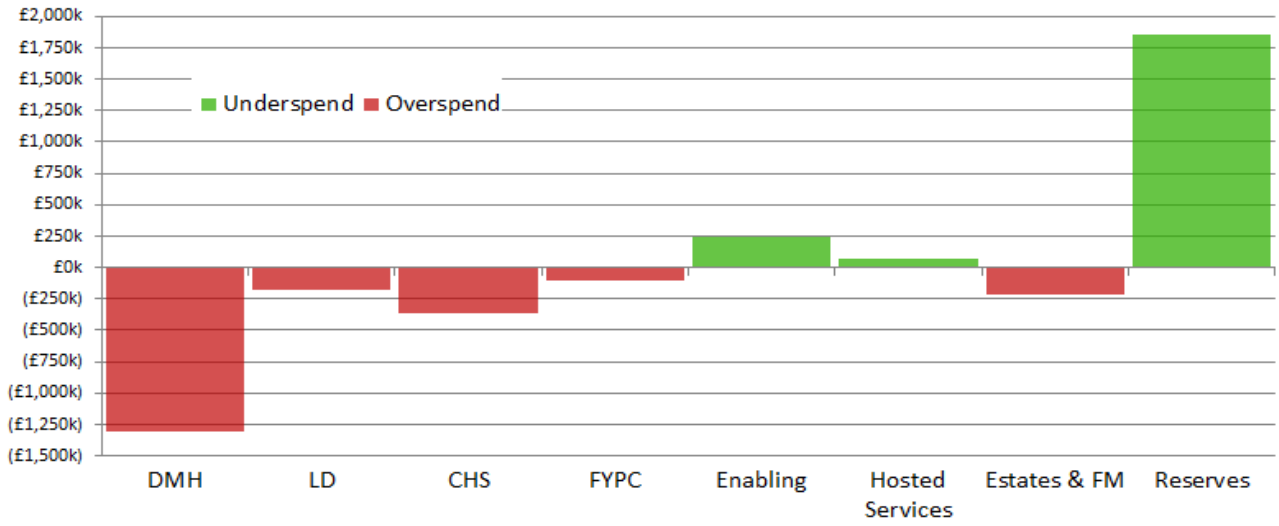
- The year-to-date income and expenditure plan (being a planned deficit of £1,817k for August) has been achieved.

- Clinical directorates continue to report overspending positions although CHS and FYPC positions have both improved substantially during the month. DMH and Estates positions moved adversely in line with previous trends. The Enabling underspend increased further during the month. In totality, operational budgets are £1.85m overspend.

- The full cost impact of the pay awards is now reflected in the year-to-date and forecast position. At the end of month 5, the value of the corresponding LPT funding allocation initially held by the ICB had not been confirmed and so in line with national guidance, a balanced position regarding the pay award has been reported. Using the national average uplift would see LPT (in line with most other mental health and community providers) short-funded. Funded at the national average, LPT's likely risk is £1.4m. As a result LPT have requested funds in line with costs and have provided evidence to the ICB to support a localised allocation methodology that reflects the actual average cost weights for pay.

- Overall with the M5 position, 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 £1,308k as at Month 5 mainly due to locum usage and OOA placements. The Medical budgets are overspent by £1,047k and OOA placements overspent by £784k. n the first quarter of this year , the directorate Bank

and Agency costs were showing a reducing trend. However for the last two months the spend has remained constant mainly due to increased cover for sickness, escort duties, a high level of observations and a general increase in acuity.

- **The Community Health Service** is reporting an overall overspend of (£367k) for the first 5 months of the year, representing a favourable movement of £198k from the previous month. The improved position is a result of reducing the additional 5 beds at Hinckley and temporary closure of Dalgliesh ward where staff have been deployed to other wards thus reducing the need of further bank and agency.

  The expected reopening of beds in October and the additional pressures of supernumerary for newly recruited staff will present a challenge in sustaining the financial position.

  Non pay budgets are overspending by (£41k), due to pressures within the continence products, mattress rental and drugs budgets.

- **The FYPC** financial position at month 5 is a £98k overspend, a favourable movement compared to last month. Agency costs reduced within the month as the CAMHS Outpatients and CAMHS CRT agency staff were converted to substantive posts. Non pay costs continued to be contained within budget, however additional costs above trend were incurred in the month against medical equipment and pathology tests. The income position improved in the month due to the gradual increase in occupancy on Welford ward and ad hoc Local Authority income. The CIP savings were below plan at month 5 and although it is forecast that the position will improve during the year as schemes develop a small deficit for the year is forecast.

- **The LDA** financial position at month 5 reported an overspend of £175k, a small increase from last month. The pay budget was overspent mainly related to negative budgets linked to the Agnes Unit and LDA management budget. Agency costs saw a further run rate reduction for the month and bank was consistent with previous periods. Non pay was reporting a break-even at month 5, as was income. The CIP was showing under delivery for month 5 and forecast deficit for the year.

- **Enabling budgets** are underspent by £240k as at M5. This is a positive movement of £181k compared to M4 (£59k underspent). Additional income relating to Medical Trainees was received in August – some of which was non recurrent. The Amica and Occupational Health Services budgets position also improved following the allocation of non-pay inflation funding.

- **Estates budgets** are overspent by £215k as at M5. This is a negative movement of £49k compared to M4. Pay costs showed an overall favourable variance of £345k due to vacancy slippage. This has helped offset overspends within non pay costs primarily relating to Patient food and Laundry Services, Lexmark Printers and a shortfall in recovering income targets.

- **The Central Reserves position** is underspent by £1.9m. 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. It should be noted that this forecast is based on 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 £1,817k planned deficit can be seen in M5. Subsequent monthly positions are expected to improve each month across the year (see green cells below) in order to deliver the £311k surplus by the end of the year. A monthly run-rate improvement of £825K (from M5 to M12) is required to achieve the plan for the year. The table below also shows where the operational overspend is higher than the planning assumption regarding overspends in the first part of the year (blue cells) – requiring the earlier than planned release of central reserves mitigations. The improvement in directorate positions in M5 has reduced this requirement in M5.

	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 £000
PLANNED monthly surplus / deficit run-rate	(601)	(469)	(373)	(233)	(141)	(26)	91	158	251	414	556	684	311
PLANNED 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
ACTUAL operational deficit run-rate	(538)	(540)	(516)	(386)	128								
ACTUAL operational cuml. YTD deficit	(538)	(1,078)	(1,594)	(1,980)	(1,852)								
Operational deficit in excess of plan - run-rate	63	(71)	(143)	(153)	269								
Operational deficit in excess of plan - cuml YTD	63	(8)	(151)	(304)	(35)								

- In the year end forecast, net likely risks total £6.7m which suggests that delivery of the forecast £0.3m surplus is high risk. Urgent work is being undertaken to identify further mitigations to negate these risks, including a weekly tracker to monitor recovery actions. This work will inform a comprehensive review of the forecast outturn position as part of the half-year (month 6) reporting to ensure that the break even forecast remains viable.

ICS FINANCIAL POSITION

- The ICS financial position was reported as off plan in month 4 (the latest information available). The ICS position was £13.8m deficit, £4.1m variance against plan (UHL £2.2m, ICB £1.9m).

- The system continues to forecast a year end deficit of £80.00m, before support funding, in line with plan. The planned deficit is made up of; UHL £64.9m deficit, LPT £0.3m surplus & ICB £15.4m deficit.

Finance Report for the period ended **31 August 2025**

APPENDICES

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 31 Aug 2025	YTD Actual M5 £000	YTD Budget M5 £000	YTD Var. M5 £000
Revenue			
Total income	181,972	179,805	2,167
Operating expenses	(182,292)	(180,125)	(2,167)
Operating surplus (deficit)	**(320)**	**(320)**	**0**
Investment revenue	399	399	0
Other gains and (losses)	0	0	0
Finance costs	(556)	(556)	0
Surplus/(deficit) for the period	**(476)**	**(477)**	**0**
Public dividend capital dividends payable	(1,340)	(1,340)	0
I&E surplus/(deficit) for the period (before tech. adjs)	**(1,817)**	**(1,817)**	**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	**(1,817)**	**(1,817)**	**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:	**(1,817)**	**(1,817)**	**0**
Trust EBITDA £000	**5,125**	**5,125**	**0**
Trust EBITDA margin %	**2.8%**	**2.9%**	**0.0%**

APPENDIX B – Efficiency savings performance

At the end of month 5, CIP performance is reported in line with plan which is delivery of £8.6m 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 deteriorate. 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.

The most significant risks in the forecast outturn (FOT) are the corporate savings phased into the second half of the year – namely the corporate cost reduction target (£1.5m) and the 'difficult decisions' target (£1.0m). In the FOT below, both are assumed to deliver in full.

CIP year-to-date performance and forecast by directorate

	M5 YTD PERFORMANCE (£'000			FORECAST OUTTURN (£'000)			FOT (£'000)	
Directorate	YTD plan	YTD actual	YTD variance	Annual Plan	FOT	Variance	Recurrent	Non-recurrent
DMH	2,326	1,698	(628)	6,210	5,750	(460)	4,109	1,642
CHS	2,479	2,439	(40)	5,404	5,404	(0)	4,914	490
FYPCLDA	1,751	1,597	(154)	4,730	4,657	(73)	4,243	414
Estates	362	497	135	2,399	1,929	(470)	1,137	792
Enabling	750	754	4	1,779	1,779	0	1,503	276
Corporate*	977	1,659	682	7,836	8,838	1,002	2,383	6,455
Unallocated								
Grand total CIPs	**8,644**	**8,644**	**(0)**	**28,358**	**28,358**	**(0)**	**18,289**	**10,069**

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

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 Actual	25/26 M5 £000s Actual	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	-445	-364	-344	-344	-344	-304	-312	-332	-332	-2,111	-4,423
Nursing - Qualified	-3,192	-266	-167	-123	-118	-126	-127	-112	-112	-104	-127	-112	-112	-112	-661	-1,452
Nursing - Unqualified	-144		-2	0	-4	-8	-3	-2	-1	-1	-2	-1	-1	-1	-16	-25
Other clinical staff costs	-145	-12	-11	-9	-15	17	0	0	0	0	0	0	0	0	-18	-18
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**	**-562**	**-494**	**-458**	**-457**	**-449**	**-433**	**-425**	**-445**	**-445**	**-2,806**	**-5,918**
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	-2	-2	-3	-3	-3	-3	-3	-3	-3	-46	-67
Nursing - Unqualified	-36		0	0	-1	0	0	-1	-1	-1	-1	-1	-1	-1	-1	-8
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**	**-2**	-2	**-4**	**-4**	**-4**	**-4**	**-4**	**-4**	**-4**	**-47**	**-75**
Consultant Costs	-370	-31	-30	-16	-23	-24	-14	-15	-15	-8	-8	-8	-8	-8	-107	-177
Nursing - Qualified	-7,723	-644	-358	-329	-264	-258	-225	-200	-200	-200	-225	-180	-165	-165	-1,434	-2,769
Nursing - Unqualified	-1,129		-31	-12	-7	-4	-2	-5	-5	-5	-11	-11	-5	-5	-56	-101
Other clinical staff costs	-326	-27	-27	3	-6	-3	-4	-4	-4	-4	-4	-4	-4	-4	-38	-65
Non clinical staff costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-total - CHS	**-9,548**	**-702**	**-447**	**-354**	**-301**	**-289**	**-245**	**-223**	**-223**	**-216**	**-248**	**-203**	**-181**	**-181**	**-1,636**	**-3,112**
Consultant Costs	-438	-37	-22	-22	-22	-22	-29	-15	0	0	0	0	0	0	-117	-132
Nursing - Qualified	-1,406	-117	-94	-70	-76	-62	-22	-30	-22	-22	-22	-22	-22	-22	-324	-486
Nursing - Unqualified	-40		0	-1	-4	-3	-1	-2	-2	-1	-1	-1	-1	-1	-9	-18
Other clinical staff costs	-23	-2	-9	-14	-10	-9	6	-8	-8	-8	-8	0	0	0	-36	-68
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**	**-96**	**-45**	**-55**	**-32**	**-31**	**-31**	**-23**	**-23**	**-23**	**-486**	**-704**
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	2	0	0	0	0	0	0	0	2	2
Non clinical staff costs	-297	-25	-6	-4	-7	-10	-36	-17	-17	-17	-17	-17	-17	-17	-63	-182
Sub-total - Enab/Host	**-202**	**-17**	**-6**	**-5**	**-6**	**-10**	**-34**	**-17**	**-17**	**-17**	**-17**	**-17**	**-17**	**-17**	**-61**	**-180**
Consultant Costs	-5,983	-499	-488	-493	-456	-491	-407	-374	-359	-352	-312	-320	-340	-340	-2,335	-4,732
Nursing - Qualified	-12,868	-1,072	-628	-539	-475	-449	-376	-345	-337	-329	-377	-317	-302	-302	-2,466	-4,775
Nursing - Unqualified	-1,349	-112	-33	-13	-16	-14	-6	-10	-9	-8	-15	-14	-8	-8	-82	-152
Other clinical staff costs	-499	-42	-47	-20	-31	4	4	-12	-12	-12	-12	-4	-4	-4	-90	-148
Non clinical staff costs	-297	-25	-6	-4	-7	-10	-36	-17	-17	-17	-17	-17	-17	-17	-63	-182
Total	**-20,996**	**-1,750**	**-1,203**	**-1,069**	**-985**	**-960**	**-820**	**-757**	**-733**	**-717**	**-733**	**-672**	**-670**	**-670**	**-5,037**	**-9,990**

Agency spend for August (month 5) is £0.82m.

YTD spend is £5.04m; this is lower (by £371k) 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 £10m, which is lower than the planned £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 compliant 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, 2 of the 4 targets were met for August's in-month performance.

Better Payment Practice Code	August (Cumulative)		July (Cumulative)	
	Number	£000's	Number	£000's
Total Non-NHS trade invoices paid in the year	15,363	43,456	11,751	31,205
Total Non-NHS trade invoices paid within target	13,919	41,828	10,603	30,098
% of Non-NHS trade invoices paid within target	**90.60%**	**96.25%**	**90.23%**	**96.45%**
Total NHS trade invoices paid in the year	314	30,151	266	24,246
Total NHS trade invoices paid within target	291	29,171	245	23,750
% of NHS trade invoices paid within target	**92.68%**	**96.75%**	**92.11%**	**97.95%**
Grand total trade invoices paid in the year	15,677	73,607	12,017	55,451
Grand total trade invoices paid within target	14,210	70,999	10,848	53,848
% of total trade invoices paid within target	**90.64%**	**96.46%**	**90.27%**	**97.11%**

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

The cumulative performance for the number of Non-NHS invoices for the first five months of the year is 90.60%, however the position is improving (Month 4: 90.23%). The in-month performance for August was 91.81%.

Cumulatively, 92% of Non NHS invoices not paid within the target period are in the estates & facilities directorate, 1323 of the 1444 late invoices relate to catering and estates invoices not being approved and paid on time, with the majority relating to catering invoices. To understand the catering invoices issue, a deep dive exercise is being conducted in September, to track the specific late invoices and identify the chief causes for delays. Processes will then be reviewed in light of the findings. The Estates & Facilities position dipped in Month 5: 270 invoices were paid late in August, compared to 136 invoices in July.

Non-compliant target – Number of NHS invoices:

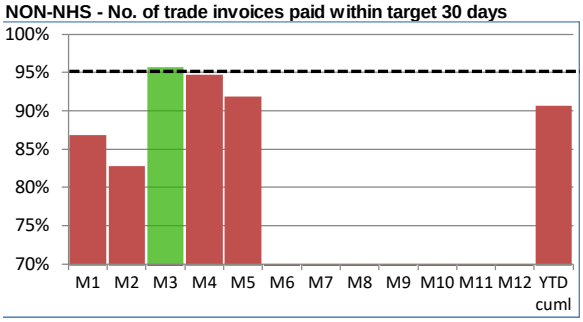
The cumulative performance for the number of NHS invoices for the first five months of the year is 92.68%. Similar to the Non NHS performance, the position is improving (Month 4: 92.11%). The in-month performance for August was 95.83%.

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, 314 NHS invoices have been paid in total, with 23 invoices being paid outside of the target period of 30 days.

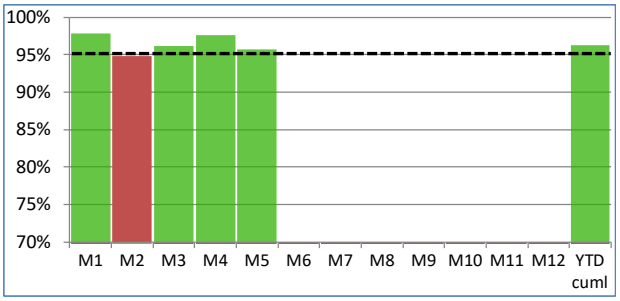
The majority of the non-compliant invoices relate to the various Enabling functions.

