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Leicestershire Partnership NHS Trust

Trust Board 25th November 2025

Declarations of Interest Report – Public Trust Board

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	

THRIVE

Board Member:	Current Declarations:	Declaration Reference:	Date Interest Arose:	Date of Annual Declaration:
	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	
	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	

Board Member:	Current Declarations:	Declaration Reference:	Date Interest Arose:	Date of Annual Declaration:
	Loyalty Interests – Ellis (formerly Berendsen)	3661	01.04.23	
	Loyalty Interests – Daughter Detective Constable Northamptonshire Police	6595	01.09.25	
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	Loyalty Interests – Leicestershire Police	5584	01.04.24	8th April 2025
	Outside Employment - Staffordshire and Stoke on Trent ICB	3649	01.05.23	
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	
Faisal Hussain Chair of the Trust	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	

Board Member:	Current Declarations:	Declaration Reference:	Date Interest Arose:	Date of Annual Declaration:
	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 Group Director of HR & OD	Nil Declaration	6252	NA	2nd April 2025

Board Member:	Current Declarations:	Declaration Reference:	Date Interest Arose:	Date of Annual Declaration:
Sam Leak Director of Community Health Services & Interim Director of FYPCLDA	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	
Linda Chibuzor Group Director of Nursing	In Progress	TBC	TBC	TBC
Bhanu Chadalavada 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	Outside Employment - Northamptonshire Healthcare FT - Joint role with LPT and NHFT	4116	19.09.23	16th May 2025

Board Member:	Current Declarations:	Declaration Reference:	Date Interest Arose:	Date of Annual Declaration:
Chief Finance Officer	Loyalty Interests – Carly Sheldon (wife) – Senior Finance Manager at Black Country ICB	4275	01.04.23	

Decision Required

Briefing – no decision required

Governance Table

For Board and Board Committees:	Public Trust Board 25th November 2025
Paper sponsored by:	Kate Dyer Director of Governance & Risk
Paper authored by:	Kay Rippin Deputy Trust Secretary
Date submitted:	17th November 2025
Name and date of other committee / forum at which this report / issue was considered:	NA
Level of assurance gained if considered elsewhere	☐Assured ☐ Partially assured ☐ Not assured

Date of next report:	January 2026
THRIVE strategic alignment:	☐ **T**echnology ☐ **H**ealthy communities ☐ **R**esponsive ☐ **I**ncluding everyone ☐ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	NA
Is the decision required consistent with LPT's risk appetite:	YES
False or Misleading Information (FOMI) considerations:	CONSIDERED
Positive confirmation that the content does not risk the safety of patients or the public:	YES
Equality considerations:	CONSIDERED

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Unconfirmed

Leicestershire Partnership NHS Trust

Minutes of the Public Meeting of the Trust Board
30th September 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 *(left meeting at 12.00pm)*
Manjit Darby, Non-Executive Director
Angela Hillery, Chief Executive
Jean Knight, Managing Director/Deputy Chief Executive
Sharon Murphy, Executive Director of Finance
Bhanu Chadalavada, Medical Director
James Mullins, Interim Chief Nurse/Interim Executive Director of Nursing, Allied Health Professionals and Quality

In Attendance:
Sam Leak, Executive Director of Community Health Services and Interim Executive Director of Families, Young People, Children, Learning Disability and Autism Services
Tanya Hibbert, Executive Director of Mental Health
Sarah Willis, Executive 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
Kamy Basra, Associate Director of Communications and Culture
Sonja Whelan, Corporate Governance Coordinator (Minutes)

TB/25-6/053	**Apologies for absence** There were no apologies received.
TB/25-6/054	**Directorate of Mental Health: Assertive Outreach Team** Tanya Hibbert introduced the service presentation for the Directorate of Mental Health which focussed on the Assertive Outreach Team. The team introduced themselves as Dawn Holding (Team Manager for Assertive Outreach), Dr Suneeta James (Consultant Psychiatrist), Dino Moeketsi (Team Lead for Assertive Outreach), Emma Walker (Team Lead for Assertive Outreach), Daniela Palade (Clinical Assistant Psychologist), and Rosie Klair (Service Manager for Specialist Services). Rosie Klair provided an overview of the assertive outreach team which provides a flexible and responsive model of care for individuals diagnosed with psychosis who are at high risk of disengagement and therefore can be vulnerable from significant harm from themselves or others. The service is structured around a three-stage model that adheres closely to the original assertive outreach framework, with each stage tailored to meet the specific

	needs and recovery goals of the service user. The service operates seven days a week. It does not run traditional clinics. Instead, all interventions are delivered within the community, wherever the service user is located. This approach ensures accessibility and continuity of care. The service is one of only three nationally recognised for maintaining fidelity to the core assertive outreach model. In addition, the trust provides several other services for individuals experiencing psychosis which support individuals through all stages, from their first episode of psychosis to individuals being compliant with their treatment. Service users may transition between these services as their needs evolve through a hub-and-spoke model. The assertive outreach team has been a pioneer within the Trust in introducing the Multi Professional Approved Clinician and Advanced Clinical Practitioner role and now has several professionals in these positions. It is currently participating in the National Intensive and Assertive Community Treatment Review alongside the Integrated Care Board (ICB), following the tragic events in Nottingham in 2023. This review aims to ensure that services are equipped to engage and treat individuals with serious mental illness who may pose a risk when untreated, and to establish clear policies and practices for intensive community-based treatment. Whilst undertaking this review, a number of service improvements have been made which include closer working relationships with social care, exploring the implementation of a caseload management and supervision tool for community services and reviewing workforce models with plans to introduce Allied Health Professional (AHP) roles to enhance multidisciplinary support. The assertive outreach team comprises a diverse range of disciplines and operates in a multidisciplinary manner, supporting both service users and staff. Current demographic data indicates that 63% of service users are male, 74% are aged between 36-65 years and the service supports both City (55%) and County (45%) areas. Dr Suneeta James then spoke about the clinical model, highlighting its focus on supporting the most difficult to engage service users with severe and chronic psychotic illnesses such as schizophrenia. Many of these individuals have a history of poor engagement with traditional services and often presented with treatment-resistant symptoms. In addition to the risks posed by their mental illness, many service users also experience comorbidities such as substance misuse and poor physical health which further complicate their care and recovery. The assertive outreach service therefore adopts a holistic approach addressing not only mental health needs but also assists with practical matters such as benefits, housing, and working closely with adult social care. The proactive nature of the multidisciplinary team (MDT) was emphasised as it fostered continuity of care, creativity in service delivery and positive risk taking and worked closely with carers and families, recognising their essential role in the service user's recovery journey. It was noted that approximately 30% of service users are currently subject to a Community Treatment Order (CTO) – a legal framework under the Mental Health Act 1983 that enables supervised treatment in the community – with the primary aim being to support service users in adhering to treatment, maintaining wellness and avoiding hospital readmission. Dawn Holding further outlined the team's approach to service delivery, highlighting the high level of flexibility offered. The team does not