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

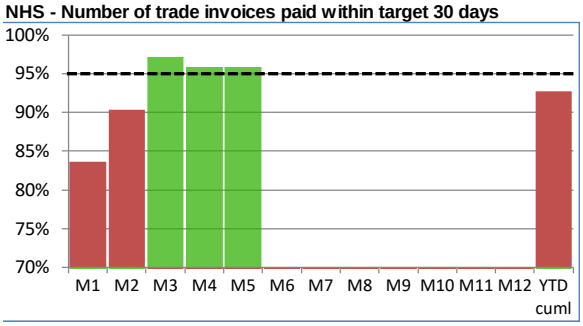
NON-NHS - No. of trade invoices paid within target 30 days



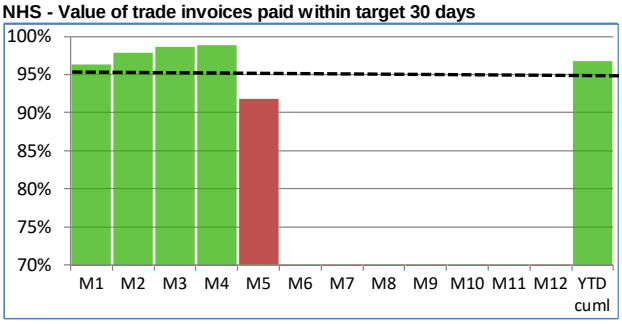
NON-NHS - Value of trade invoices paid within target 30 days



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 a capital plan of £13.5m at the start of the year, comprising £11.5m operational capital and £2m property lease investment. In addition, the Plan includes an additional £5m PDC funding to support a number of national schemes detailed in the table below. The MH Out of Area Placements (OAPs) funding is supported by NHSE with early fees expected in M06, and final approval & allocations in October/November when contracts are issued to suppliers. In month 06 we are due to receive an additional GB Energy funding £456k to install solar panels on 5 more hospital sites, bringing our total allocation from GB Energy to £574k. Overall this equates to a revised plan of £18.7m.

Capital expenditure up to the end of August totals £3.149m, which is £343k (12%) above planned levels for August 2025. The majority of spend relates to the Belvoir Unit refurbishment and Hinckley Hub lease conversion costs.

	Annual Revised Plan	Aug Actual	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation	13,066	5,083	12,198	(868)
Cash reserves	2,840	(241)	4,186	1,346
Capital borrowings repayments	(4,447)	(1,865)	(4,444)	3
Total System operational capital	**11,459**	**2,977**	**11,940**	**481**
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	71	118	0
Estates Critical Infrastructure Risk (CIR)	2,129	34	2,129	0
National Programmes (PDC)	**5,017**	**105**	**5,017**	**0**
PFI capital lifecycle costs	**202**	**67**	**202**	**0**
Total Capital funds	**18,678**	**3,149**	**19,159**	**481**
Application of Funds				
Estates	**£'000**	**£'000**	**£'000**	**£'000**
Strategic schemes	(1,497)	0	(1,057)	440
Capital staffing	(567)	(209)	(567)	0
Estates backlog programme	(3,470)	(126)	(4,226)	(756)
Estates rolling programme	(2,107)	(82)	(2,723)	(616)
Medical devices	(170)	0	(170)	0
Directorate investment	(7,430)	(2,187)	(6,613)	817
PFI Agnes Unit capital lifecycle costs	(202)	(84)	(202)	0
	(15,443)	**(2,688)**	**(15,558)**	**(115)**
IM&T investment	**(1,235)**	**(461)**	**(1,601)**	**(366)**
Operational Capital	**(16,678)**	**(3,149)**	**(17,159)**	**(481)**
IFRS16 - Right of Use Leases	**(2,000)**	**0**	**(2,000)**	**0**
Total Capital Expenditure	**(18,678)**	**(3,149)**	**(19,159)**	**(481)**
(Over)/underspend	**0**	**(0)**	**0**	**0**

Capital changes since plan:

The total capital envelope totals £19.159m which is an increase of £481k on the opening capital plan. This increase is due to an additional operational capital allocation from NHSE. There has been no allocation change this month, however, there have been changes between schemes, as shown in the table below.

2025/26 Changes: M05

		Opening Plan	Changes	Revised Plan	Comments
		£'000	£'000	£'000	
	M05 Position	**(18,678)**	**(481)**	**(19,159)**	Additional non-cash allocation from LLR ICB - M03 £295k, and M04 £186k
M05	Changes to Plan over £100k				
M05	Backlog Maintenance (Holding Fund)	(1,600)	(400)	(2,000)	Increased to cover Trust Wide Boiler replacements (Exc Feilding Palmer (£200k), and Roof replacement at Springfield (£200k)
M05	Replacement boilers and Gas Main (Feilding Palmer)	0	(200)	(200)	Urgent works at Feilding Palmer
M05	Ventilation Action Group - Trust Wide Ventilation Survey	(56)	(169)	(225)	Increase to include recommendations from Ventilation Action group
M05	Site Electrical Supply	(150)	(150)	(300)	Additional cost to build sub-station - risk of losing supply if Trust cannot demonstate energy distribution around site
M05	Soundproofing Audiology - extend timeline to 26/27	(300)	100	(200)	
M05	Wakerley ward - extend works into 26/27	(450)	300	(150)	Main works moved into 26/27
M05	Acacia refurbishment - increase works extended into 26/27	(885)	685	(200)	Costs will include Design fees, long-lead items and garden/fence works Jan-March 26
M05	Contingency	(966)	(180)	(1,146)	
		(4,407)	(14)	(4,421)	
M05	Changes less than £100k				
M05	Junior Doctors on-call room	(70)	(70)	(140)	
M05	Tarmac	(100)	(50)	(150)	Additional costs Lough
M05	Rev to Capital - Laptops purchased by services	(66)	(36)	(102)	46 new laptops
M05	H&S - Fire	(438)	(18)	(456)	Fire Door replacements
M05	Childrens Comm House Radiators	0	(15)	(15)	New bid to CMG 15/09
M05	Gwendolen House Modernisation	0	(14)	(14)	
	Replace Distribution Board	(10)	(10)	(20)	
M05	Belvoir Ward AHU replacement	(10)	(3)	(13)	Small increase in planned cost
M05	Replacement Boilers	(53)	(2)	(55)	
M05	Wellsky - VAT adjustment	(26)	(1)	(27)	
M05	CQC - Bathrooms	(300)	43	(257)	Revised figure on completion
M05	Watermead Skylights	(50)	50	0	
M05	Acute Wards Ensuites - extend timeline into 26/27	(540)	140	(400)	
		(1,663)	14	(1,649)	
	Net Change in month		0		
	Other schemes	(12,608)	(481)	(13,089)	
	TOTAL	**(18,678)**	**(481)**	**(19,159)**	

Capital forecasts

From Month 5 we are required to identify any slippage or cost pressures on national programme schemes, in order to support potential allocation deferrals into 26/27. After this exercise, the default expectation will be that organisations manage slippage within their own resources.

From Month 8 it is important to avoid significant movements in capital forecasts as it leaves little time to repurpose allocations. If an organisation underspends by more than 10% of its 25/26 national programme allocation for reasons it could reasonably have foreseen, then NHSE will deduct 20% of the value of the underspend from the organisation's 26/27 operational capital allocation.

For LPT this would be a reduction of £3.7m on our opening capital allocation (£18.6m 25/26). We are undertaking deep dives of our capital position to inform this work.

APPENDIX F - SoFP, cash and working capital

PERIOD: August 2025	2024/25 31/03/25 Audited £'000's	2025/26 31/08/25 August £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	132,331	131,997
Intangible assets	4,422	3,829
IFRS16 - Right of use (ROU) assets	18,538	17,642
Trade and other receivables	920	920
Total Non Current Assets	**156,211**	**154,388**
CURRENT ASSETS		
Inventories	436	453
Trade and other receivables	8,747	10,531
Short term investments	0	0
Cash and Cash Equivalents	19,547	24,806
Total Current Assets	**28,730**	**35,790**
Non current assets held for sale	**0**	**0**
TOTAL ASSETS	**184,942**	**190,178**
CURRENT LIABILITIES		
Trade and other payables	(28,128)	(36,187)
Borrowings	(4,481)	(4,482)
Provisions	(3,298)	(3,171)
Other liabilities	(6,755)	(7,214)
Total Current Liabilities	**(42,662)**	**(51,054)**
NET CURRENT ASSETS (LIABILITIES)	**(13,932)**	**(15,264)**
NON CURRENT LIABILITIES		
Borrowings	(39,939)	(38,600)
Provisions	(899)	(899)
Total Non Current Liabilities	**(40,838)**	**(39,499)**
TOTAL ASSETS EMPLOYED	**101,442**	**99,625**
TAXPAYERS' EQUITY		
Public Dividend Capital	108,228	108,228
Retained Earnings	(24,744)	(26,561)
Revaluation reserve	17,958	17,958
Other reserves	0	0
TOTAL TAXPAYERS EQUITY	**101,442**	**99,625**

Non-current assets

Property, plant, and equipment (PPE) amounts to £132m, and includes capital additions of £3.15m, offset by depreciation charges.

Right of Use (ROU) leased assets account for £17.6m of total non-current assets.

Current assets

Current assets of £35.8m mainly includes cash of £24.8m, and receivables of £10.5m.

Current Liabilities

Current liabilities amount to £51.1m with trade and other payables making up £36.2m of this balance.

Other liabilities of £7.2m 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 £15.3m.

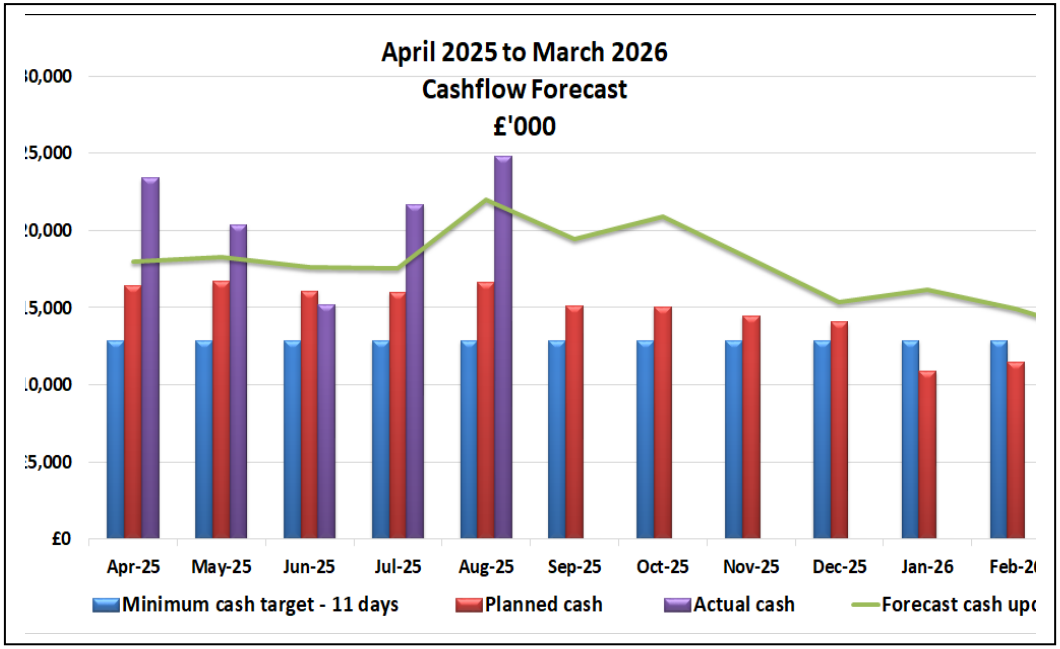
Taxpayers' Equity

August's deficit of £1.8m is reflected within retained earnings.

Public dividend capital balance is £108.2m at the end of August. 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 August £24.8m, an increase of £5.3m since the start of the financial year. This delivers 21 operating days cash. This is above the planned level for August of 14 days cash. The improved cash position relates to the increase in creditors – these will clear in September.



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	22,025	19,445	20,868	18,105	15,378	16,144	14,915	13,172
Actual cash	23,383	20,358	15,205	21,682	24,806	-	-	-	-	-	-	-

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	19	17	18	15	13	14	13	11
Actual cash days	20	17	13	19	21	-	-	-	-	-	-	-

Receivables

Current receivables (debtors) total £10.5m, an increase of £1.8m since the start of the year. Most of this increase relates to outstanding contract recharges with other NHS providers.

Receivables	Current Month August 2025					
	NHS	Non NHS	Emp's	Total	% Total	% Sales Ledger
	£'000	£'000	£'000	£'000		
Sales Ledger						
30 days or less	885	2,228	9	**3,122**	**27.26%**	**79.9%**
31 - 60 days	13	95	2	**110**	**0.96%**	**2.8%**
61 - 90 days	1	39	6	**46**	**0.40%**	**1.2%**
Over 90 days	0	428	200	**628**	**5.48%**	**16.1%**
	899	2,790	217	**3,906**	**34.11%**	**100.0%**
Non sales ledger	2,919	3,706	0	**6,625**	**57.86%**	
Total receivables current	**3,818**	**6,496**	**217**	**10,531**	**91.97%**	
Total receivables non current		920		920	**8.03%**	
Total	**3,818**	**7,416**	**217**	**11,451**	**100.00%**	**0.0%**

Debt greater than 90 days stands at £0.63m; this is a decrease of £21k 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 5 is 5.48% (last month: 4.68%).

The bad debt provision is £0.4m and covers all Non-NHS debt greater than 12 months old. Ex-employee debts of £8k have been written off since the start of the year (none in Month 5).

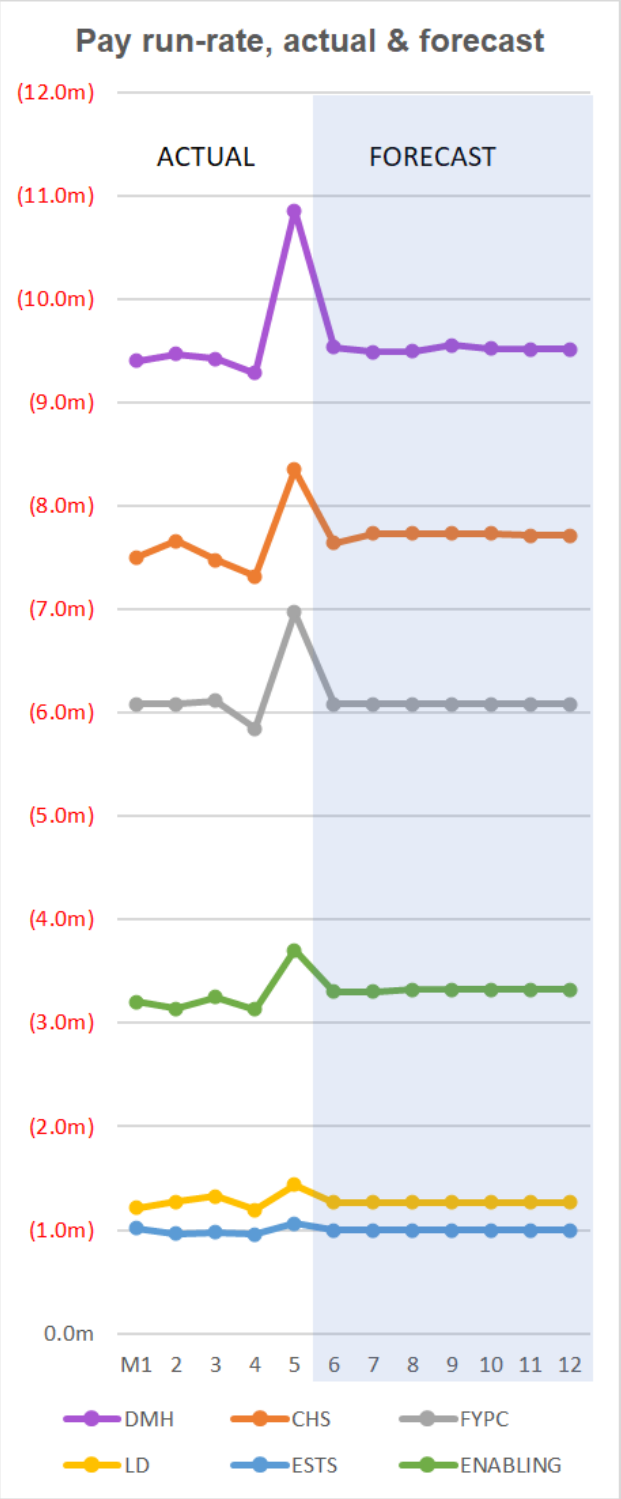
Payables

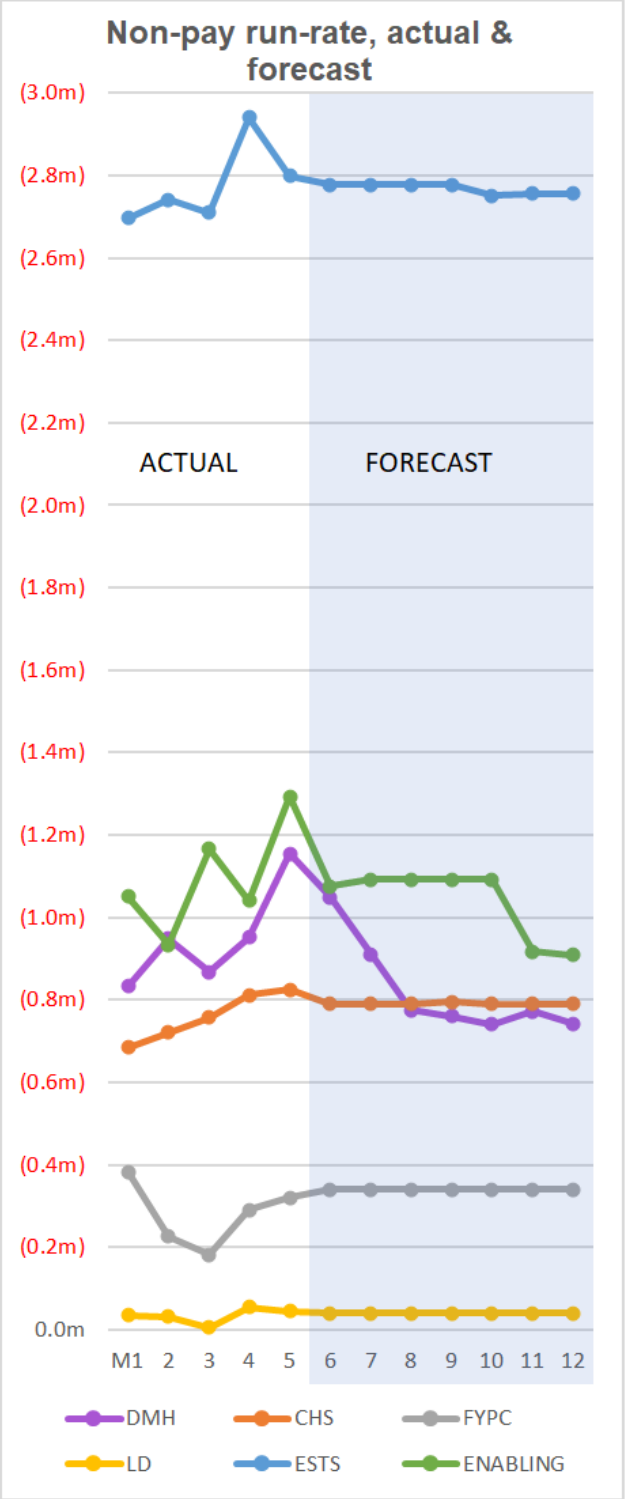
The current payables position in month 5 is £36.2m – an increase of £8.1m since the start of the year. Other liabilities of £7.2m relate to deferred income. It mainly relates to income carried forward from previous years, for provider collaborative and Secure Digital Environment initiatives.

Borrowings

Current and non-current borrowings total £43.1m. 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

DIRECTORATES	BEST CASE £000	LIKELY STRETCH* £000	LIKELY FOT £000	WORST CASE £000
DMH	(1,243)	(1,690)	(1,690)	(1,917)
CHS	0	(250)	(450)	(1,000)
FYPC	200	200	0	(200)
LD	(200)	(200)	(300)	(500)
ESTS	(112)	(358)	(446)	(646)
ENABLING	550	492	432	0
HOSTED	100	100	50	(200)
TOTAL DIRECTORATE FOT VARIANCE:	**(705)**	**(1,706)**	**(2,404)**	**(4,463)**

CORPORATE / NOT YET ALLOCATED	BEST CASE £000	LIKELY STRETCH* £000	LIKELY FOT £000	WORST CASE £000
Orginal plan gap mitigations				
ABSORB ELEMENT OF NON-PAY INFLATION COSTS	1,056	1,056	1,056	1,056
£1.5m NON-REC EXP GAINS TARGET:	500	260	34	0
£2m NON-REC INCOME TARGET:	0	(450)	(750)	(1,750)
DIFFICULT DECISIONS / FURTHER NON-RECURRENT TARGETS:	0	(480)	(976)	(976)
UNALLOCATED CIP TARGET	(977)	(977)	(977)	(977)
CORPORATE SERVICES RE-ALIGNMENT:	(500)	(1,250)	(1,500)	(1,500)
Sub-total - position re: original plan gap mitigations:	**79**	**(1,841)**	**(3,113)**	**(4,147)**
Other mitigation identified to date				
Interest receivable minor gain over budget:	251	120	38	(79)
Slippage on internal investments:	375	265	186	0
Sub-total 'mitigations' (reserves) position:	**705**	**(1,456)**	**(2,889)**	**(4,226)**
Pay award shortfall if net CUF applied (net of original contingency):	**0**	**(1,250)**	**(1,402)**	**(1,402)**
TOTAL CORPORATE PRESSURES / MITIGATIONS:	**705**	**(2,706)**	**(4,291)**	**(5,628)**
TOTAL TRUST	**0**	**(4,412)**	**(6,695)**	**(10,091)**

**Likely stretch - includes the impact of stretching the mitigations that are within our control to the upper end of estimates (compared to best case which also includes best outcome for issues beyond our control e.g pay award funding)*

Leicestershire Partnership NHS Trust

TRUST BOARD MEETING

Month 5 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 30/09/2025 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 19/09/2025 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:	

T

Leicestershire Partnership NHS Trust

Trust Board – 30.09.25

Board Performance Report – August 2025 (Month 5)

Purpose of the report

To provide the Trust Board with an overview of Trust performance against an agreed set of KPI's for August 2025 (M5 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:

- As requested, monthly referral numbers have been added to the exception reports for the metrics in the 'Access Waiting Times' section.

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.

Changes in assurance based on SPC trends from the previous month are as follows:

- ADHD incompletes - trend has moved from special cause of improving nature to common cause no significant change.
- Speech Therapy - new exception has been added this month as sufficient data points are now in place; an exception report has now been included for this KPI.
- CMHT 52-week waiters - trend has moved from special cause of improving nature to common cause no significant change.
- Dynamic Psychotherapy Service 52-week waiters - trend has moved from special cause of concerning nature to common cause no significant change.

- CAMHS 52-week waiters - trend has moved from common cause no significant change to special cause of concerning nature.
- Safe staffing – number of wards not meeting >80% fill rate for Registered Nurses (Day) has moved to special cause of concerning nature this month - this will be monitored to assess requirement for an exception report should the trend continue.

All other metrics remain unchanged.

The exception report summary and individual exception reports contain analytical and operational commentary covering performance and improvement actions for services demonstrating a special cause concern against an agreed target.

Decision required

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

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 Prakash Patel, Head of Information Anne Senior, Associate Director	
Date submitted:	19.08.25	
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):	This report will be presented to the September Accountability Framework Meeting prior to sharing at Trust Board.	
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	Standard month end report	
CRR/BAF considerations:	List risk number and title of risk	
	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	

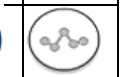
NHS
Leicestershire Partnership
NHS Trust

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%	Jul-25	50.5%	50.2%	F	
Memory Clinic (18 week Local RTT) - Incomplete pathway	>=92%	Jul-25	54.1%	59.2%	F	L
ADHD (18 week local RTT) - Incomplete pathway	>=92%	Jul-25	8.7%	9.4%	F	
CINSS (6 weeks) - Incomplete Pathway	>=95%	Jul-25	36.3%	34.9%	F	L
Speech Therapy - Voice, Respiratory and Dysfluency - Routine (6 weeks) - Incomplete Pathway	>=95%	Jul-25	20.8%	19.3%	F	L
Community Paediatrics (18 weeks) - Incomplete pathway	>=92%	Jul-25	12.0%	13.0%	F	L
Childrens Audiology (6 week wait for diagnostic procedures) - Incomplete pathway	>=99%	Jul-25	25.3%	27.5%	F	
Adult General Psychiatry - Community Mental Health Teams and Outpatients – Treatment waits - No of Waiters	0	Aug-25	49	50	F	
Cognitive Behavioural Therapy - Treatment waits - No of waiters	0	Aug-25	58	60	F	H
Dynamic Psychotherapy - Treatment waits - No of waiters	0	Aug-25	10	13	F	
Therapy Service for People with Personality Disorder - Treatment waits - No of waiters	0	Aug-25	230	266	F	L
Medical/Neuropsychology - Treatment waits - No of Waiters	0	Aug-25	116	95	F	H
ADHD (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	Jul-25	5661	5398	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	Jul-25	8	9	F	L
Community Paediatrics - assessment waits over 52 weeks - No of waiters	0	Jul-25	6022	5858	F	H
Community Paediatrics Treatment (excl ND) - No of waiters	0	Aug-25	44	38	F	L
All Neurodevelopment (inc CAMHS, SALT, PAEDS) - Treatment waits - No of waiters	0	Aug-25	1473	0	F	H
CAMHS - Treatment waits (excl ND) - No of waiters	0	Aug-25	100	80	F	H
All LD - Treatment waits - No of waiters	0	Aug-25	0	0	F	L
Children's SALT Communication & Dysphagia - No of waiters	0	Aug-25	1831	1858	F	H
Children's Physiotherapy - No of waiters	0	Aug-25	20	18	F	H
Adult Eating Disorders Community - Treatment waits - No of waiters	0	Aug-25	6	16	F	
Vacancy Rate	<=10%	Aug-25	10.6%	10.6%	F	L
Sickness Absence	<=5.0%	Jul-25	5.4%	5.2%	?	
Agency Costs	<=£922,333	Aug-25	£820,254	£959,892	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**	**Aug-25**	**0**	**0**		
Clostridium difficile infection rate	**<=12**	**Aug-25**	**1**	**0**		
Normalised Workforce Turnover (Rolling previous 12 months)	**<=10%**	**Aug-25**	**7.2%**	**7.3%**		
Core Mandatory Training Compliance for substantive staff	**>=85%**	**Aug-25**	**98.4%**	**98.1%**		
Staff with a Completed Annual Appraisal	**>=80%**	**Aug-25**	**95.3%**	**94.7%**		
% of staff from a BME background	**>=22.5%**	**Aug-25**	**32.7%**	**32.7%**		
% of staff who have undertaken clinical supervision within the last 3 months	**>=85%**	**Aug-25**	**94.0%**	**95.2%**		

EXCEPTION REPORTS MATRIX SUMMARY

		Assurance		
		Achieving Target 	**Inconsistently Achieving Target** 	**Not Achieving Target** 
Variation/Trend	**Special Cause - Improvement** 	Normalised Workforce Turnover / Core Mandatory Training Compliance for substantive staff / % of staff from a BME background / % staff clinical supervision		*Waiting Times* : TSPPD 52 wks / MHSOP Memory Clinic 52 Wks / Community Paediatrics Treatment 52 Wks / LD 52 Wks Agency Cost / Vacancy Rate
	Common Cause 	MRSA Infection Rate / Clostridium difficile infection rate Staff with a Completed Annual Appraisal		*Waiting Times:* Adult CMHT / ADHD / Children's Audiology / CMHT 52 Wks/ DPS 52 wks / Adult ED Community 52 wks
	Special Cause - Concern 			*Waiting Times:* Stroke & Neuro / Speech Therapy / Memory Clinic / Community Paediatrics / CBT 52 weeks / Medical_Neuro 52 wks / ADHD 52 weeks / Community Paediatrics 52 wks assessment / All Neurodevelopment 52 Wks / CAMHS - Treatment waits / Children's SALT Communication & Dysphagia 52 Wks / Children's Physiotherapy 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%**	**Aug-25**	**7.2%**	**7.3%**		
Vacancy Rate	**<=10%**	**Aug-25**	**10.6%**	**10.6%**		
Sickness Absence (in arrears)	**<=5.0%**	**Jul-25**	**5.4%**	**5.2%**		
Agency Costs	**<=£922,333**	**Aug-25**	**£820,254**	**£959,892**		

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**	**Aug-25**	**4**	**4**		
Safe staffing - No. of wards not meeting >80% fill rate for RNs - Night	**0**	**Aug-25**	**2**	**3**		

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%	Aug-25	100.0%	98.7%				
	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		Aug-25	0.0%	0.0%				
	TRUST	Monthly	The percentage of inpatients discharged with a subsequent inpatient admission within 30 days - 16+ years		Aug-25	5.8%	7.2%				
	TRUST	Monthly	The number of patient safety incidents reported within the Trust during the reporting period		Aug-25	1516	1966				
	TRUST	Monthly	The rate of patient safety incidents reported within the Trust during the reporting period		Aug-25	67.3%	68.5%				
	TRUST	Monthly	The number of such patient safety incidents that resulted in severe harm or death		Aug-25	31	11				
	TRUST	Monthly	The percentage of such patient safety incidents that resulted in severe harm or death		Aug-25	2.0%	0.6%				
	MHSDS	Monthly (a quarter in arrears)	72 hour Follow Up after discharge (Aligned with national published data)	>=80%	Jun-25	91.0%	91.0%				
NHS Oversight	TRUST	Monthly	2-hour urgent response activity	>=70%	Aug-25	83.2%	85.2%				
	TRUST	Monthly	Daily discharges as % of patients who no longer meet the criteria to reside in hospital		Aug-25	28.1%	31.2%				
	TRUST	Monthly	Out of Area Placement - Inappropriate Bed Days	0	Aug-25	365	175				
	ICB	Monthly	Reliance on specialist inpatient care for adults with a learning disability and/or autism		Aug-25	26	29				
	ICB	Monthly	Reliance on specialist inpatient care for children with a learning disability and/or autism		Aug-25	1	1				
		Monthly	Overall CQC rating (provision of high quality care)		2021/22	2					
		Monthly	CQC Well Led Rating		2021/22	2					
		Quarterly	NHS Oversight Framework Segment		Q1	2	2				
	MHRA	Monthly	National Patient Safety Alerts not completed by deadline		Aug-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	Aug-25	0	0				
	TRUST	Monthly	Clostridium difficile infection rate	<=12	Aug-25	1	0				
	UHL	Monthly (In Arrears)	E.coli bloodstream infections		Jul-25	0	1				
	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	<=55.5	Aug-25	58.8	57.0				
	TRUST	Monthly	Average Length of stay - Community Hospitals	<=23.5	Aug-25	24.4	24				
	TRUST	Monthly	Community Care Contacts - CHS	Plan=82337	Aug-25	84292	89968				
	TRUST	Monthly	Community Care Contacts - FYPC	Plan=9334	Aug-25	8979	10220				
	TRUST	Monthly	Community Services Waiting List over 52 weeks	Target =0 Plan=6211	Aug-25	6067	6022				
Access Waiting Times - DMH	TRUST	Monthly (In Arrears)	Adult CMHT Access (6 weeks routine) - Incomplete pathway	>=95%	Jul-25	50.5%	50.2%				
	TRUST	Monthly (In Arrears)	Memory Clinic (18 week Local RTT) - Incomplete pathway	>=92%	Jul-25	54.1%	59.2%				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - Incomplete pathway	>=92%	Jul-25	8.7%	9.4%				
	TRUST	Monthly (In Arrears)	Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral - complete pathway	>=60%	Jul-25	60.0%	69.2%				
Access Waiting Times - CHS	TRUST	Monthly (In Arrears)	CINSS (6 weeks) - Incomplete Pathway	>=95%	Jul-25	36.3%	34.9%				
	TRUST	Monthly (In Arrears)	Speech Therapy - Voice, Respiratory and Dysfluency - Routine (6 weeks) - Incomplete Pathway	>=95%	Jul-25	20.8%	19.3%				
Access Waiting Times - FYPCLDA	TRUST	Monthly (In Arrears)	CAMHS Eating Disorder (one week) - Complete pathway	>=95%	Jul-25	100.0%	100.0%				
	TRUST	Monthly (In Arrears)	CAMHS Eating Disorder (four weeks) - Complete pathway	>=95%	Jul-25	87.5%	80.0%				
	TRUST	Monthly (In Arrears)	Community Paediatrics (18 weeks) - Incomplete pathway	>=92%	Jul-25	12.0%	13.0%				
	TRUST	Monthly (In Arrears)	Childrens Audiology (6 week wait for diagnostic procedures) - Incomplete pathway	>=99%	Jul-25	25.3%	27.5%				

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)		Aug-25	0.0%	2.6%				
	TRUST	Monthly	(5-18yrs) Percent of RHAs sent to LA in month within 12 months of previous assessment (City/County/Rutland)		Aug-25	100.0%	97.3%				
	TRUST	Monthly	(0-4yrs) Percent of RHAs sent to LA in month within 6 months of previous assessment (City/County/Rutland)		Aug-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	Aug-25	49	50				
	TRUST	Monthly	Adult General Psychiatry - Community Mental Health Teams and Outpatients – Treatment waits - Longest Waiter		Aug-25	141	193				
	TRUST	Monthly	Cognitive Behavioural Therapy - Treatment waits - No of waiters	0	Aug-25	58	60				
	TRUST	Monthly	Cognitive Behavioural Therapy- Treatment waits - Longest waiter (weeks)		Aug-25	85	81				
	TRUST	Monthly	Dynamic Psychotherapy - Treatment waits - No of waiters	0	Aug-25	10	13				
	TRUST	Monthly	Dynamic Psychotherapy - Treatment waits - Longest waiter (weeks)		Aug-25	85	81				
	TRUST	Monthly	Therapy Service for People with Personality Disorder - Treatment waits - No of waiters	0	Aug-25	230	266				
	TRUST	Monthly	Therapy Service for People with Personality Disorder - Treatment waits - Longest waiter (weeks)		Aug-25	185	276				
	TRUST	Monthly	Medical/Neuropsychology - Treatment waits - No of Waiters	0	Aug-25	116	95				
	TRUST	Monthly	Medical/Neuropsychology- Treatment waits - Longest Waiter		Aug-25	148	143				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	Jul-25	5661	5398				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - assessment waits over 52 weeks - Longest waiter (weeks)		Jul-25	388	383				
	TRUST	Monthly (In Arrears)	MHSOP Memory Clinics (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	Jul-25	8	9				
	TRUST	Monthly (In Arrears)	MHSOP Memory Clinics (18 week local RTT) - assessment waits over 52 weeks -Longest waiter (weeks)		Jul-25	66	152				