	discharge service users for non-engagement; instead, disengagement prompts increased input and outreach. Many service users have been known to the team for extended periods and staff develop strong familiarity with their needs and circumstances. All interventions are delivered in community settings, wherever the service user is located, which includes unconventional environments such as tents or public spaces. Staff often go to considerable lengths to locate individuals, including visiting known frequented places or adjusting visit times to early mornings, evenings, or weekends. This persistence ensures continued engagement and support, even when service users attempt to avoid contact. As mentioned previously, a hub-and-spoke model is in place with neighbourhood teams, allowing staff to attend MDT meetings and referral discussions. This model facilitates real time decision making and reduced reliance on formal referral forms. The team manages any of its service users in crisis and does not refer them to the crisis team during working hours. If the crisis team becomes involved out of hours, the service user is handed back to the team the following day where intensive support is provided. Staff support and safety is prioritised; debriefing and peer support are offered following critical incidents, all staff use lone worker devices whilst in the community, clinical records are regularly updated on SystmOne and daily handovers ensure continuity of care, with care plans adjusted as needed. Two anonymised patient stories were then shared to illustrate the complexity and flexibility of the service's approach to care. The first case involved a service user with a diagnosis of schizophrenia and a chronic physical health condition. The individual was not managing his physical health effectively and was failing to collect prescribed medication. The team supported by accompanying him to appointments and liaising with the relevant physical health services. Staff trained in phlebotomy and ECG monitoring were involved in ensuring the patient received appropriate physical health checks. This case highlighted the team's role in bridging the gap between mental and physical healthcare and the importance of proactive engagement to maintain overall wellbeing. The second case described a long-term service user with a history of poor engagement, substance misuse and repeated contact with the criminal justice system; despite a significant forensic history, the individual did not meet the threshold for forensic mental health services. Following a custodial sentence, subsequent deterioration in mental health, a long admission in hospital under Section 3 of the Mental Health Act and discharge on a CTO, the team successfully supported him in the community through a flexible care package, adjusted according to need. This enabled the individual to remain out of hospital for several years, demonstrating the effectiveness of sustained adaptable support in complex cases. An audio recording was then shared which featured a service user who has been supported by the assertive outreach team for approximately 12 years. The individual described the support received across various aspects of life, including domestic, social and medical needs. He highlighted the team's assistance with attending medical appointments and managing financial matters. This support had significantly improved his ability to cope day-to-day. Initially, the service user expressed scepticism and wariness towards

	the team due to uncertainty about their intentions. However, over time, he came to trust the service due to consistent care and attention provided and expressed gratitude for the support received. A letter of appreciation was then shown from the family of a service user which expressed deep gratitude for the care and support their son had received from the assertive outreach service. Following this, a series of staff recordings were played to further illustrate the team's experiences and perspectives:- Dino Moeketsi, a senior practitioner with 15 years' experience, described the work as both clinically and managerially challenging, yet rewarding. He emphasised the need for creativity in engaging with highly marginalised service users, often in non-traditional settings. Emma Walker, also a senior practitioner, spoke about the flexibility of the service and the ability to respond quickly to changing needs. She valued the opportunity to support vulnerable individuals in diverse ways – from clinical interventions to emotional and practical support – and expressed fulfilment in building meaningful relationships with services users and their families. Daniela Palade, an associate psychologist, reflected on the unique nature of psychological work in the community and described the importance of building trust through consistent presence and validation. The Chair thanked the team for their presentation and invited any questions or comments. James Mullins acknowledged the challenging nature of the team's work and praised the team's skill, dedication and evident enjoyment of their roles, noting that the appreciation expressed by service users and families is a testament to the team's impact and offered thanks for their efforts. Angela Hillery echoed these sentiments, describing the presentation as compelling and highlighted the team's commitment, compassion and perseverance, particularly their strong person-centred approach. She also remarked on the psychological safety experienced by both service users and staff and the team were then invited to reflect on how this had been achieved. Dawn Holding attributed the team's resilience to a supportive environment where open communication is encouraged, and staff feel empowered to express discomfort without judgment. Faisal Hussain also thanked the team, highlighting the compassionate care evident throughout the presentation and the team's success in building rapport with marginalised and vulnerable individuals, and enquired about collaboration with the voluntary and community sector to support service delivery. Dawn Holding explained that the hub-and-spoke model enables access to local networks and confirmed the team works closely with social care and voluntary sector partners, particularly during discharge planning and transitions to neighbourhood services. Liz Anderson commended the team's inspiring work with some of the most

	vulnerable individuals in society, particularly their efforts to support service users remaining at home and acknowledged the value of clinical psychologists, noting the shortage in training and recruitment. Noting that while trust and rapport eventually enable community support, the early relationship appeared intensive and potentially vulnerable, and Liz Anderson asked how the team managed this phase and whether it involved challenges such as readmissions or transferring care. Dawn Holding responded by confirming that readmissions do occur but the team does not 'pass people back' and service users are only transitioned once they reach a certain level of stability. Also highlighted was the increasing number of younger referrals to the service and the importance of collaboration with other teams familiar with service users in seeking insights and strategies to improve engagement. Jean Knight offered her thanks to the team for their ongoing dedication and support in caring for highly complex patients. Bhanu Chadalavada also expressed thanks to the team and noted that much of the work being done aligned with national thinking around building relationships that foster trust and improve engagement, and suggested the team should continue exploring ways to share these experiences. Sarah Willis acknowledged the team's emphasis on mutual support and raised a question regarding additional measures the trust could offer to support staff health and wellbeing during the upcoming winter period, recognising the seasonal challenges. In response, Dawn Holding noted that while challenges occur throughout the year, the team benefits from strong relationships with neighbourhoods. In adverse weather conditions, staff adapt by supporting patients locally and covering for one another as needed. Dawn expressed confidence in the team's preparedness for winter highlighting recent recruitment efforts and the addition of new staff members. The Chair reflected on the importance of *trust* in service delivery, noting that this was strongly supported by feedback from the patient voice. The Chair also emphasised the value of supporting individuals not only with their mental health but also with their physical health, recognising the significance of a holistic approach to care and the team's ability to retain staff was a powerful indicator of a positive working environment. The Chair then asked about the demographics of service users and whether the current profile reflected the wider community, or whether there may be individuals who need the service but are not currently accessing it. In response, Rosie Klair explained the service includes several pathways for individuals with suspected or diagnosed psychosis and while full coverage could not be guaranteed, the team works closely with neighbourhood leads to identify and escalate cases requiring support. Dawn Holding added that a previous survey had shown Leicester City to have the second highest proportion of individuals within a psychotic cluster nationally, suggesting that current figures are in line with expectations. It was noted that a historical trend of individuals moving from county areas into the city was partly due to resource availability and a shift toward a younger client group in recent referrals had been observed. On behalf of Board, the Chair thanked the team once again.