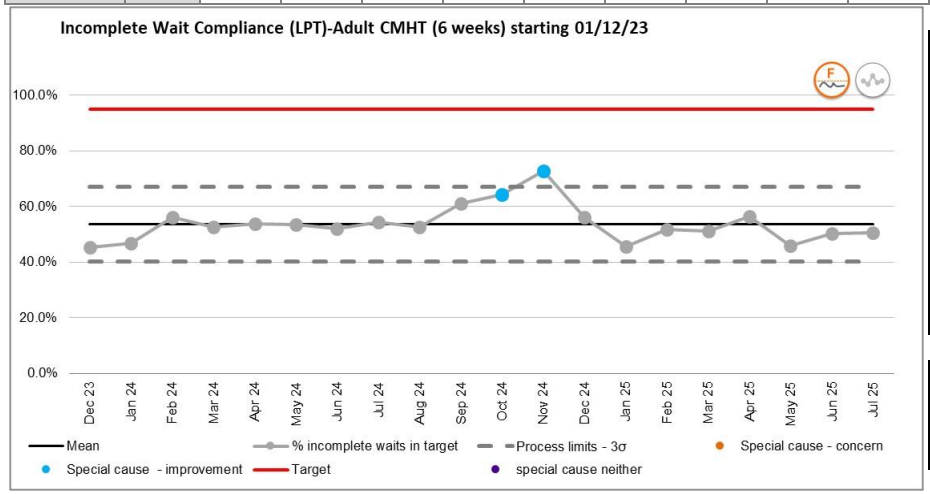
Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
52 Week Waits - FYPCLDA	TRUST	Monthly (In Arrears)	Community Paediatrics - assessment waits over 52 weeks - No of waiters	0	Jul-25	6022	5858				
	TRUST	Monthly (In Arrears)	Community Paediatrics - assessment waits over 52 weeks - Longest waiter (weeks)		Jul-25	185	191				
	TRUST	Monthly	Community Paediatrics Treatment (excl ND) - No of waiters	0	Aug-25	44	38				
	TRUST	Monthly	Community Paediatrics Treatment (excl ND) - Longest waiter		Aug-25	141	136				
	TRUST	Monthly	All Neurodevelopment (inc CAMHS, SALT, PAEDS) - Treatment waits - No of waiters	0	Aug-25	1473	1415				
	TRUST	Monthly	All Neurodevelopment (inc CAMHS, SALT, PAEDS) - Treatment waits - Longest waiter (weeks)		Aug-25	254	250				
	TRUST	Monthly	CAMHS - Treatment waits (excl ND) - No of waiters	0	Aug-25	100	80				
	TRUST	Monthly	CAMHS - Treatment waits (excl ND) - Longest waiter (weeks)		Aug-25	81	77				
	TRUST	Monthly	All LD - Treatment waits - No of waiters	0	Aug-25	0	0				
	TRUST	Monthly	All LD - Treatment waits - Longest waiter (weeks)		Aug-25	51	50				
	TRUST	Monthly	Children's SALT Communication & Dysphagia - No of waiters	0	Aug-25	1831	1858				
	TRUST	Monthly	Children's SALT Communication & Dysphagia - Longest waiter		Aug-25	117	115				
	TRUST	Monthly	Children's Physiotherapy - No of waiters	0	Aug-25	20	18				
	TRUST	Monthly	Children's Physiotherapy - Longest waiter		Aug-25	119	115				
	TRUST	Monthly	Children's Continence - No of waiters	0	Aug-25	0	0				
	TRUST	Monthly	Children's Continence - Longest waiter		Aug-25	25	25				
	TRUST	Monthly	Audiology - No of waiters	0	Aug-25	0	0				
	TRUST	Monthly	Audiology - Longest waiter		Aug-25	42	46				
	TRUST	Monthly	Adult Eating Disorders Community - Treatment waits - No of waiters	0	Aug-25	6	16				
	TRUST	Monthly	Adult Eating Disorders Community - Treatment waits - Longest waiter (weeks)		Aug-25	69	80				

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%	Aug-25	86.1%	85.9%				
	TRUST	Monthly	Occupancy Rate - Community Beds (excluding leave)	>=93%	Aug-25	92.5%	91.7%				
	TRUST	Monthly	Delayed Transfers of Care	<=3.5%	Aug-25	5.7%	4.5%				
	TRUST	Monthly	Gatekeeping	>=95%	Aug-25	100.0%	98.7%				
	TRUST	Monthly	Admissions to adult facilities of patients under 18 years old	0	Aug-25	0	1				
Quality & Safety	TRUST	Monthly	No. of Complaints		Aug-25	20	27				
	TRUST	Monthly	No. of Concerns		Aug-25	34	37				
	TRUST	Monthly	No. of Compliments		Aug-25	169	198				
	TRUST	Monthly	Safe staffing - No. of wards not meeting >80% fill rate for RNs - Day	0	Aug-25	4	4				
	TRUST	Monthly	Safe staffing - No. of wards not meeting >80% fill rate for RNs - Night	0	Aug-25	2	3				
	TRUST	Monthly	Care Hours per patient day		Aug-25	11.5	11.8				
	TRUST	Monthly	No. of Long term Segregations		Aug-25	1	1				
	TRUST	Monthly	No. of episodes of seclusions >2hrs		Aug-25	15	4				
	TRUST	Monthly	No. of episodes of prone (Supported) restraint		Aug-25	0	0				
	TRUST	Monthly	No. of episodes of prone (Unsupported) restraint		Aug-25	0	1				
	TRUST	Monthly	Total number of Restrictive Practices		Aug-25	186	279				
	TRUST	Monthly (In Arrears)	No. of Category 2 pressure ulcers developed or deteriorated in LPT care		Jul-25	124	137				
	TRUST	Monthly (In Arrears)	No. of Category 3 pressure ulcers developed or deteriorated in LPT care		Jul-25	14	13				
	TRUST	Monthly (In Arrears)	No. of Category 4 pressure ulcers developed or deteriorated in LPT care		Jul-25	12	8				
	TRUST	Monthly (In Arrears)	No. of repeat falls		Jul-25	62	42				

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		Aug-25	88	85				
	TRUST	Monthly	LD Annual Health Checks completed - YTD		Aug-25	25.6%	21.2%				
	TRUST	Monthly	LeDeR Reviews completed within timeframe - Allocated		Aug-25	7	2				
	TRUST	Monthly	LeDeR Reviews completed within timeframe - Awaiting Allocation		Aug-25	13	5				
	TRUST	Monthly	LeDeR Reviews completed within timeframe - On Hold		Aug-25	8	6				
HR Workforce	TRUST	Monthly	Normalised Workforce Turnover (Rolling previous 12 months)	<=10%	Aug-25	7.2%	7.3%				
	TRUST	Monthly	Vacancy Rate	<=10%	Aug-25	10.6%	10.6%				
	TRUST	Monthly (In Arrears)	Sickness Absence	<=5.0%	Jul-25	5.4%	5.2%				
	TRUST	Monthly (In Arrears)	Sickness Absence Costs		Jul-25	£1,095,517	£1,062,162				
	TRUST	Monthly (In Arrears)	Sickness Absence - YTD	<=5.0%	Jul-25	5.1%	5.1%				
	TRUST	Monthly	Agency Costs	<=£922,333	Aug-25	£820,254	£959,892				
	TRUST	Monthly	Core Mandatory Training Compliance for substantive staff	>=85%	Aug-25	98.4%	98.1%				
	TRUST	Monthly	Staff with a Completed Annual Appraisal	>=80%	Aug-25	95.3%	94.7%				
	TRUST	Monthly	% of staff from a BME background	>=22.5%	Aug-25	32.7%	32.7%				
	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%	Aug-25	94.0%	95.2%				

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

DMH	Target	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
	>=95%	52.6%	61.2%	64.4%	72.8%	56.1%	45.6%	51.7%	51.1%	56.4%	45.9%	50.2%	50.5%
No of Referrals		226	198	342	442	319	251	310	338	413	348	314	448



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
53.6%	40.0%	67.0%

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 specialist teams connecting with all Neighbourhood teams. Expected outcome is that patients will have timely access most appropriate service(s) to meet their needs, patient experience and service efficiency – ongoing

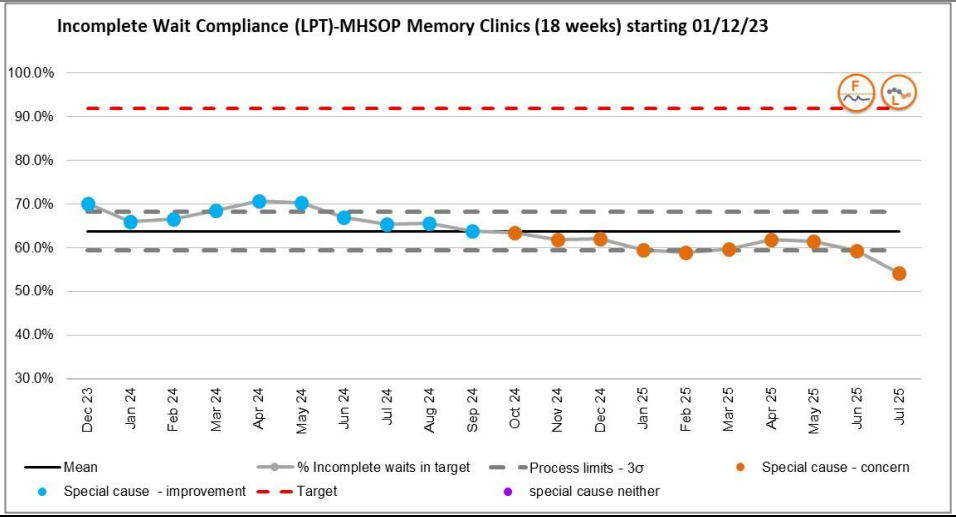
Weekend clinics commenced 19/07/25 to support clearing CAP backlog of routine referrals. Going forward routine referrals will be sent directly to MDT Front Door as business as usual. At the time of this report, daily CAP referrals sent to Charnwood, Melton and Hinckley teams with other teams to follow.

Work continues to progress caseloads review programme. Medical workforce transformation plan workstreams will review caseload and patient cohorts in outpatient clinics with the expected outcome of reduced consultant caseloads, bringing these within agreed thresholds, and supporting increased retention of medical staff and improved patient flow. Caseload reviews commencing in City East starting from the longest overdue recall patient. This long term target has a completion date of April 2026.
Work is underway to ensure appropriate clinical pathways for patients identified as on Clozapine or require a depot to ensure timely access to treatment. This is being led by the Head of Nursing with a timescale extended until the end of September 2025 to enable specialist point of care testing equipment to be purchased.

Continued recruitment to Consultant posts to increase capacity, to date 3 substantive consultants have been appointed with 2 commencing in August.

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

DMH	Target	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
	>=92%	65.5%	63.9%	63.4%	61.9%	62.1%	59.4%	58.9%	59.7%	61.9%	61.5%	59.2%	54.1%
No of Referrals		171	186	239	191	197	184	196	253	218	207	240	184



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
63.8%	59.0%	68.0%

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

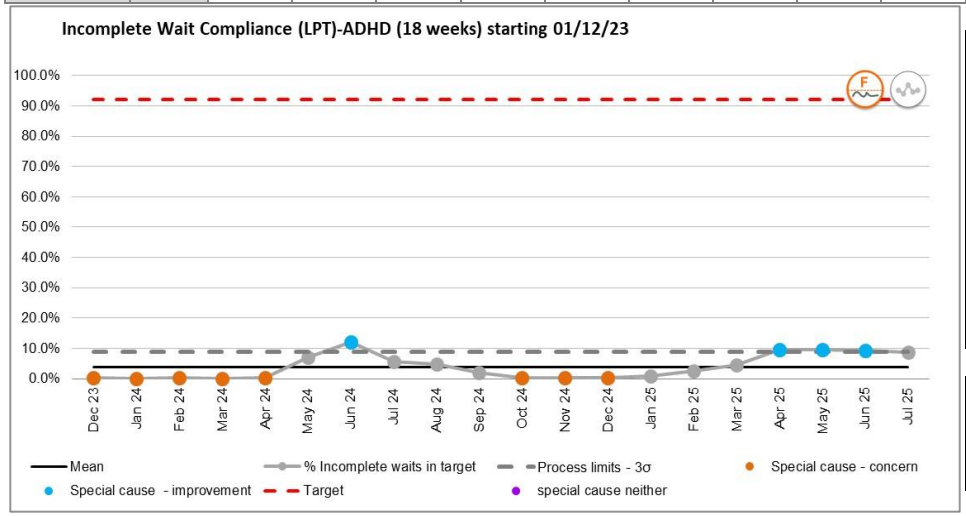
Implementation of rapid access clinics going well, with noted improvement in numbers waiting and length of wait where patients are seen and diagnosed in rapid access clinics.

Work underway to review capacity and demand in rapid access clinics in absence of weekend assessment slots in 2025/26. Team Lead/Manager has fedback that clinical team are fully engaged, morale is high, and this has had a postive impact on productivity and flow.

Work underway to triage waiting list and identify those for advanced dementia pathway, enabling a shortened assessment and more timely diagnosis. Proposal presented to Finance, Planning and Performance meeitng and approved at DMT 09/07/25. Community Manager and Matron to action from September 2025.

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

DMH	Target	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
	>=92%	4.9%	2.0%	0.2%	0.4%	0.3%	0.9%	2.5%	4.5%	9.5%	9.6%	9.4%	8.7%
No of Referrals		334	328	391	329	258	314	292	311	247	216	268	266



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
3.9%	-1.0%	9.0%

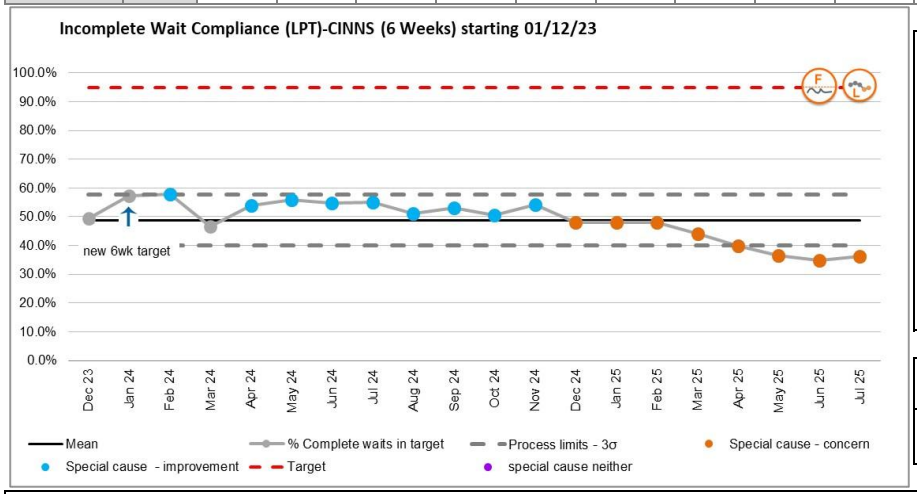
Operational Commentary (e.g. referring to risk, finance, workforce)

Following the ICB and EMB agreement to commence work to develop a more efficient pathway with shorter waits for assessment and treatment, ensuring patients are signposted to the most appropriate service to meet their needs. A new group has been established co-chaired by DMH Exec Director and ICB Associate Director to oversee workstreams to take forward Adult ADHD pathway transformation. This includes increasing productivity (reviewing other service models), development and implementation of Right to Choose framework for LPT, devising training packages for GPs and LPT staff and become an accredited provider of ADHD training in the East Midlands, and 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 back into stock although some shortages likely to continue until October 2025. Ongoing monitoring of the medication supply in place with no current concerns.

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

CHS	Target	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
	>=95%	51.1%	53.1%	50.5%	54.1%	48.0%	48.1%	47.9%	44.0%	39.9%	36.6%	34.9%	36.3%
No of Referrals		216	219	209	203	170	222	174	210	203	219	180	189



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
48.8%	40.0%	58.0%

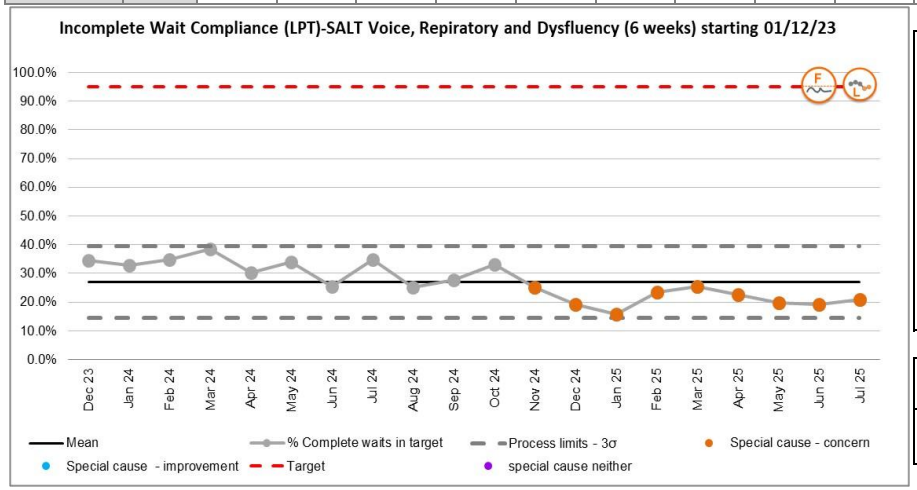
Operational Commentary (e.g. referring to risk, finance, workforce)

Key actions:
1. Individualised job plans have been rolled out to all staff
2. Senior oversight at every PTL and PTL efficiencies and process improvements have been made to maximise available slots
3. Waiting list trajectory completed with best, likely and worst case scenarios (likely case takes account of current long term sickness, maternity, vacancies and transformation actions)

Next steps:
4. Embed new internal referral process within the service
5. Monitoring new patients and clinical contacts by staff member following new job plans
6. OT Memory Group to commence in October 2025
7. Trajectories for waiting times compliance and clinical contacts

EXCEPTION REPORT - Speech Therapy - Voice, Respiratory and Dysfluency - Routine (6 weeks) - Incomplete pathway *(Month in arrears)*

CHS	Target	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
	>=95%	25.3%	27.7%	33.0%	25.1%	19.2%	15.7%	23.4%	25.4%	22.6%	19.7%	19.3%	20.8%
No of Referrals		74	79	120	83	67	68	78	100	72	73	58	63



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.

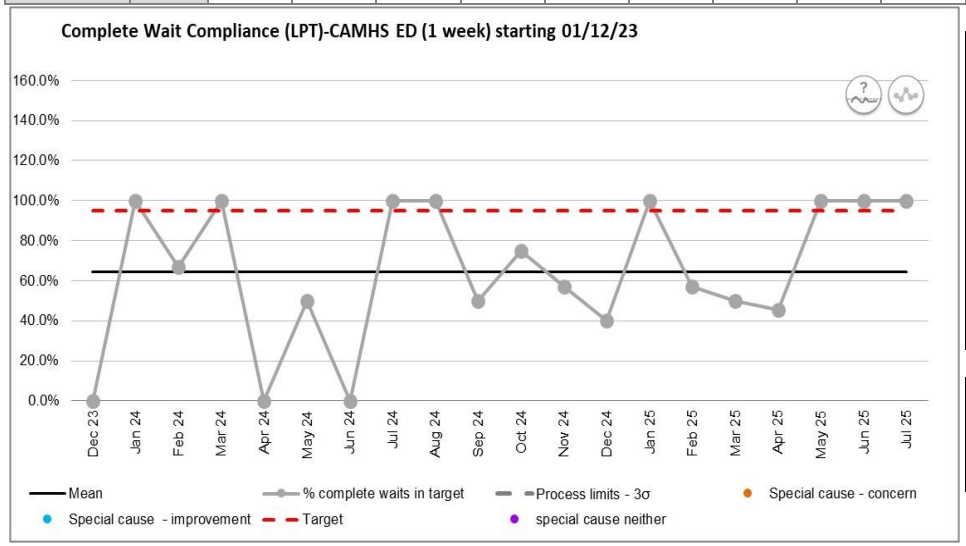
Mean	Lower Process Limit	Upper Process Limit
27.1%	15.0%	40.0%

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

- Voice lead clinician started in post on 18th August
- Additional bank B6 in post to undertake initial assessments only
- Cough group extended to include County patients with good uptake
- Scoping further group work opportunities to increase efficiency and productivity.
- Validation of waiting list with opt in letters sent where clinically appropriate
- PTL process changes to strengthen waiting list management

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

FYPCLDA	Target	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
	>=95%	100.0%	50.0%	75.0%	57.1%	40.0%	100.0%	57.1%	50.0%	45.5%	100.0%	100.0%	100.0%
No of Referrals		2	3	11	6	4	5	5	8	8	2	2	3



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.

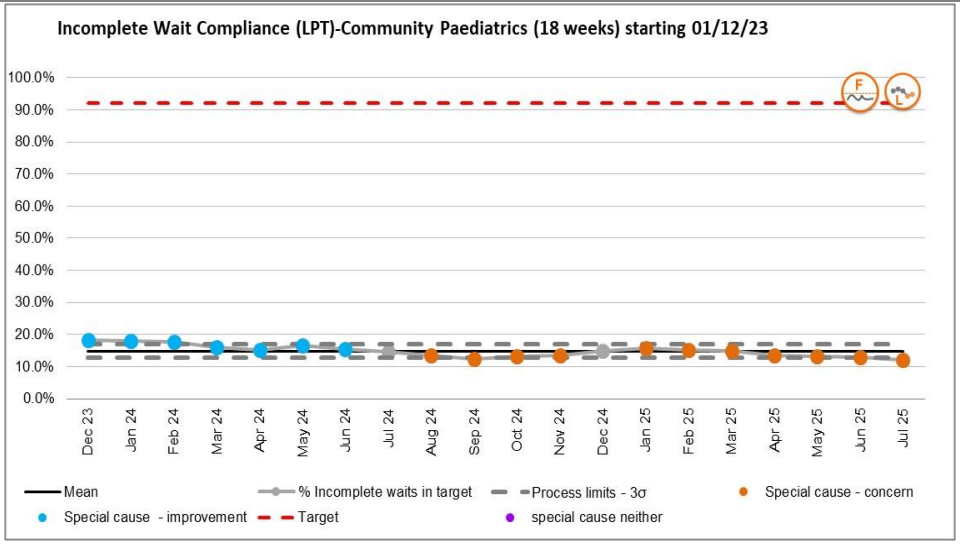
Mean	Lower Process Limit	Upper Process Limit
64.6%	-40.0%	169.0%

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

A recovery plan in place and continues to maintain KPI at 100%.

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

FYPCLDA	Target	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
	>=92%	13.4%	12.5%	13.2%	13.4%	14.8%	15.6%	15.2%	15.0%	13.6%	13.2%	13.0%	12.0%
No of Referrals		150	262	334	325	300	366	318	345	271	269	286	290



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.

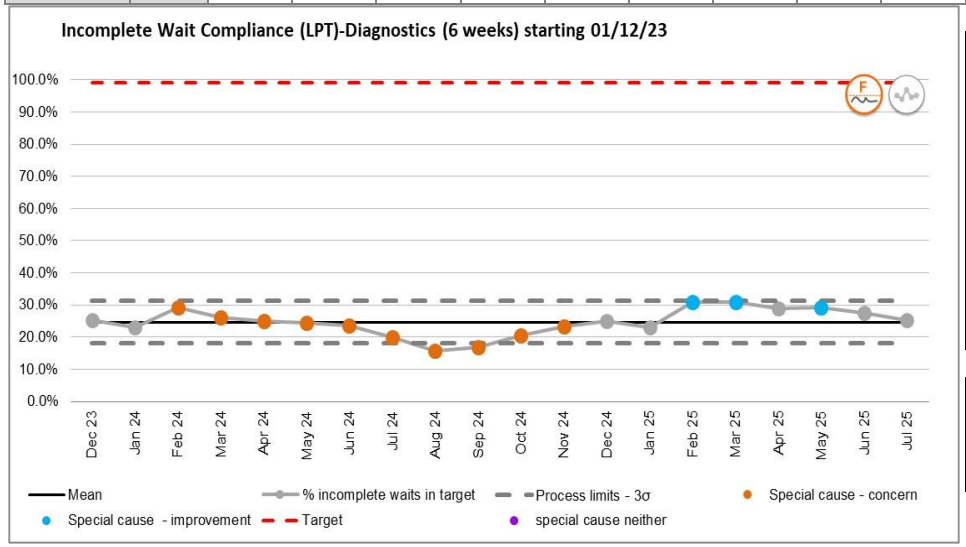
Mean	Lower Process Limit	Upper Process Limit
14.8%	13.0%	17.0%

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

This is a multidisciplinary pathway (with a multi-referral point for access) and is directly impacted by ND waits. Triage system in place based on clinical acuity and safe caseload management. ND precommitment monies enabled additional clinicans to be on boarded to support increased activity and flow. Majority of CYP waiting are for neurodevelopmental assessment (narrative shared and agreed with the ICB with onward flow to NHSE), the service continues to prioritise referrals at triage as urgent or routine with urgent patients offered appointments within 18 weeks. Webinars on initial findings of benchmarking attended, awaiting national steer of expectations. SBARs shared with CYP Partnership Group as agreed and actions identified as a System to take forward. Trajectory for return to 18 week treatment wait for Core services finalised and shared with ICB and NHSE - positively received. Recovery date of Feb 2026.

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

FYPCLDA	Target	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
	>=99%	15.7%	16.9%	20.4%	23.3%	24.9%	23.0%	31.0%	30.8%	29.0%	29.2%	27.5%	25.3%
No of Referrals		265	265	354	332	282	333	302	310	310	293	243	206



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.

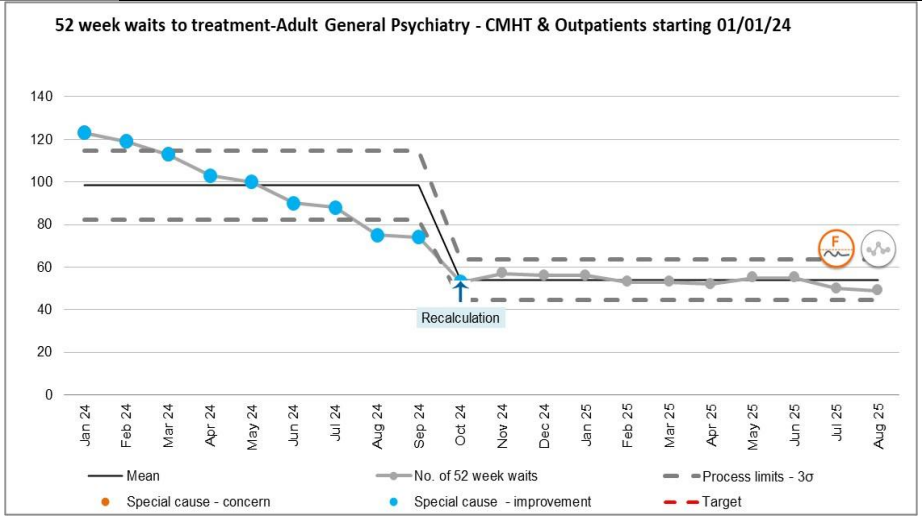
Mean	Lower Process Limit	Upper Process Limit
24.7%	18.0%	31.0%

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

The service remains fragile - formally added as a fragile service through EMB SBAR process. System level assurance and governance group remains active, conversations ongoing and progressing around future direction of service provision. Strategy and Partnerships now supporting the meeting. Next step to share System approach with LPT Exec for agreement to progress. Waiting list validation ongoing with a focus on mitigation lists. Service currently has no over 52 week waiters and priority given to patients with longest waits to maintain this position. Non-compliant with planned trajectory with narrative provided to ICB / NHSE to explain variance, as well as resubmission of trajectory (with no change to milestones). Planned milestones met at refurbished estate at Beaumont Leys and plans progressing for refurbishment at Hynca Lodge - appointments booked into new estate to commence usage from September. 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 until Jan 2026, as well as agreement for spend on bank agency to deliver joint UHL Super Sundays (being finalised). IQIPS benchmarking assessment completed and submitted on time with site visits scheduled for week commencing 22nd Sept.

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

	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
DMH	0	75	74	53	57	56	53	53	52	55	55	50	49



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
54	44.6	63.4

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.

Waiting list for each team 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

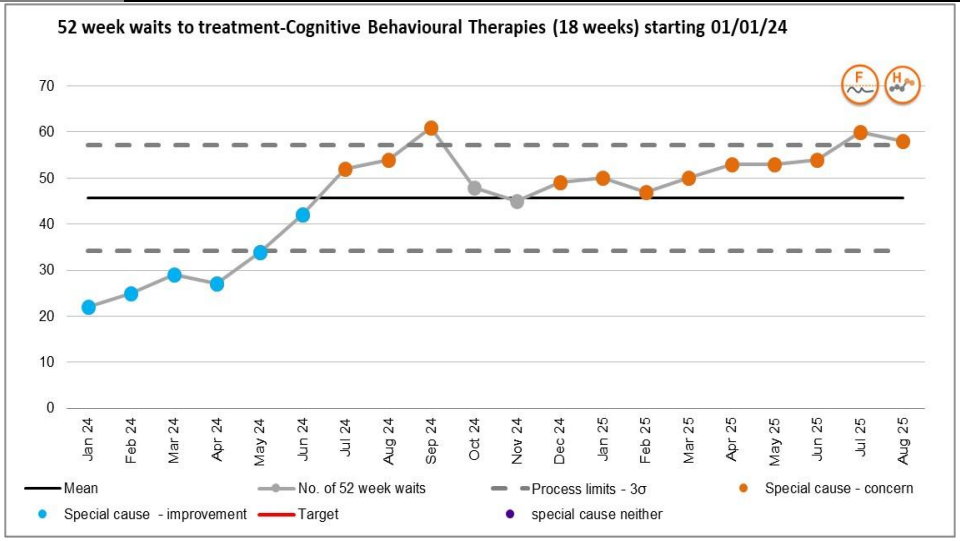
The longest waits for outpatient appointments are due to limitations in medical capacity.

Substantive recruitment to Consultant posts progressing. Expected outcome is increased capacity and improved consistency of care for patients. To date 3 new substantive community consultants have been recruited too. Further work on recruitment continues to progress.

Work continues to progress 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	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
DMH	0	61	48	45	49	50	47	50	53	53	54	60	58



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
45.7	34.2	57.1

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

The CBT service continues to reduction in DNAs for assessment appointments as a service priority, this requires collaborative wortk with 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 with the aim of improving productivity and efficiency.

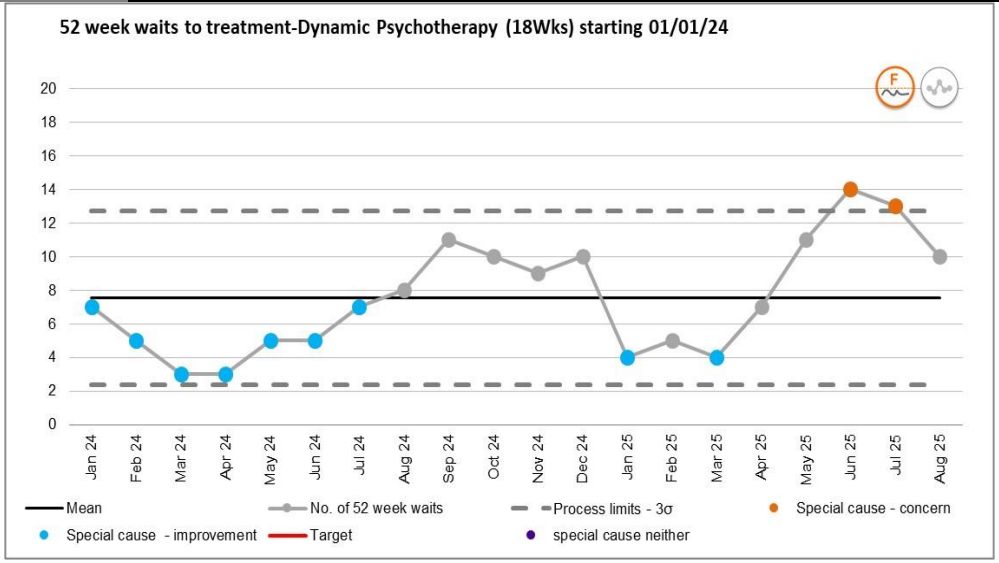
CBT has representation at all neighbourhood mental health team's psychological consulter meetings and contributes to clinical discussions on formulation and psychological interventions. Aim is to reduce referrals of people not ready or able to be helped by a CBT intervention.

Above work has supported a reduction in average wait times for treatment from 75 weeks in May 2025 to 58.6 weeks in June 2025 and 48.5 weeks in August.

There are 141 patients on CBT treatment waiting list, the total number of people waiting for treatment has increased since April 2025; numbers waiting longer than 52 weeks increased during July, however, the service remains ahead of the 52-week trajectory for August.

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

	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
DMH	0	11	10	9	10	4	5	4	7	11	14	13	10



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
7.6	2.37	12.73

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

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), most now have start dates for treatment.

The MBTi patients 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 an extra MBTi group to accommodate increase in people waiting, two of these groups will start in September. The team will also offer individual MBTi as an exception to those unable to attend groups.

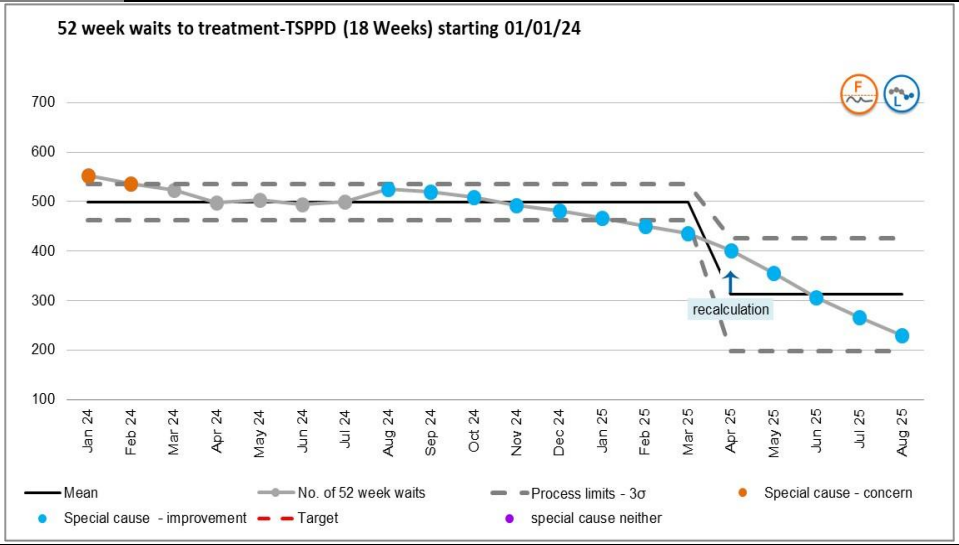
Planning to start a new analytic group which will increase capacity. Action due to be completed end of September 2025.

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

Working on approaches to ensure patients are made aware at assessment that appointment offers are limited and specifc times etc. cannot be guaranteed.

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

	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
DMH	0	520	509	492	481	467	451	435	401	355	307	266	230



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
311.8	198.1	425.5

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

Development of consultation and training support to enhance the primary care offer in place albeit at a small scale. 2 x 8a Psychologist expected in post October 2025 with the expected outcome to provide support to primary care and prevent referrals for low level support entering secondary care services.

All TSPPD referrals to come through Neighbourhood Teams via agreed directorate wide secondary care referral criteria. Business as usual will be provided by the Mental Health Neighbourhood Teams during the transition period. Continue TSPPD
Specialist Consulter weekly meeting to manage TSPPD referrals. MHCAP now attending. Linking with neighbourhood teams to work on referrals coming through front door to support earlier intervention.