TB/25-6/055	**Questions from the Public (verbal)** There were no public questions.
TB/25-6/056	**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/25-6/057	**Minutes of Previous Public Meeting held 29 July 2025 (Paper B)** The minutes were approved as an accurate record of proceedings. **Resolved:** The Board approved the minutes.
TB/25-6/058	**Matters Arising (Paper C)** There were no matters arising.
TB/25-6/059	**LPT Trust Board Workplan 2025/26 (Paper D)** Kate Dyer presented the workplan for information highlighting the additional item around service presentation follow-ups. **Resolved:** The Board received this report for information.
TB/25-6/060	**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. The following key points were highlighted:- • As this was the Chair's last public meeting she expressed appreciation for having had the opportunity to lead this Board and serve the wider community. • Following many months of working closely together to ensure a smooth transition, Faisal Hussain will take up the post of Interim Chair on 1 November 2025. • It was confirmed that all NED appraisal documents had been submitted to NHSE prior to the deadline of 30 September 2025. • From 1 November 2025, Josie Spencer and Melanie Hall will step into the roles of interim Deputy Chair and Interim Senior Independent Director (SID) respectively. Faisal Hussain, on behalf of the Board, extended thanks to the Chair for her dedication and support, stating it had been an honour and privilege to work alongside her. Appreciation was also expressed to Josie Spencer and Melanie Hall for stepping into their roles. Faisal Hussain went on to reflect on a recent Internationally Educated Nurses Graduation Ceremony, describing it as a truly wonderful event that showcased the nurses' commitment, personal journeys, and the values they bring to the service. It was particularly inspiring to witness their transformation within the LPT family and their progression into more senior roles. The AHPs Fellowship Celebration Day was also mentioned, noting the presentations from research and innovation projects were deeply patient-centred and left a strong impression.

	Manjit Darby shared reflections on attending Leicester PRIDE, expressing strong support for the event and highlighting the importance of visible leadership for the LGBTQ+ community, particularly in light of the current political climate which has left some individuals feeling unsettled. She was moved by the sense of solidarity and support at the event and emphasised the need for the leadership team to continue championing inclusivity. The Chair acknowledged this as an important point and thanked Manjit for bringing it to the Board's attention. **Resolved:** The Board received this report for information.
TB/25-6/061	**Chief Executive's Report (Paper F)** The Chief Executive introduced this report which provided an update on current local issues and national policy developments since the last meeting. Key points highlighted were:- • Supporting the LGBTQ+ community was acknowledged and the active role of the staff network was highlighted with Sam Leak as the executive sponsor. The network had recently shared concerns and the importance of listening, responding and continuing to support staff and communities was emphasised. • Thanks were offered to all for the segmentation results achieved in Quarter 1, noting that LPT landed as a Level 2 overall, ranking 17th out of 61 non-acute providers – a strong foundation for future progress. • Board was reminded of the importance of winter vaccination programmes, and members were urged to promote and participate in preventative health measures. • Recognition was given to the AGM and Annual Awards – with thanks to the communications team for their work in showcasing achievements and supporting event delivery. The value of local and national awards was highlighted, noting that being shortlisted is a significant achievement and helps validate LPT's practices. • Finally, thanks were extended to the Chair for exemplifying value-based leadership, offering constructive challenge, and advocating for community and mental health services. Josie Spencer reflected on the discussion around supporting the LGBTQ+ community and expressed interest in the upcoming comprehensive review on health inequalities affecting this group noting that a report and recommendations were expected in December and requested these be included in future updates. Josie also welcomed news that the Enable Health Team in West Leicestershire had been selected as one of the national pilot sites and asked whether feedback would be provided on how the pilot's objectives are improving health and wellbeing within the community. In response, Angela Hillery confirmed that findings from both areas would be brought back to the Board. Liz Anderson commented on the Leicester West pilot, describing it as an incredible opportunity for the Trust and expressed appreciation for the initiative, particularly given the significant needs within the West Leicestershire community. It was noted that one of the initial achievements

	was securing commitment from all partners during the bidding process, which was not accomplished in every area. This collective commitment was a vital foundation for progressing the work and reflected the strength of collaboration across the system. Sam Leak provided an update on the neighbourhood programme, adding that both herself and David Williams were actively involved in the system-wide board meetings to progress the work and she welcomed the support from the accelerator site, describing it as a valuable opportunity to advance integrated neighbourhood working. While the current focus is on West Leicestershire, it was confirmed that learning from the pilot will be actively shared across Leicester City, where deprivation and inequality are also present, and extended to Rutland, adopting a share and learn approach across the wider system. The Chair referred to vaccinations and suggested the next Board development session could include a collective offer to Board members around vaccinations. In addition, she shared positive feedback received from members of the team involved in the development of the Healthy Together Helpline who were attending the Annual Awards. Lastly, the Chair commended the use of Raising Health funds to support homeless patients highlighting the social value impact. **Resolved**: The Board received this report for information.
TB/25-6/062	**Environmental Analysis (Verbal)** Angela Hillery provided an update on the following:- • Oversight framework ratings would be continuous and dynamic in nature. It was noted the mental health sector had some impact through the segmentation and rankings with quite a lot of providers in mental health having gone into 3s and 4s which had caused some concern. A review of metrics was anticipated in the new year. • Claire Murdoch, the National Director had stepped down and thanks were publicly offered for her work in the mental health sector. • The ICB cluster were now in a position to move towards their shared leadership team - this was expected to be operational and in-situ shortly. Jean Knight provided an update as follows:- • A presentation at the Leicester City Health and Wellbeing Board from the Centre Project was praised for its quality and impact. • The Healthwatch Annual Report was presented at both Leicester City and Leicestershire Health and Wellbeing Boards alongside respective public health presentations. • A strong emphasis on vaccinations was noted, particularly within the City, and welcomed by all. • There were 62 board service visits undertaken during July and August which had provided valuable opportunities to observe compassionate care and hear directly from staff. • October will be promoted as Freedom to Speak Up Month extending beyond the nationally recognised week. Staff drop-in sessions are planned and thanks were offered to those supporting these activities.
TB/25-6/063	**Board Assurance Framework (Paper G)**

	Kate Dyer presented this report which provided an overview of the strategic risks and a revised format to better highlight the risk profile and oversight mechanisms. Risks were mapped against the THRIVE Strategy showing which can be overseen at Group level and which are specific to LPT. The visual 'wheel' in the report illustrated key risks by THRIVE domain with high-risk areas primarily falling under the 'Responsive' and 'Efficient and Effective' domains. Key risk themes included finance, funding, environment, timely access and patient safety - consistent with previous profiles. The only item requiring Board approval was a minor wording change to BAF04, aligning it with NHFT for consistency across the Group. The nature of the risk remained unchanged and the wording update supported clearer oversight. Hetal Parmar queried whether any interim actions were required to mitigate patient safety concerns associated with BAF 3.2. Kate Dyer confirmed that all current mitigating actions were outlined within the report and comprised substantial workstreams embedded across governance structures and the wider organisation. It was noted that page 57 of the meeting papers pack provided assurance regarding the management of this risk. The Chair noted that most risks had evolved since their initial identification and queried what might influence movement in BAF 5.2 and BAF 5.3. Sharon Murphy responded that BAF 5.3 was originally escalated due to concerns around capital funding and the long-term strategic impact of limited investment in infrastructure particularly in relation to the Bradgate redevelopment. However, the forthcoming medium-term allocations expected in late October may offer opportunities to invest further in infrastructure potentially affecting the risk status. Paul Sheldon added that the organisation was continually balancing competing priorities which also influenced the pace and nature of progress on risks. **Resolved:** The Board received this report and approved the re-wording of BAF04.
TB/25-6/064	**Audit and Risk Committee AAA Highlight Report: 12 September 2025 (Paper H)** Hetal Parmar introduced this report and drew attention to the following:- • No alert items to escalate. • Advisory item - the HFMA checklist and the related actions – it was agreed to make the proposal to close as there were now other checklists and plans in place that superseded what was originally there. Each of the open actions would be referenced to the new plans to ensure a clear audit trail. • Assurance items - a new corporate offence of *failure to prevent fraud* came into effect from 1 September 2025 affecting all public sector organisations and 360 Assurance was supporting the Trust on the implications and next steps to ensure risks associated with the legislation were mitigated. - The Committee concluded that the other Level 1 committees were functioning as it would like in terms of meeting frequency, attendance etc.

	Resolved: The Board received this report for information and assurance.
TB/25-6/065	**Audit and Risk Committee Annual Effectiveness Review 2024-25 (Paper I)** Hetal Parmar introduced this report which articulated the way in which the Audit and Risk Committee functions and evaluates itself. Kate Dyer confirmed that assurance had been provided that the Committee had been well run during the year. **Resolved:** The Board received this report for information and assurance.
TB/25-6/066	**Trust Board Annual Effectiveness Review 2024-25 (Paper J)** Kate Dyer introduced this report which provided an annual review of the effectiveness of the Trust Board for 2024-25. The review process is undertaken following receipt of assurance for all Level 1 committees, ensuring the Board is appropriately supported and functioning effectively. It was noted that feedback from Deloitte, following their review of leadership and governance, had been incorporated into the report. It also highlighted key successes, achievements and future plans. In conclusion, Kate Dyer confirmed the Board was deemed to have appropriately met its terms of reference and workplan, and had operated effectively throughout the year. Jean Knight noted minor inaccuracies in the attendance records and agreed to provide feedback outside of the meeting. ***Post Meeting Note*****:** *it was identified that Jean Knight was incorrectly recorded as being absent for the May and July Board meetings and Angela Hillery was incorrectly recorded as being present for the July meeting. These discrepancies were due to data entry inputting errors within the report.* **Resolved:** The Board received this report for information and assurance.
TB/25-6/067	**Clinical Plan 2025-2030 (Paper K)** Bhanu Chadalavada introduced this report which described the themes and priorities for all clinical and enabling directorates at Leicestershire Partnership NHS Trust for the next five years. It was a culmination of ideas and ambitions, reflecting on what was most important on the journey to improving patient care and staff wellbeing. The content of the Plan had been developed through consultation with staff and services to enable the ongoing development of the Trust within a rapidly changing and challenging environment. David Williams then explained the distinction between the overarching organisational strategy and the team directorate specialism plans and emphasised the importance of avoiding multiple disconnected strategies that can lead to confusion and a lack of cohesion. It was noted that extensive engagement had taken place with a wide range of stakeholders to ensure the strategy is inclusive and meaningful across different groups. The Chair acknowledged the value of this approach and noted the challenge of ensuring the strategy resonates with its core audience. Josie Spencer added that the draft Plan had been well received at the Quality and Safety Committee (QSC) and Sharon Murphy also confirmed it

	had been well received at the Business Development Group (BDG). Tanya Hibbert raised the importance of the organisation's prevention work suggesting this could be more explicitly drawn out under the health inequality section. Bhanu Chadalavada confirmed he would incorporate this into the ongoing evolution of the Plan. Manjit Darby asked whether there were plans to produce a plain English, patient-faced version to ensure it was accessible and meaningful to service users. The Chair acknowledged this may take the form of a 'plan on a page' and noted that support from the communications team may be required. Liz Anderson commended the Plan noting it aligned well with current NHS priorities but wondered how it ensured equal prioritisation across all clinical areas. Melanie Hall also praised the comprehensive approach and asked how opportunities and shared learning across the Group would be exploited. In response Bhanu Chadalavada confirmed that prevention is a key component particularly in addressing rising demand and improving access through neighbourhood work. A more accessible version for services users would be developed in liaison with the communications team, and access would apply proportionately across all directorates. It was noted that collaboration with NHFT, including joint work on research, innovation, education and shared practice would be ongoing. The Chair concluded this should serve as a flexible framework, adaptable to each directorate, and welcomed the Group level connectivity given the complexity of the area. Sarah Willis proposed mapping the content across to the existing People Plan pack which is monitored through the People and Culture Committee (PCC) to avoid duplication and ensure integrated oversight; this included aligning relevant enablers with the workforce agenda. The Chair agreed, emphasising the importance of ensuring appropriate governance and avoiding duplication across committees noting that QSC would also require visibility of progress. **Resolved:** The Board received this report and approved the Clinical Plan and the Year 1 priorities identified recognising it would continue to evolve.
TB/25-6/068	**LPT Green Plan 2025-2028 (Paper L)** Paul Sheldon introduced this refreshed LPT Green Plan which set 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 had been reviewed by both the Finance and Performance Committee (FPC) and the Strategic Executive Board (SEB) and represented significant progress compared to the previous three years, and incorporated completed actions and provided a stronger foundation moving forward. The Plan also reflected new initiatives such as recent solar panel