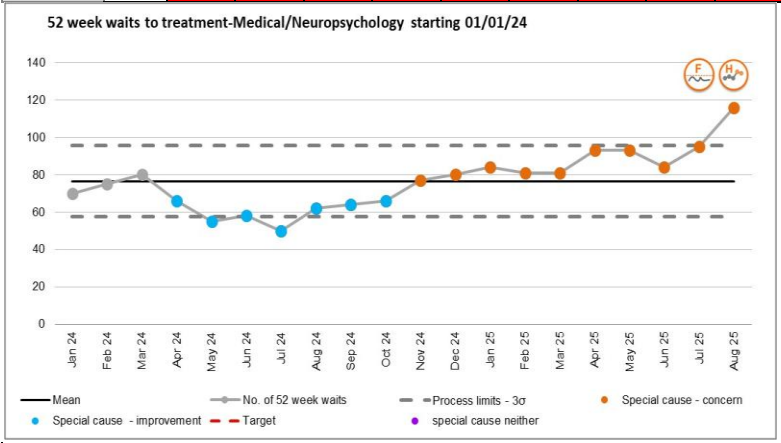
Agree and implement a clinical model for the current TSPPD waiting list and governance processes to work through waiting list before transforming provision. Finalise operational planning for clearance of waiting list and monitor implementation through weekly task and finish group

Neighbourhood Team clinical model to be tailored to better meet the needs of people with personality difficulties. Part of IN2 and reporting through project structure.

Establish 'Personality Disorder Hub, including full implementation of SCM. Development contingent on current waiting list being cleared.
Continue SCM supervision groups for clinical leads to allow clinical leadership of SCM, begin definition of MBT Hub criteria.
Supporting implementation of new MBT-I programme and enhanced formulation through clinical supervision/support

EXCEPTION REPORT - Medical/Neuropsychology (treatment) - No of waiters over 52 weeks

	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
DMH	0	64	66	77	80	84	81	81	93	93	84	95	116



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
76.5	57.5	95.5

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

Medical Psychology

Despite updated capacity and demand summary no UHL funding available for extra staffing to meet demand. Continue to be long waits for general medical(approx. 52 weeks) and pain psychology (about 104 weeks). There are no lenghty waits for assessment or treatment within specialisms with dedicated funding however high demand in the renal service risks growing waits going forward.

To manage waits in pain a proposal was presented to UHL for discussion. This proposed new referrals are offered only group intervention or signposting at present. This is being considered with a review meeting planned for early October. In the interim the number of one-to-one sessions per patient is capped with patients encouraged to attend a group or are signposted to other services where appropriate.

For general medical referrals, as well as capping number of sessions offered we are trialling a waiting list review, which will be offered to all patients on the list (aiming for this to be offered after 6 months on the list in the long term) ensuring remaining on the list is appropriate and consider alternative opitons.

Working towards filling vacancies in pain and general medical, with cover for maternity leave through bank psychologists where possible.

Neuropsychology 52 weeks

No patients waiting longer than 52 weeks. Current longest wait Feb 2025. Trajectory for waiting list to reduce to approx 6 months by year end.

Additional 8b role has commenced and this has reduced the waiting time.

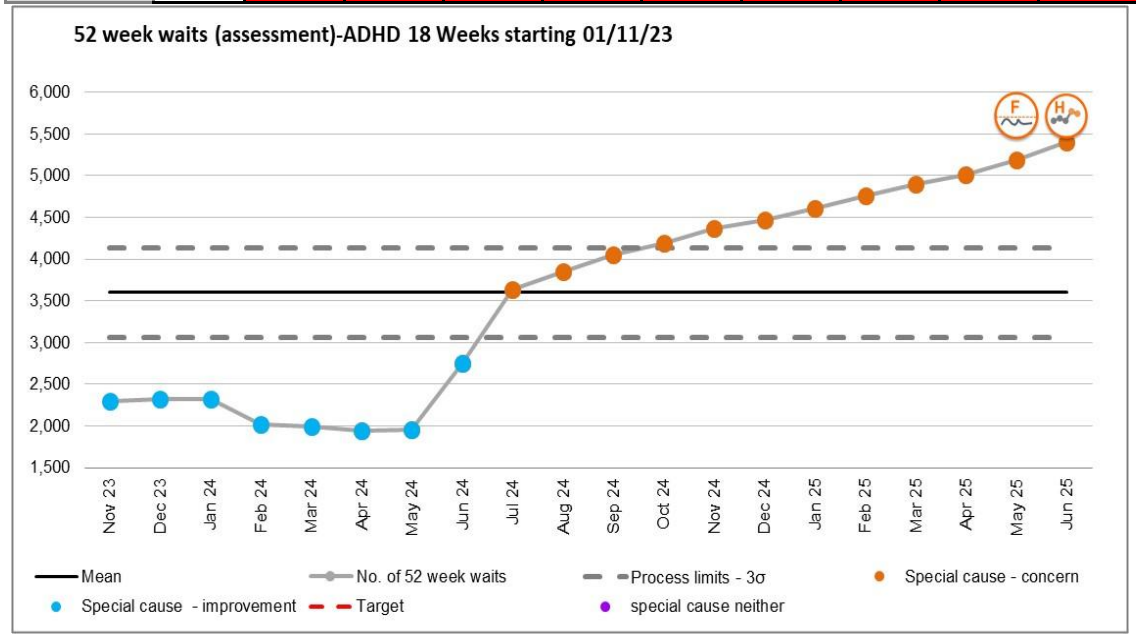
Assistant Psychologist providing telephone triage to support waiting list validation, contact is being made with those on the waiting list for over 6 months to ensure treatment remains relevant. Ensuring the waiting list is an accurate illustration of those who still wish to access the service, reducing DNAs and cancellations. The Assistant Psychologist supporting this work left post in August and post has been re-recruited to with new postholder due to start in Nov 2025.

Repeat assessments to be offered by Assistant Psychologists if clinically suitable to reduce the need for qualified appointments from 2 to 1. The Assistant Psychologist who was supporting this work left post in August and post has been re-recruited to with new postholder due to start in Nov 2025.

Joint Medical Psychology and Neuropsychology Action - Monthly complex case discussions with NHS Talking Therapies (VITA Minds) to facilitate and support people to be seen in the

EXCEPTION REPORT - ADHD 18 weeks (assessment) - No of waiters over 52 weeks *(Month in arrears)*

	Target	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
DMH	0	3851	4051	4193	4372	4467	4607	4757	4898	5014	5190	5398	5661



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
3769.5	3197.0	4341.9

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

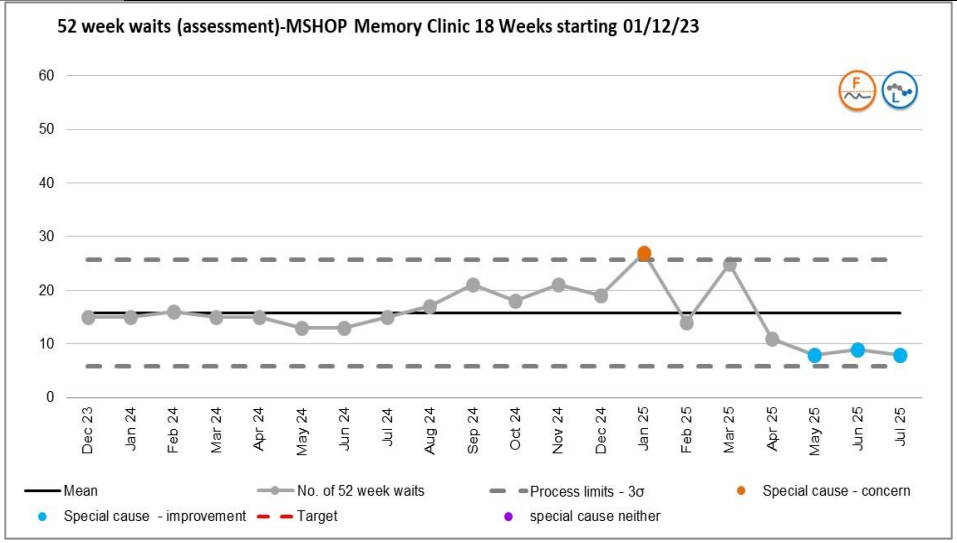
Following the ICB and EMB agreement to commence work to develop a more efficient pathway with shorter waits for assessment and treatment, ensuring patients are signposted to the most appropriate service to meet their needs. A new group has been established co-chaired by DMH Exec Director and ICB Associate Director to oversee workstreams to take forward Adult ADHD pathway transformation. This includes increasing productivity (reviewing other service models), development and implementation of Right to Choose framework for LPT, devising training packages for GPs and LPT staff and become an accredited provider of ADHD training in the East Midlands, and 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 back into stock although some shortages likely to continue until October 2025. Ongoing monitoring of the medication supply in place with no current concerns.

EXCEPTION REPORT - MHSOP Memory Clinics 18 week local RTT (assessment) - No of waiters over 52 weeks

(Month in arrears)

	Target	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
DMH	0	17	21	18	21	19	27	14	25	11	8	9	8



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
15.8	5.8	25.7

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

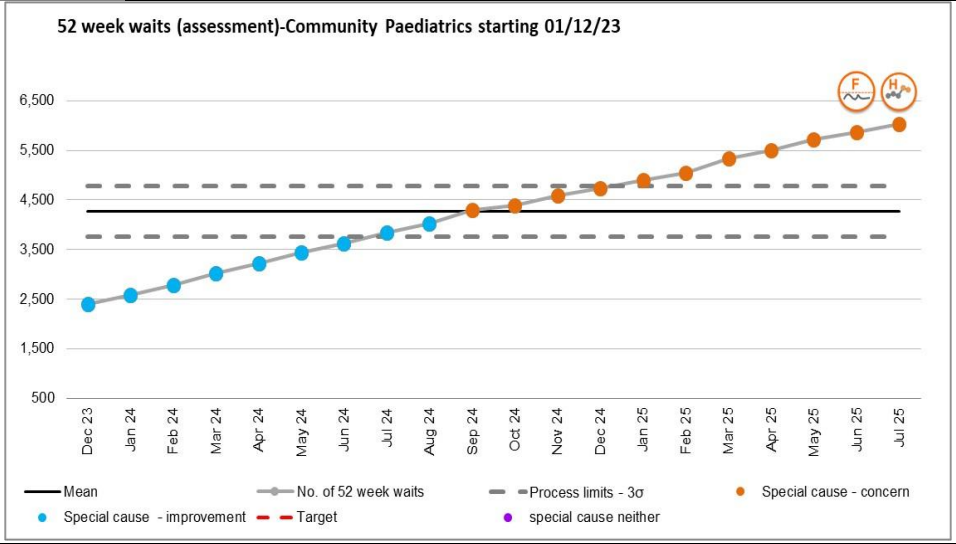
Implementation of rapid access clinics going well, with noted improvement in numbers waiting and length of wait where patients are seen and diagnosed in rapid access clinics.

Work underway to review capacity and demand in rapid access clinics in absence of weekend assessment slots in 2025/26. Team Lead/Manager has fedback that clinical team are fully engaged, morale is high, and this has had a postive impact on productivity and flow.

Work underway to triage waiting list and identify those for advanced dementia pathway, enabling a shortened assessment and more timely diagnosis. Proposal presented to Finance, Planning and Performance meeitng and approved at DMT 09/07/25. Community Manager and Matron to action from September 2025.

EXCEPTION REPORT - Community Paediatrics (assessment) - No of waiters over 52 weeks *(Month in arrears)*

	Target	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
FYPCLDA	0	4017	4303	4392	4586	4740	4895	5044	5335	5509	5723	5858	6022



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.

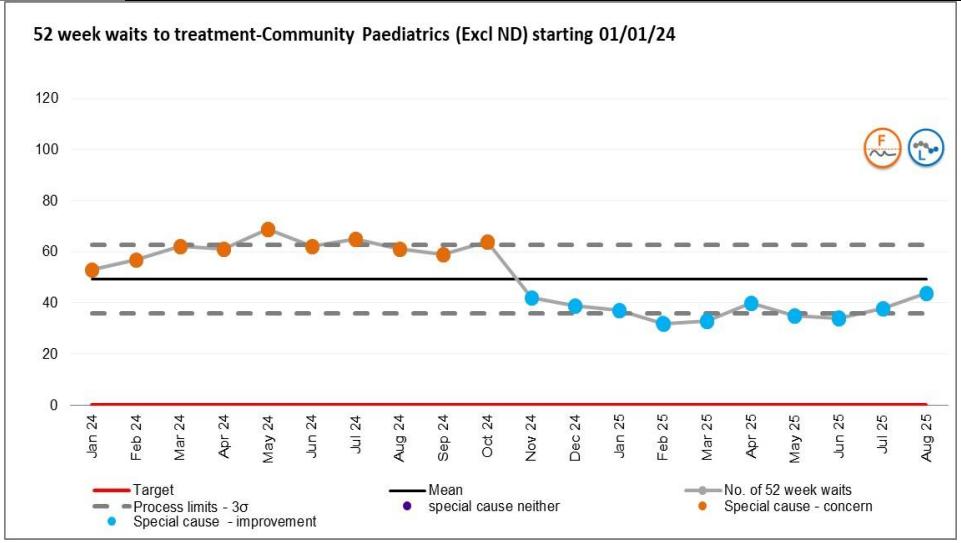
Mean	Lower Process Limit	Upper Process Limit
4265.2	3757.51	4772.79

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

Patients waiting in excess of 52 weeks are all waiting for an ND intervention. 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. Investment 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. A targeted transformation workstream is reporting through Transformation and Quality Improvement Group. Programme management support identified with new acting up Head of Transformation and Business Development. Core waits trajectory agreed with ICB/NHSE to ensure no over 52 week waits for this patient cohort.

EXCEPTION REPORT - Community Paediatrics (Excl ND) (treatment) - No of waiters over 52 weeks

	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
FYPCLDA	0	59	64	42	39	37	32	33	40	35	34	38	44



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.

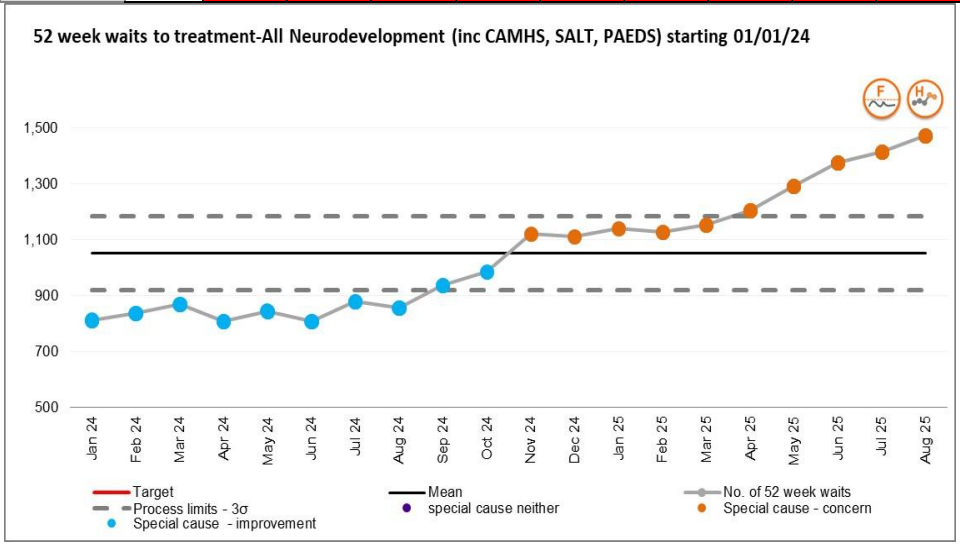
Mean	Lower Process Limit	Upper Process Limit
49.4	36.1	62.7

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

Patients are intertwined with some ND related concerns (SALT, EP, School Observations, etc) and work continues to be able to fully differentiate. 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	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
FYPCLDA	0	937	985	1121	1113	1140	1128	1155	1205	1294	1378	1415	1473



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.

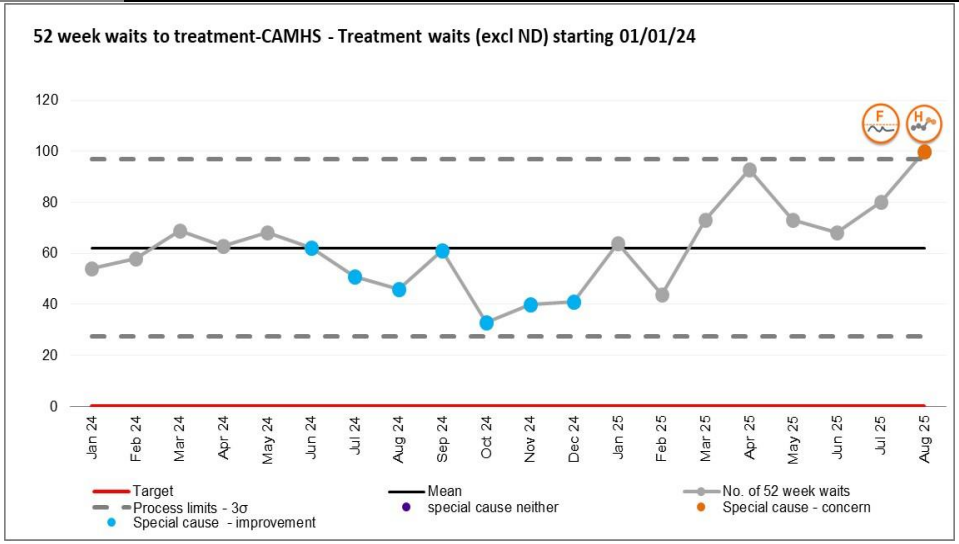
Mean	Lower Process Limit	Upper Process Limit
1052.7	920.4	1185.0

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 the PTL focuses 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. ND waits will be discussed as part of the Trust-wide work on the access policy, with focus on longest waiters to give assurance that all policies are being applied robustly.