	installations and successful efforts to reduce food waste. Also emphasised was the plan's connection to the THRIVE strategy and its development through collaboration with staff ensuring input from clinical and operational perspectives. Hetal Parmar raised two questions. Firstly, if the LPT specific percentage of scope 3/procurement related emissions were known and secondly, if specific initiatives had been identified which were having the greatest impact on reducing emissions, in order to help prioritise future efforts and support achievement of the net zero target. In response, Paul Sheldon confirmed that while the exact LPT figure was not known, emissions levels were broadly in line with the national average. He then outlined current priorities, including collaboration with procurement to support local sourcing, transitioning both trusts to a single electric vehicle fleet and consideration of improving electric vehicle charging points across the estate. The Chair confirmed the Board's approval of the Green Plan and thanked all involved. **Resolved:** The Board received and approved the Green Plan.
TB/25-6/069	**LPT Winter Plan 2025-2026 (Paper M)** Sam Leak introduced this report which presented the Winter Plan, developed collaboratively with partner organisations and across all LPT directorates. A draft was submitted in August 2025 and received positive feedback from NHS England (NHSE), with a request to strengthen the super surge component, which was subsequently addressed. NHSE also requested separate provider plans for University Hospitals of Leicester (UHL) and LPT, a change from previous years. The LPT plan aligned with the system plan and had been reviewed through the necessary governance processes. The final version was circulated to Board in advance due to tight submission deadlines, with BAF components requiring sign-off by the Chair and Chief Executive. The Chair confirmed Board approval. **Resolved:** The Board received this report and approved the final submission of the plan to NHSE.
TB/25-6/070	**Quality and Safety Committee AAA Highlight Report: 19 August 2025 (Paper N)** Josie Spencer introduced this report and drew attention to the following:- • Alert items - The number of waits over 52weeks. - CQC assessment of community based mental health services. - A review of the separate safety forum and quality forum meetings had taken place and feedback awaited on whether to continue with the approach moving forward. - Capacity to complete investigations and actions – a further review to be received at the next QSC meeting.

	• No advisory items highlighted. • Assurance items - Good presentation on transformation and quality improvement work which received significant assurance in terms of the outcome for patients. • Celebratory items - Shortlisting of colleagues for HSJ awards was acknowledged. **Resolved:** The Board received this report for information and assurance.
TB/25-6/071	**Safe Staffing Report (Paper O)** James Mullins introduced this report which provided a full overview of nursing safe staffing during the month of July 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:- • Workforce pressures – there are still vacancies, and the report provided the detail around turnover and sickness. • Healthcare Support Workers (HCSWs) – there had been a slight increase in sickness. • Temporary workforce usage remained high in some areas. • There had been a decrease in falls in CHS, an increase in DMH and a small increase in FYPC. Most were low or no harm. • No Cat4 pressure ulcers reported since March 2024. • Reduction in safe staffing related incidents. Manjit Darby reported that PCC had reviewed sickness management within the organisation and received good assurance on tracking processes. Additionally, a comprehensive review of staff turnover and exit interviews was currently being examined in a subgroup of PCC. Sarah Willis added that turnover is currently very low and below target, with a strong pipeline of newly qualified nursing staff joining this month. While temporary staffing remains necessary due to supernumerary support for new starters, the temporary workforce is well-established within LPT, mitigating safety concerns. **Resolved:** The Board received this report for information and assurance.
TB/25-6/072	**Patient Safety Report (Paper P)** James Mullins presented this report which provided assurance of the efficacy of the incident management and Duty of Candour compliance processes. Incident reporting supporting this paper had been reviewed and refreshed to assure that systems of control continued to be robust, effective, and reliable thus underlining the commitment to continuous improvement of incident and harm minimisation. The report also provided assurance around Being Open, 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 top five reported patient safety incidents during July and August 2025 came under the categories of tissue viability/pressure ulcers, self-harm, violence and assault, care/treatment under restraint, and falls. The incident figures were contained on page 2 of the report. There was continued focus around these areas and active improvement workstreams. Melanie Hall welcomed the transparency in reporting, particularly around restraint and treatment incidents and suggested that future reports could include patient numbers alongside incident counts; this would provide greater insight into whether incidents are concentrated among a small number of patients or more broadly distributed, helping the Board better understand patient acuity and ward pressures. James Mullins confirmed this would be possible. The Chair agreed, noting the value of such data in identifying specific patient needs contributing to incident peaks and commended the continued development of the report and its usefulness in helping the Board focus on key areas. **Action:** Future reports to include data on patient numbers to provide greater insight into incident distribution and patient acuity. **Resolved:** The Board received this report for information and assurance.
TB/25-6/073	**Annual Complaints and Concerns Report 2024-25 (Paper Q)** James Mullins presented this report which presented feedback received by the Trust between 1 April 2024 and 31 March 2025 including an overview of complaints, concerns and compliments. The report outlined the Trust's overall regulatory performance, as well as the learning and changes made to process throughout the year. Also included was feedback received through the Trust's Friends and Family Test (FFT) to provide a complete picture of all feedback received in 2024-25. The key areas mentioned were:- • 262 complaints registered - this was a 9% increase on the previous year • the Complaints and PALS Team compliance to acknowledge complaints within three working days remained at 96%, this exceeded the 90% target set by the Trust. As a result, an improvement plan was in place to reach trajectory by December 2025. • Consistent top themes were around patient care, communication, appointments and access. • 78% of complaints are upheld or partly upheld showing significant opportunities for service improvement • Learning actions taken included better discharge, ambulance booking process, and clearer communication on catheter and medical care. • Reopened complaints had significantly reduced • FFT satisfaction had increased to 90% • Priorities for 2025-26 were to achieve 90% response compliance, expand staff training to include compassionate leadership, standardising

	complaint pathways across directorates and strengthen the use of local resolution meetings and digital systems. In conclusion, while complaints and volumes were rising, improvements in quality, responsiveness and learning demonstrated progress. Sam Leak asked what factors were contributing to improvements, given that the complexity of complaints and workforce challenges remained consistent. James Mullins responded that the complaints team has been proactive in working with directorate teams and Heads of Nursing and highlighted the most significant impact had come from close collaboration with FYPCLDA, where a large proportion of complaints originate, particularly from families of young people. Hetal Parmar raised a query about the extent to which waiting lists may be influencing complaint volumes and whether this could be quantified. He also suggested including a trend line on the outcomes chart (page 5 of the report) to better understand the impact beyond just reducing complaint numbers. James Mullins advised that many complaints related to access and waiting times and continuous improvement work was ongoing around this. He agreed that including outcome trends in future reports would be valuable and confirmed this would be actioned. **Action:** Future reports to include outcome trends. **Resolved:** The Board received the report for information and assurance.
TB/25-6/075	**Finance and Performance Committee AAA Highlight Report: 21 August 2025 (Paper R)** Melanie Hall introduced this report and drew attention to the following:- • Alert item - UHL's migration to the Nervecentre Patient Administration System had resulted in 60,000 erroneous records being entered onto the system – it was hoped this would be resolved in due course. • Advise items - There was a focus on the forecast risks, particularly capital and a deep dive into the CIP and value delivery schemes. - Robert Tool, the ICB Finance Officer, had attended FPC - this was useful in receiving insight from a more regional perspective. - The AFM update picked up on monitoring the trend in waiters – this was reviewed in great detail and included the wide ranging efforts being made to tackle these issues. • Assurance item - An update was received on the new Provider Selection Scheme (PSR) and the new procurement legislation and the committee was assured by LPTs response and progress in implementing the necessary changes. • Celebratory item

	- Two quality improvement areas were highlighted; community nursing teams using ISLA digital pathway platform and the Speech and Language Therapy (SALT) team introducing a digital questionnaire. **Resolved:** The Board received the report for information and assurance.
TB/25-6/075	**Finance Report – Month 5 (Paper S)** Sharon Murphy introduced this report which provided an update on the Trust financial position for the period ended 31 August 2025. Key points were highlighted as:- • A £1.8m deficit was being reported as per the plan. • Clinical directorates were overspending by £1.9m; which was a similar value to month 4. • Estates were overspending £215k, corporate teams were underspending by £240k – these supported general delivery, as did the release of reserves. • The run rate table on page 6 of the report showed a positive in-month run-rate. This had reduced the year-to-date run-rate variance against plan which was a positive movement, although some planning gaps still needed closing and the in-year risks needed mitigating particularly around the shortfall and the pay award funding. • The likely forecast outturn was between £4.4m and £6.7m overspend. • Executive conversations continued to take place to ensure all actions supported delivery of safe services. • A breakeven position was still forecast. • A financial review meeting took place for LLR as NHSE was concerned about this System. • Cash was in a good position with 21 operating days. • Better Payment Practice Code (BPPC) – cumulatively, two of the four targets were achieved. Of the two not achieving target, the position did improve in-month. • A deep dive is being undertaken into the causes of late payment of estates invoices. • A LPT/LLR review of capital with the NHSE team took place to see if some of the allocations from 2025-26 could be deferred into 2026-27 – a response was currently awaited. • Accurate capital forecasting was essential as future guidance would penalize variances over 10% - potentially reducing next year's allocation by up to 20%. • Following delivery of the 2024-25 revenue plan an additional £11k had been approved for capital spend. Josie Spencer asked about the financial position of the Integrated Care System (ICS) and whether recovery was expected, expressing concern that LPT may face increased financial pressure if the position does not improve. Sharon Murphy responded that NHSE has made clear its expectation for improvement across the System and confirmed that while LPT is willing to support where possible, the current focus must remain on delivering its own financial plan, and at present, did not see scope for LPT to go further. The Chair sought clarity on whether there remained a financial gap for

	which no delivery schemes had yet been identified. Sharon Murphy explained that extensive work had been undertaken to identify schemes, particularly workforce reduction initiatives, in line with planning guidance. However, not all schemes had delivered as expected due to factors such as delayed approval from NHSE around the MARS scheme. It was noted that mitigations were being explored through weekly escalation and tracking a £2.5m gap was considered deliverable within the context of a £450m gross income organisation. The Chair offered thanks and proposed revisiting the financial position at an upcoming Board Development Session to ensure collective understanding and oversight. **Resolved:** The Board received this report for information and assurance.
TB/25-6/076	**Performance Report – Month 5 (Paper T)** Sharon Murphy presented this report which provided an overview of the Trust's performance against Key Performance Indicators (KPIs) for August 2025. Salient points highlighted were:- • Consistent KPI performance observed overall though trending lower in memory services, speech therapy and community paediatrics. • 52 week waits - decreased in five out of seven of the DMH services, increased in ADHD and medical-neuro psychology, decreased in two out of seven FYPC services. This continues to be reviewed in the Access Delivery Group meeting. Indications are that the Access Policy is not being consistently applied and there are some system changes that could help support improved recording which would help to reduce the number of over 52 week waiters. • All metrics were reviewed at the last Accountability Framework Meeting and there was nothing to escalate to Board. Jean Knight reminded members that a deep dive on waiting times was scheduled for the next Board Development session. Angela Hillery highlighted that neurodiversity, particularly ADHD, continued to be a significant contributor to waiting times and LPT was working with ICB colleagues to understand approaches in other areas, recognising that improving this position was a shared responsibility across the system. It was noted that ADHD related waiting times were a national issue and the importance of identifying commissioning related challenges was emphasised. **Resolved:** The Board received this report for information and assurance.
TB/25-6/077	**Charitable Funds Committee AAA Highlight Report: 11 September 2025 and Terms of Reference (Paper U)** Faisal Hussain introduced this report and drew attention to the following:- • the Terms of Reference had been agreed at CFC and were appended to the report for Board approval. • The committee had introduced a deadline-based approach to prevent the continued accumulation of reserves. This approach would be reviewed in 6 months' time. **Resolved:** The Board received the report and approved the Terms of

	Reference.
TB/25-6/078	**People and Culture Committee AAA Highlight Report: 13 August 2025 (Paper V)** Manjit Darby introduced this report and drew attention to the following:- • An initiative had been launched with weekly meetings to address team level non-compliance around mandatory training. • There had been a sustained rise in employee relations (ER) cases – these were being tracked. • A presentation had been received on the impact and outcomes of the job train recruitment system where positive outcomes had been identified. • Congratulations were offered to the Our Future, Our Way Change Leaders programme which had been shortlisted for an HSJ Award. **Resolved:** The Board received the report for information and assurance.
TB/25-6/079	**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/25-6/080	**Any Other Urgent Business** There was no other business.
TB/25-6/081	**Papers/updates not received in line with the work plan:** n/a
Close – date of next public meeting: Tuesday, 25 November 2025	

C

NHS
Leicestershire Partnership
NHS Trust

Public Trust Board 25 November 2025

Matters arising from the Public Trust Board meeting held 30 September 2025

Action sheet

Minute no.	Action/ issue	Lead	Due date	Status	Evidence
TB/25-6/072	**Patient Safety Report:** future reports to include data on patient numbers to provide greater insight into incident distribution and patient acuity	James Mullins	17.11.25	Complete	To be included in November 2025 report (confirmed by JM 28.10.25).
TB/25-6/073	**Annual Complaints and Concerns Report:** future reports to include outcome trends to support understanding the broader impact of complaints work.	James Mullins	17.11.25	Complete	To be included in next annual report (confirmed by JM 28.10.25).