EXCEPTION REPORT - CAMHS (excl ND)(treatment) - No of waiters over 52 weeks

	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
FYPCLDA	0	61	33	40	41	64	44	73	93	73	68	80	100



Analytical Commentary

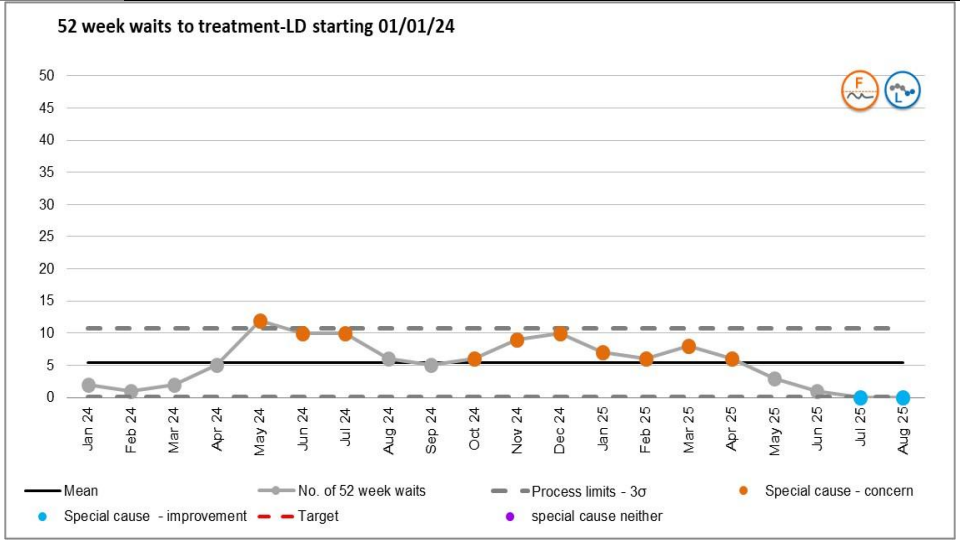
The metric is showing a common cause variation with no significant change. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

Mean	Lower Process Limit	Upper Process Limit
62.1	27.3	96.8

Operational Commentary (e.g. referring to risk, finance, workforce): **There are currently 100 CYP waiting over 52 weeks for treatment in CAMHS, an increase of 20 CYP. The service has a weekly meeting to review those waiting in addition to the PTL.**
56 CYP in Outpatient - 32 awaiting treatment and 24 awaiting Psychiatric opinion.
1 CYP for Paediatric Psychology for treatment and has now been taken on for treatment.
1 CYP for Young Peoples Team and has now has a future appointment.
There are 42 waiters for groupwork which is a increase of 17 since last month. All of these CYP waiting over 12 months have been reviewed, have a clear plan in notes, and appointments offered to start group.

EXCEPTION REPORT - LD&A (treatment) - No of waiters over 52 weeks

	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
FYPCLDA	0	6	9	10	7	6	8	6	3	1	0	0	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.

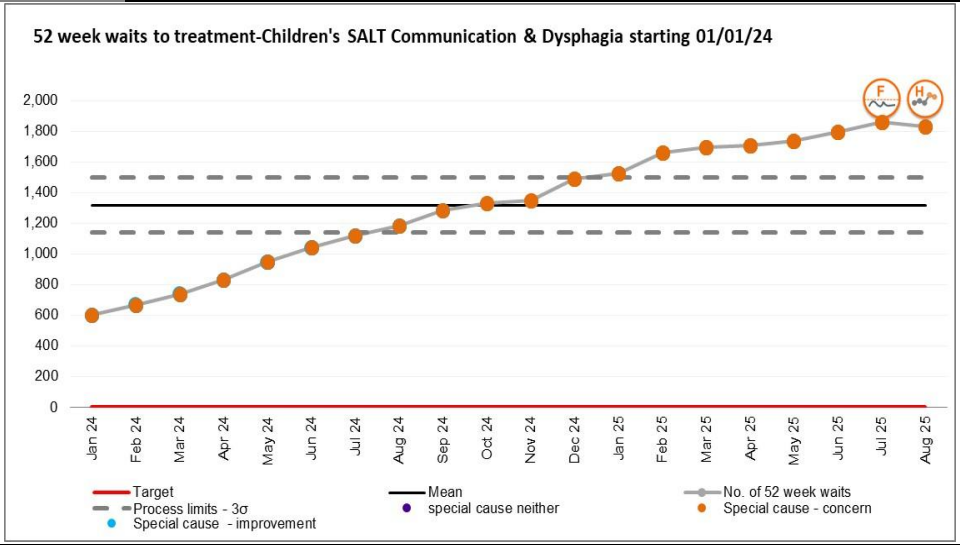
Mean	Lower Process Limit	Upper Process Limit
5.5	0.1	10.8

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

Zero 52 week waits maintained for third month. Ongoing close work on waiters over 40 weeks to ensured maintained position.

EXCEPTION REPORT - Children's SALT Communication & Dysphagia (treatment) - No of waiters over 52 weeks

	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
FYPCLDA	0	1284	1328	1346	1489	1524	1661	1692	1704	1734	1794	1858	1831



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.

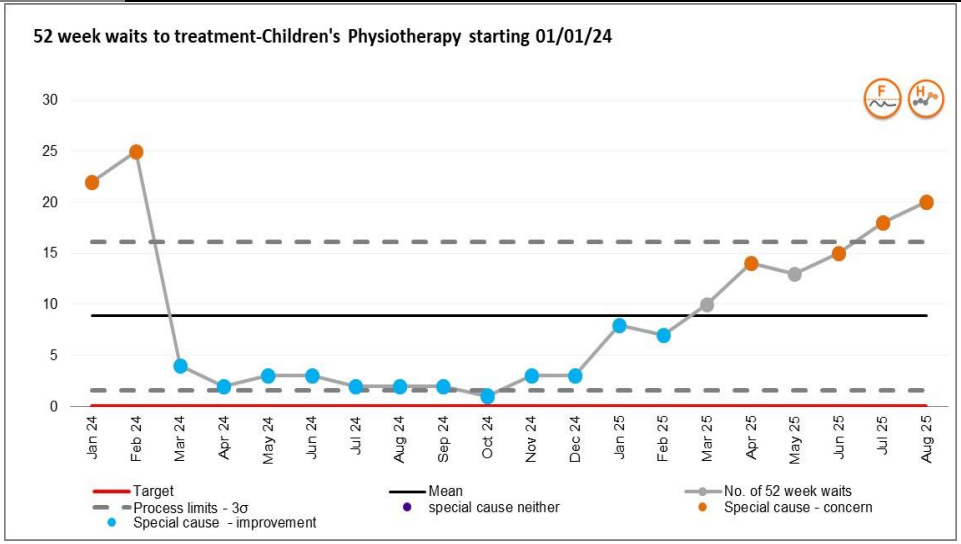
Mean	Lower Process Limit	Upper Process Limit
1318.2	1138.16	1498.24

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

Updated service specification and referral guidelines launched to reinforce specialist nature of Speech and Language Therapy Service and support referrals to be made to the most appropriate agency where this is not secondary care.
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 in place.
Robust digital offer in place 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 will support capacity and productivity .
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.

EXCEPTION REPORT - Children's Physiotherapy (treatment)- No of waiters over 52 weeks

	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
FYPCLDA	0	2	1	3	3	8	7	10	14	13	15	18	20



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
8.9	1.6	16.1

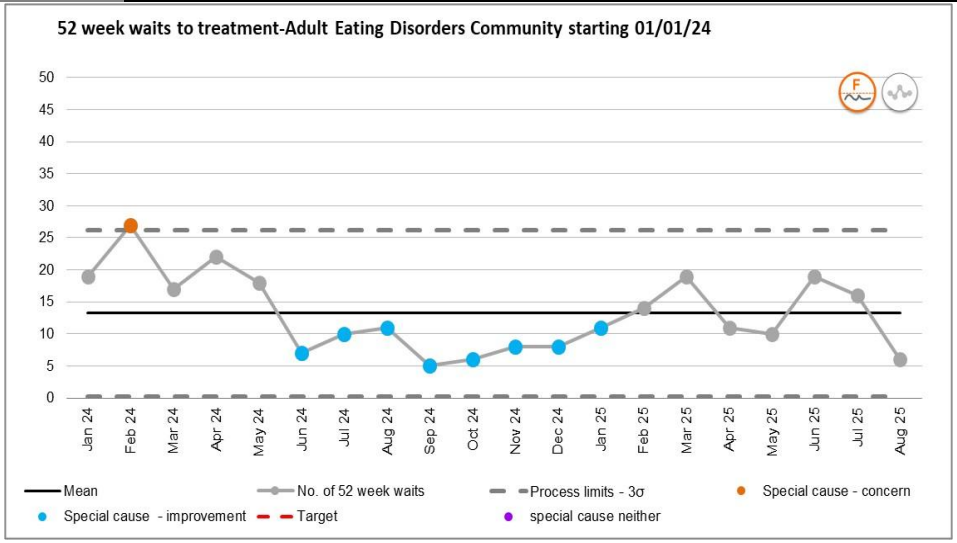
Operational Commentary (e.g. referring to risk, finance, workforce): 20 CYPs

waiting over 52 weeks: 19 CYPs are waiting for a joint tone management appointment. Awaiting capacity from Comm Paeds team. Quality Improvement Project commenced to support options for long term intervention for these CYP

1 CYP is on the physical disability monitoring clinic waiting list. CYP cancelled appointment in March 2025, was not brought to appointment on 17th June 2025. She has an appointment on 16th September 2025. Low risk case and potential discharge after next review

EXCEPTION REPORT - Adult Eating Disorders Community (treatment) - No of waiters over 52 weeks

	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
FYPCLDA	0	5	6	8	8	11	14	19	11	10	19	16	6



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.

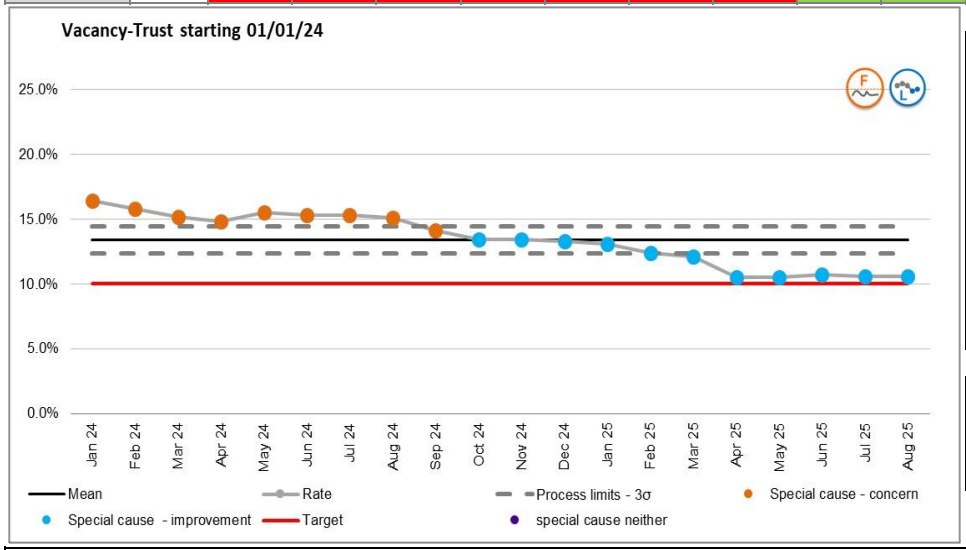
Mean	Lower Process Limit	Upper Process Limit
13.2	0.18	26.22

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

Significant reduction in over 52 week waits from 16 to 6 of which one is a DQ issue and will be addressed. A new group intervention is being trialed, starting Sept 9th, with a number of long waiters allocated to this group. Robust application of the Access Policy is in place e.g. those who have had 2 or more reasonable offers have been advised they will be discharged if they do not attend. All patients are now offered My Guidance as at first stage of support / information giving. Those not taking this offer up are reviewed by assessors and may be discharged where safe to do so. Some patients under 25 have been offered transfer to First Steps (VCSE) who are commissioned to provide interventions to this age group but have declined this option and future options for these patients will be considered.

EXCEPTION REPORT - Vacancy Rate

	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
TRUST	<=10%	14.1%	13.4%	13.4%	13.3%	13.1%	12.4%	12.1%	10.5%	10.5%	10.7%	10.6%	10.6%
DMH		17.2%	16.4%	15.9%	15.7%	16.4%	15.5%	14.9%	13.2%	13.4%	13.8%	12.3%	12.4%
CHS		15.4%	14.1%	13.4%	13.1%	12.9%	12.4%	12.8%	11.0%	10.2%	9.7%	10.0%	10.1%
FYPCLDA		13.3%	13.0%	13.9%	14.2%	12.7%	11.9%	11.3%	9.0%	9.0%	9.9%	10.6%	10.0%



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
31.4%	12.0%	14.0%

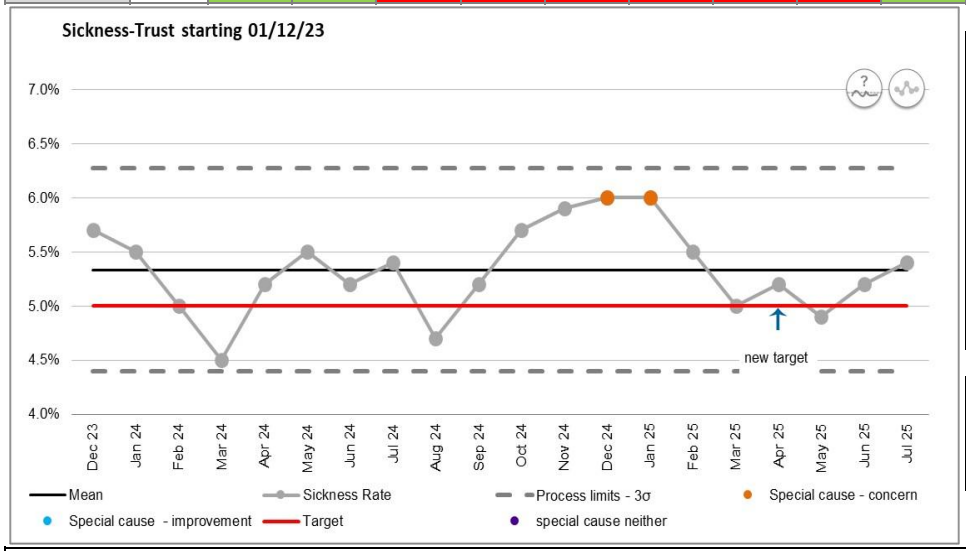
Operational Commentary (e.g. referring to risk, finance, workforce)

For Aug-25, the Trust vacancy rate remains consistent at c 10.6%. 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	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
TRUST	<=5.0%	4.8%	5.2%	5.7%	5.9%	6.0%	6.0%	5.5%	5.0%	5.2%	4.9%	5.2%	5.4%
DMH		6.2%	6.4%	6.8%	6.4%	6.3%	7.1%	6.4%	5.7%	6.2%	5.2%	5.9%	6.2%
CHS		5.1%	5.7%	6.2%	6.7%	6.9%	6.7%	5.8%	5.2%	5.3%	5.5%	6.0%	6.1%
FYPCLDA		3.8%	4.3%	5.0%	5.6%	5.5%	5.2%	5.1%	4.6%	4.6%	4.4%	4.7%	4.8%



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%

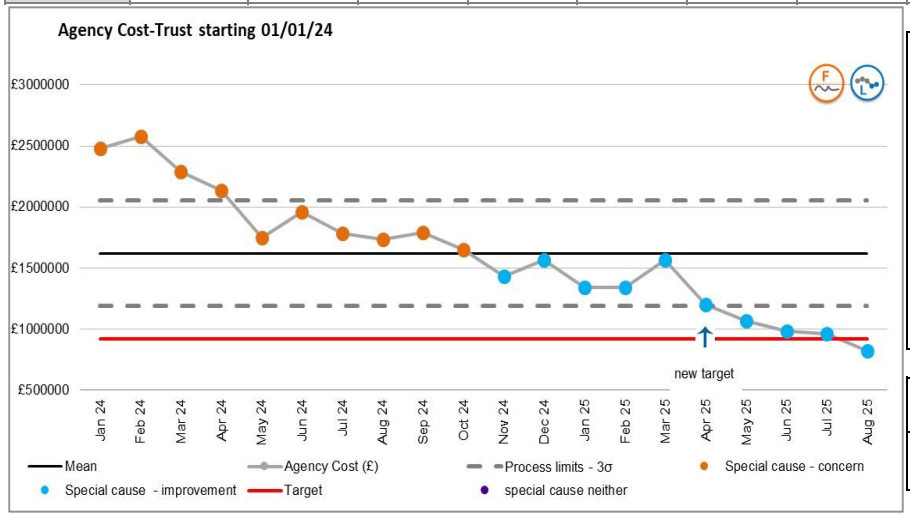
Operational Commentary (e.g. referring to risk, finance, workforce)

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	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
TRUST	<=£922,333	£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	£959,892	£820,254
DMH		£700,309	£699,373	£662,096	£613,750	£570,697	£512,094	£876,766	£615,701	£585,755	£548,266	£561,694	£494,207
CHS		£728,299	£796,173	£726,933	£645,533	£779,216	£653,190	£538,428	£446,756	£353,928	£301,236	£289,274	£244,662
FYPCLDA		£280,540	£252,964	£273,926	£175,987	£197,407	£159,573	£143,524	£134,518	£123,986	£129,128	£98,711	£47,309



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
1621577.9	1187518.5	2055637.3

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.

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		Jun-25	89.0%	90.0%	
MHSDS 72hr Follow-Ups - LPT	>=80%	Jun-25	91.0%	91.0%	
MHSDS CMHealth 2+ Contacts - LLR	0	Jun-25	15230	14960	
MHSDS CMHealth 2+ Contacts - LPT		Jun-25	15175	14895	
MHSDS CMH referrals-spells waiting for a full clock stop - LLR		Jun-25	9220	9595	
MHSDS CMH referrals-spells waiting for a full clock stop - LPT		Jun-25	9210	9540	
MHSDS CMH referrals-spells waiting more than 104 weeks for a 2nd contact - LLR		Jun-25	205	220	
MHSDS CMH referrals-spells waiting more than 104 weeks for a 2nd contact - LPT		Jun-25	210	205	
MHSDS open CMH referrals-spells waiting for a 2nd contact - LLR		Jun-25	3010	3285	
MHSDS open CMH referrals-spells waiting for a 2nd contact - LPT		Jun-25	3020	3275	
MHSDS CYP 1+ Contacts - LLR	17745	Jun-25	18620	18475	
MHSDS CYP 1+ Contacts - LPT		Jun-25	10505	10435	
MHSDS CYP referrals-spells waiting for a full clock stop - LLR		Jun-25	6125	6005	
MHSDS CYP referrals-spells waiting for a full clock stop - LPT		Jun-25	5670	5510	
MHSDS CYP referrals-spells waiting more than 104 weeks for a 1st contact - LLR		Jun-25	605	650	
MHSDS CYP referrals-spells waiting more than 104 weeks for a 1st contact - LPT		Jun-25	575	625	
MHSDS open CYP CMH referrals-spells waiting for a 1st contact - LLR		Jun-25	2380	2370	
MHSDS open CYP CMH referrals-spells waiting for a 1st contact - LPT		Jun-25	2140	2005	
MHSDS CYP ED Routine (Interim) - LLR		Jun-25	51.0%	31.0%	
MHSDS CYP ED Routine (Interim) - LPT	>=95%	Jun-25	51.0%	31.0%	
MHSDS CYP ED Urgent (Interim) - LLR		Jun-25	64.0%	50.0%	
MHSDS CYP ED Urgent (Interim) - LPT	>=95%	Jun-25	64.0%	50.0%	
MHSDS EIP 2 Week Waits - LLR		Jun-25	71.0%	64.0%	
MHSDS EIP 2 Week Waits - LPT	>=60%	Jun-25	69.0%	66.0%	
MHSDS Individual Placement & Support (IPS, Rolling 12 month) - LLR	758	Jun-25	810	805	
MHSDS Individual Placement & Support (IPS, Rolling 12 month) - LPT		Jun-25	810	805	
OAPs Bed Days (inappropriate only) - LLR		Jun-25	530	610	
OAPs Bed Days (inappropriate only) - LPT		Jun-25	505	495	
OAPs active at the end of the period (inappropriate only) - rolling quarter - LLR		Jun-25	0	5	
OAPs active at the end of the period (inappropriate only) - rolling quarter - LPT		Jun-25	0	5	
MHSDS Perinatal Access - (Rolling 12 month) - LLR	1220	Jun-25	1180	1195	
MHSDS Perinatal Access - (Rolling 12 month) - LPT		Jun-25	1200	1205	
MHSDS Restrictive Interventions per 1000 bed days - LLR		Jun-25	-	-	
MHSDS Restrictive Interventions per 1000 bed days - LPT		Jun-25	61	47	
MHSDS - Data Quality DQMI - LLR		May-25	45.4%	55.6%	
MHSDS - Data Quality DQMI - LPT	>=95%	May-25	94.0%	93.0%	
MHSDS - Data Quality SNoMED CT - LLR		May-25	97.0%	96.0%	
MHSDS - Data Quality SNoMED CT - LPT	>=100%	Jun-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
Meeting Date: 11 September 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						
Approval of Terms of Reference	CFC/25/040	Faisal Hussain	The Terms of Reference are attached as an appendix to the highlight report for Board approval. The Committee approved the Terms of Reference.			
ADVISE: Advise the Board of areas subject to on-going monitoring or development or where there is negative assurance						
Any further risks identified during discussion today to add to risk register?	CFC/25/044	Faisal Hussain	The Committee considered the potential risk around the time spent on the bids – increasing our underlying reserves figure – that have been approved by Raising Health, the funds not being used by services, and the projects not being delivered. The Committee has agreed to support the idea of giving a deadline on funds and when they should be used by. Progress will be reviewed in six months. Fundraising manager will work and support Directorates with implementation.			
ASSURE: Inform the Board where positive assurance has been received						
Quarterly Finance Report including Pipeline Report, investment performance & legacies	CFC/25/038	Lorraine Newstead	• The overall fund balance for Quarter 1 closed at £2.45m. This is an increase of £40k (2%) since the start of the financial year.			

			• Forecast income for the year is currently £725k which is £10k in excess of planned levels of £715k. • Expenditure at Q1 totals £115k, with the majority of spend supporting patient wellbeing & amenities (£49k) and charity running costs (£48k). In addition to this there are outstanding expenditure commitments of £417k (excluding the £200k buffer). • Fixed asset investments have increased by £49k due to the improvement in the investment return. • The closing cash balance at the end of the year is £486k, a reduction of £6k since the start of the year.			
Promoting Charitable Funds and Delivering the Strategy: Fundraising Managers' Report	CFC/25/037	Magdalena Korytkowska	• Raising Health sends out regular press releases which are well received by the media. One of the press releases about the flow headsets resulted in two interviews where Raising Health was mentioned. This generated a few additional donations through the website. • We have received many gifts in kind donations, totalling to nearly £10k. • Homeless Mental Health Service Families Event took place on 12 August 2025. • Beacon Sensory room – installation of equipment will take place on 16 October 2025. • The Hinckley Hub Sensory Room - opening day is planned to take place on 8 October 2025.			
Approval of Letter of Engagement to support the 2024/25 internal audit accounts review	CFC/25/039	Lorraine Newstead	The Committee approved the letter of engagement for the provision of an independent examination of the annual accounts of Raising Health 2024/25.			
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding						

Promoting Charitable Funds and Delivering the Strategy: Fundraising Managers' Report	CFC/25/037	Magdalena Korytkowska	• The Impact Report 2024/25 is being launched at the AGM taking place today (11 September 2025). CFC recognised the excellent production and promotion of this key document and thanked all those involved for their work. • The Committee thanked Magdalena Korytkowska and Adele Stacey for their hard work on the let's get gardening appeal which culminated in the open day on Monday 8th September at BMHU where funders, supporters and friends of Raising Health were invited – an excellent event. This has been a long running project which has been in motion for a few years. The staff and patients are very happy with the outcome and this therapeutic sensory garden is already making a great impact on the patients and service users.			

Leicestershire Partnership NHS Trust

Charitable Funds Committee Terms of Reference

Version:	2025/26 V1.3
Executive Lead:	Director of Finance
Approval Committee:	Charitable Funds Committee
Date approved:	TBC
Review date:	TBC

Purpose

The Charitable Funds Committee (CFC) has been established to exercise Leicestershire Partnership NHS Trust's (Trust) functions as the sole corporate trustee of Leicestershire Partnership NHS Trust's Raising Health Charitable Fund (Registered Charity Number 1057361) including all subsidiary funds.

The Trust board is regarded as having collective responsibility for exercising the functions of the corporate trustee. The Trust board delegates these functions to the CFC, as a level 1 sub-committee of the Trust board, within any limits set out in these Terms of Reference and the charitable funds section of Standing Financial Instructions.

Where an NHS Trust is the sole corporate trustee of a charity, the individual persons who, from time to time, are responsible for the management of the corporate body, i.e. the members of the trust or other officers, are not themselves trustees of the charity. The duties, responsibilities and liabilities of trusteeship lie with the body corporate.

As LPT is the corporate trustee it will appoint/nominate appropriate representation from the Board to act as corporate trustees on its behalf on the Charitable Funds Committee.

Duties

- To develop the strategy and objectives of the Charity.
- To oversee the implementation of an infrastructure appropriate to the efficient and effective running of the Charity.
- To oversee the development and delivery of the fundraising strategy.
- To oversee the expenditure of the Charity (including all approved projects), ensuring all expenditure is in furtherance of the charitable activities and in accordance with Trust Standing Orders, Standing Financial Instructions and Schemes of Delegation.
- Ensure that the income and property of the Charity are applied for the purpose set out in the governing document and for no other purpose.
- Ensure that the banking arrangements for the charitable funds are kept entirely distinct from the Trust's NHS funds.
- Have a general duty of protecting the property of the Charity and use the charitable monies proactively i.e., for the benefit for which they were given.
- Manage the investments of the charitable funds pursuant to section 2 of the Trustee Act 2000 and, if necessary, appoint, as required, investment advisors.
- Oversee the performance of external investment managers.
- Monitor the consistency of the investment of funds within its policy on ethical investment and pay due regard to equality in all decisions.

- Monitor the performance of all aspects of the Charity's activities and ensure that it adheres to the principles of good governance and complies with all relevant legal requirements including charity law, and with the requirements of the Charity Commission as regulator.
- Ensure that the Trust's policies and procedures for charitable funds investments, donations, legacies and bequests, fundraising and trading income are in date and complied with.
- Receive any audit reports from internal or external Audit which relate to Charitable Funds.
- Receive the annual accounts of the Charity along with the Annual Trustees Report for the Charity Commission within the agreed timescales.
- Oversight of relevant areas of risk. Including the escalation of any risk via the Highlight report.
- Ensure that the Committee and the Terms of Reference are reviewed annually

Membership

- Two non-executive directors (one of whom will chair the committee, one of whom will act as deputy chair of the committee)
- Director of Finance
- Director of Strategy and Partnerships
- Charitable Funds Finance Manager

Attendance

Regular attendees to the committee shall include:

- Financial Controller
- Associate Director of Communications and Culture
- Director of Governance & Risk (Company Secretary)
- Fundraising Manager
- The Committee may also require ad hoc attendance from Trust staff and external advisors.

Financial approval levels

Directors and Officers must take account of the provisions of the Scheme of Delegation before taking action. Expenditure authorisation limits are set out below:

- Charitable Funds Finance Manager up to £500
- Director of Finance or delegated officer £500 to £3,000
- Committee approval of items of expenditure which exceed the delegated limits of fund managers (£3,001 to £50,000). Where this is undertaken virtually by email, three Committee members are required to confirm approval.
- Any bid exceeding the Committee's approval limit of £50,000 will be escalated to Trust Board for approval.

Quoracy

- The Committee quorum is two board members, at least one of whom is a non-executive director.
- Any meetings that are not quorate will continue and any decisions made will be ratified by those absent within 10 days of the meeting. A record of these agreements made will be held by the secretary of the meeting.

Secretariat

Frequency of Meetings

- The Committee shall normally meet at least quarterly but not less than twice a year and at such

other times as the Chair of the Committee shall require at the exigency of the business.

- Members will be expected to attend at least three-quarters (75%) of all meetings.
- Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, and any other person required to attend, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to Committee members, and to other attendees as appropriate, at the same time.
- The agenda for each meeting will include an item "Declarations of interest in respect of items on the agenda".

Record of Meetings

- The secretary shall record the proceedings and resolutions of all Committee meetings, including the names of those present and in attendance.
- Draft minutes of each meeting will be circulated promptly to the Chair for review and then circulated to members for checking.

Reporting Responsibilities:

- The Committee shall make whatever recommendations to the Trust Board it deems appropriate on any area within its remit where action or improvement is needed.
- Minutes of meetings will be taken for all meetings and circulated to all committee members in advance of the next meeting.
- The Committee shall produce a Highlight report for the Trust Board after each meeting that will give a level of assurance for key agenda items received.
- The Committee shall produce for the Trust Board an annual report on the work it has undertaken during the year.

Declarations of Interest:

- All Charity Committee members will act independently of the interests of the beneficiary bodies and make decisions autonomously from outside consideration and on the basis of factors relevant to the Charity's objectives.
- Conflicts of interest and loyalty must be actively managed and avoided. Where a conflict exists the Committee member must declare the interest and it should be recorded in the minutes of the meeting. During a meeting, if a conflict of interest is established, the Committee should determine whether or not such conflict can be managed, and if not, the member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. The Chair's decision on this shall be final.
- Committee members must ensure that the charity is run solely in the interests of its beneficiaries and must not act at the behest of the NHS Trust where this is not the case.

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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: 13 August 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						
Workforce Development Group Triple A	PCC/25/70		Mandatory Training Compliance: "Gold Call" initiative launched with weekly meetings to address team-level non-compliance, identify root causes, and improve completion rates.	4.1 5.1		
Employee Relations Update	PCC/25/71		High levels of casework: There has been a sustained rise in employee relations (ER) cases, prompting additional resources. Some cases are prolonged due to extended investigations.	5.1	33	
ASSURE: Inform the Board where positive assurance has been received						
NHS 10-Year Plan: Workforce Update	PCC/25/68		NHS 10-Year Plan: Workforce Update A summary of the Section 7 workforce chapter was provided. A more detailed workforce strategy aligned with the NHS 10-Year Plan is expected later in the year.	4.1 5.1		
Our People Data (Month 3)	PCC/25/69		Bank & Agency Staffing: Usage remains below plan; overtime and additional hours have also decreased. Recruitment: Pipeline affected by vacancy controls; MARS programme expected to support reduction in substantive workforce numbers. ER Cases: Data shows an increase in cases; further analysis required. Recommendation to include themes and learnings from past cases. Sickness Absence: Anxiety, stress, and depression are leading causes with further work in directorates to support. Wellbeing Support: OD team developing tailored interventions for high-need teams. Focus remains on identifying workforce hotspots and reducing agency use while maintaining patient safety. Committee found the people dashboard very informative and effective.	4.1 5.1	14 33	
Workforce Development Group Triple A	PCC/25/70		Trade Union Facilities: Latest report published on the Trust website. Assurance provided on IR35 compliance regarding off-payroll arrangements.	4.1 5.1		

Flexible Working Requests	PCC/25/72		Flexible Working Requests – Summary Total Requests (Aug 2024–Jun 2025): 337 Approved: 310, Partially Approved: 12, Rejected: 9 High approval rate across directorates; oversight through HR director for equity and fairness. Committee confirmed confidence in current processes.	4.1		
Job train Benefits realisation - 12 month review	PCC/25/73		Committee received a presentation on the impact and outcomes of the Job train recruitment system following its implementation in July 2024 with additional investment. Key outcomes identified were: £66k cost saving achieved through workforce reduction lower numbers of staff required in the team. Recruitment recovery position reached by December 2024; SLA met by March 2025. System improvements include: Faster onboarding of new starters. Reliable and efficient contract production. Launch of bulk LPT induction by OD team. Continuous feedback loop with candidates and hiring managers; average rating 4.5/5. The committee acknowledged this as a success story and commended the team for their dedication and positive contribution.	4.1	14 16	
Culture, Leadership and Inclusion, OD quarterly update	PCC/25/74		Our Future, Our Way Change Leaders programme shortlisted for an HSJ Award, recognising innovation in leadership development. Online induction process revised to increase capacity. Updated 90-day toolkit now live on uLearn and adopted by LLR as a model of good practice. Continued support for leadership and development programmes across the Trust. New Trust strategy THRIVE, mission, and vision successfully embedded. Long service awards held with new categories to enhance recognition. Use of hotspot data at joint PCC meetings supports targeted improvement and learning. Leadership Conference: Committee assured on current OD activities and direction	5.1	17	
AFM Triple A Summary & Escalations Report	PCC/25/76		Committee assured on the progress and outcomes reported.	4.1		
Group OD and Together against racism update	PCC/25/77		Committee received overview of progress and impact measurement across OD initiatives across the group workstreams, with a focus on collaboration and strategic alignment. The oversight paper presented, highlighted the	5.1	17 49	

			value log which captures saving in training delivery costs and avoidance of duplication and unnecessary spending due to the joint work. Committee assured on the on the direction and effectiveness of the group OD programme and collaborative efforts.			
Policy Progress	PCC/25/78		All policies in date.			
Freedom to Speak Up Update	PCC/25/79		In Quarter 1, a total of 36 cases were reported relating to worker safety, wellbeing, inappropriate behaviours and bullying and harassment. Joint working continues with the THRIVE strategy in collaboration with NHFT, alongside planning for Speak Up Month in October. 82% of staff have completed FTSU training	5.1		
Professional Registration Annual Report	PCC/25/80		Committee confirmed assurance on the robustness of the registration and revalidation processes.	4.1		
Equality Standards 2024/25 – WRES, WDES, Bank WRES	PCC/25/82		Annual publication of WRES and WDES data received presented in a simplified format to support directorates in identifying hotspot areas. WRES shows some progress, but further improvement is needed. Actions underway are, launch of a new talent development programme for ECM staff Bands 5–7 later this year. Joint group leadership development programme planned, with evaluation to follow. Committee confirmed assurance on the reporting and planned actions.	5.1	17 49	
CELEBRATING OUTSTANDING: Share any practice, innovation, or action that the Committee considers to be outstanding						
Celebratory Acknowledgements	PCC/25/86		Committee noted level of reporting to this committee and the level of detail and clarity presented is excellent. The pack offers a phenomenal overview of the organisation's current workforce position and provides a clear and comprehensive view of key metrics, challenges, and progress. This level of reporting is seen as a valuable tool for strategic oversight and decision-making.			