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Leicestershire Partnership NHS Trust

LPT Trust Board Workplan 2025/26 v12

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

T H R I V E

		27- May-25	24-June-25	29-July-25	30-Sep-25	25-Nov-25	27-Jan-26	31-Mar-26
Item/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 ltd item ***(Confidential Agenda)***	Every meeting Dir Gov & Risk	X		X	X	n/a	n/a	n/a

		27- May-25	24-June-25	29-July-25	30-Sep-25	25-Nov-25	27-Jan-26	31-Mar-26
Item/Theme		Enabling	EGM (LPT Dev)	CHS	DMH	FYPCLDA	Enabling	CHS
					PLAN CLOSED			
Strategy and System Working:								
All received September 2025: • LPT Clinical Plan 2025-2030 • LPT Green Plan 2025-2028 • LPT Winter Plan 2025-2026								
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 *(18.12.25)*	X *(17.02.26)*
Safe Staffing Monthly Report	Every meeting Group Chief Nurse	X		X	X	X	X	X
Patient Safety Report (to include learning from deaths)	Every meeting Group Chief Nurse	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 Group Chief Nurse				X			
Confidential Patient Safety Report ***(Confidential Agenda)***	Every meeting Group Chief Nurse	X		X	X	X	X	X
Finance and Performance:								
Finance and Performance Committee AAA Report	Every meeting Dir Fin & Perf	X		X	X	X	X	X

		27- May-25	24-June-25	29-July-25	30-Sep-25	25-Nov-25	27-Jan-26	31-Mar-26
Item/Theme		Enabling	EGM (LPT Dev)	CHS	DMH	FYPCLDA	Enabling	CHS
		(15.04.25)		*(19.06.25)*	*(21.08.25)*	*(23.10.25)*	*(22.12.25)*	*(19.02.26)*
Finance Report	Every meeting Dir Fin & Perf	X		X	X	X	X	X
Performance Report	Every meeting Dir Fin & Perf	X		X	X	X	X	X
Charitable Funds Committee AAA Report	Quarterly Chair, CFC	~~X~~ ~~18.03.25~~ Deferred to July		X 18.03.25 and 26.06.25	X 11.09.25		X 19.12.25	X 13.03.26
Approval of Annual Financial Plan ***(Confidential Agenda)***	Annual Dir Fin & Perf							X
People and Culture:								
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 Group Chief People Officer							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							

		27- May-25	24-June-25	29-July-25	30-Sep-25	25-Nov-25	27-Jan-26	31-Mar-26
Item/Theme		Enabling	EGM (LPT Dev)	CHS	DMH	FYPCLDA	Enabling	CHS
Appointment of Senior Independent Director, Deputy Chair, Chairs of Committees	As required							
EGM Agenda								
Going Concern Assessment	Annual Dir Fin & Perf		X					
Audited Financial Accounts	Annual Dir Fin & Perf		X					
Letter of Representation	Annual Dir Fin & Perf		X					
KPMG ISA 260 and Auditors Annual Report	Annual Dir Fin & Perf		X					
Head of Internal Audit Opinion	Annual Dir Gov & Risk		X					
Annual Governance Statement	Annual Dir Gov & Risk		X					
LPT Quality Account 2024/25	Annual Group Chief Nurse		X					
LPT Annual Report 2024/25	Annual Group Chief People Officer		X					

E

Leicestershire Partnership NHS Trust

Trust Board 25th November 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 October - November. 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 step into the role of Interim Group Chair, I would like to begin by expressing my sincere gratitude to Crishni Waring for her outstanding leadership and dedication during her tenure.
As part of my transition, I am undertaking a comprehensive induction, which has provided valuable opportunities to meet staff, partners, and stakeholders across our organisations.

In light of the recent move to an Interim Joint Chair arrangement, we have reviewed the structure and responsibilities of our Non-Executive roles. As part of this, Josie Spencer will assume the position of Interim Deputy Chair, and Melanie Hall will take on the role of Senior Independent Director during this period.

I would also like to take this opportunity to thank Manjit Darby, who will be leaving her role as Non-Executive Director at the end of this month, for her positive contribution and support to LPT throughout her time with us.

Finally, I am pleased to confirm that all NED appraisal documents were submitted to NHSE ahead of the 30th September 2025 deadline, and mid-year reviews will be taking place over the coming weeks

Board Development

At our recent LPT Board Development session we took the opportunity to explore the current NHS context and receive a planning and financial update, we reviewed and agreed our Provider Capability Assessment submission, ahead of the national deadline and discussed our Armed Forces development as a Trust.

Board members received presentations on CMHT Waiting times and a deep dive into waiting times, including waiting well and those waiting over 52 weeks. We explored our processes and oversight, assurances on how patients are kept safe whilst waiting and planned actions to be taken.

We met with colleagues from NHFT for a Joint Board Development Workshop on 13th November 2025 and took the time to consider both organisations Freedom to Speak Up self-assessment and reflection tools as a wider group.

We were also joined by Weightmans LLP for a session on Mental Health Act Training.

Working with Partners and Stakeholders

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

- East Midlands Alliance (EMA) Learning Event
- Leicestershire & Northamptonshire Academic Health Partners (LNAHP)
- Meetings with ICB NEDs and Derbyshire Healthcare NHS Foundation Trust Quality & Safety Committee NED Chair
- System Chair/CEO Meetings
- LLR UEC Collaborative

Public, Patient and Staff Engagement

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

- Freedom To Speak Up Roadshows
- Staff Conference - Where I belong Every Voice Matters
- Consultant Interviews
- Medical Education Conference
- Daisy Award Celebration

- Carers Rights Event
- Service Visit: Mental Health Act team
- Service Visit: Bed Management Team

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

Proposal

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

Decision required – Please indicate:

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

Governance table

For Board and Board Committees:	Trust Board November 2025	
Paper sponsored by:	Faisal Hussain, Interim Group Chair	
Paper authored by:	Sinead Ellis-Austin, Faisal Hussain	
Date submitted:		
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	N/A	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	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)
Elizabeth Anderson	30/09/2025	Medical Education Conference	I
Melanie Hall	01/10/2025	External Auditor Tender Moderation	I
Josie Spencer	03/10/2025	East Midlands Alliance Learning Event	E
Melanie Hall	06/10/2025	External Auditor Tender Moderation	I
Faisal Hussain	06/10/2025	Introductory Meeting: NHFT ANED	E
Faisal Hussain	06/10/2025	Introductory Meeting: NHFT NED	E
Faisal Hussain	06/10/2025	Chair/Director Corporate Governance (LPT)	I
Faisal Hussain	06/10/2025	1:1 Chair	I
Faisal Hussain	06/10/2025	External Auditor Tender Moderation	I
Melanie Hall	08/10/2025	LPT NED 1:1	I
Faisal Hussain	08/10/2025	Introductory Meeting: NHFT Deputy Chair	E
Faisal Hussain	08/10/2025	Raising Health Governance Meeting	I
Faisal Hussain	08/10/2025	Member Webinar: Support for Working Carers	E
Manjit Darby	08/10/2025	FTSU Road Roadshow	
Faisal Hussain	09/10/2025	LPT Trust Board Agenda	I
Faisal Hussain	09/10/2025	ICB CEO	E
Faisal Hussain	09/10/2025	1:1 LPT NED	I
Faisal Hussain	09/10/2025	Raising Health Meeting	I
Melanie Hall	13/10/2025	Service visit – Single Point of Access	I
Chair/NEDs	13/10/2025	LPT NED Catch up	I
Faisal Hussain	13/10/2025	NHFT Corporate Governance Meeting	E
Josie Spencer	14/10/2025	FTSU meeting	I
Faisal Hussain	14/10/2025	Introductory Meeting: NHFT Executive Director	E
Faisal Hussain	14/10/2025	Introductory Meeting: NHFT NED	E
Faisal Hussain	14/10/2025	Chair, ICB Chair	E
Faisal Hussain	14/10/2025	1:1 Chair	I
Faisal Hussain	14/10/2025	Introductory Meeting: NHFT NED	E
Faisal Hussain	15/10/2025	NHS Confed MH Chairs Conference Call	E
Faisal Hussain	15/10/2025	Introductory Meeting: NHFT NED	E
Faisal Hussain	15/10/2025	Introductory Meeting: NHFT Executive Director	E
Faisal Hussain	16/10/2025	NHSE Leadership Event	E
Melanie Hall	17/10/2025	Team Brief	I
Faisal Hussain	20/10/2025	Introductory Meeting: NHFT/LPT NED	I
Melanie Hall	20/10/2025	Introductory Meeting: Incoming Interim Chair	I
Faisal Hussain	20/10/2025	Introductory Meeting: NHFT/LPT NED	I
Faisal Hussain	20/10/2025	Introductory Meeting: NHFT Executive Director	E
Faisal Hussain	20/10/2025	Chair/CEO	I
Faisal Hussain	20/10/2025	LPT NED Catch Up	I
Josie Spencer	21/10/2025	FTSU Roadshow	I
Hetal Parmar	22/10/2025	GGI: Derbyshire's model	E
Josie Spencer	22/10/2025	Meeting with ICB NED	E
Faisal Hussain	23/10/2025	NHFT Board Development Session	E

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Hetal Parmar	24/10/2025	FTSU Roadshow	I
Faisal Hussain	28/10/2025	LPT Board Development Session	I
Faisal Hussain	29/10/2025	NHS Confed MH Chairs Conference Call	E
Faisal Hussain	30/10/2025	NHFT Board Agenda Setting Meeting	E
Faisal Hussain	30/10/2025	Introductory Meeting: LPT Executive Director	I
Faisal Hussain	04/11/2025	LPT ANED Interviews	I
Melanie Hall	05/11/2025	Hudson & Hayes AI in the NHS webinar	E
Josie Spencer	05/11/2025	LPT ANED Stakeholder panel	I
Faisal Hussain	05/11/2025	Staff Conference: Every Voice Matters	I
Melanie Hall/Faisal Hussain	06/11/2025	External Auditor Bidder presentations	I
Faisal Hussain	06/11/2025	1:1 CEO	I
Faisal Hussain	07/11/2025	NHFT Staff Governor Induction	I
Faisal Hussain	07/11/2025	NHFT Quality Awards	I
Melanie Hall	10/11/2025	Service Visit with Mental Health Act team	I
Chair/NEDs	10/11/2025	LPT NED catch up	I
Josie Spencer	10/11/2025	Staff Conference: Every Voice Matters	I
Faisal Hussain	10/11/2025	NHS Conference All member Chairs Group	E
*Josie Spencer	11/11/2025	FTSU meeting	I
*Faisal Hussain	11/11/2025	Introductory Meeting: NHFT NED	I
*Melanie Hall	12/11/2025	Health & Wellbeing Roadshow	I
*Josie Spencer	12/11/2025	Derbyshire Healthcare NHS Foundation Trust QSC NED Chair	E
*Faisal Hussain	12/11/2025	Introductory Meeting: LPT Executive Director	I
*Faisal Hussain	14/11/2025	LNAHP Board Agenda Review Meeting	E
*Faisal Hussain	14/11/2025	Browne Jacobson	E
*Melanie Hall	17/11/2025	Counter Fraud Awareness training	I
*Manjit Darby	17/11/2025	Daisy Award	I
*Josie Spencer	18/11/2025	Counter Fraud Awarness Training	E
*Faisal Hussain	18/11/2025	LNAHP Board	E
*Faisal Hussain	18/11/2025	Joint Corporate Governance Meeting	I
*Faisal Hussain	19/11/2025	NHS Confed MH Chairs Conference Call	E
*Faisal Hussain	19/11/2025	2:1 NED SIDs	I
*Faisal Hussain	19/11/2025	1:1 CEO	I
*Melanie Hall	20/11/2025	Carers Rights Event	I
*Melanie Hall	26/11/2025	Transformation & QI Meeting	I
*Faisal Hussain	26/11/2025	LPT NED Mid-Year Reviews	I
*Faisal Hussain	26/11/2025	NHS Confed MH Chairs Conference Call	E
*Faisal Hussain	26/11/2025	Chair/Deputy Chair 2:1s	I
*Faisal Hussain	27/11/2025	NHFT Trust Board	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
LNAHP = Leicestershire & Northamptonshire Academic Health Partners
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
SIDs = Senior Independent Directors
UEC = Urgent & Emergency Care
UHL = University Hospitals of Leicester
UHN = University Hospitals of Northamptonshire
UoL = University of Leicester
FTSU = Freedom To Speak Up

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Leicestershire Partnership NHS Trust

Public Trust Board 25th November 2025

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 Updates

Advanced Foundation Trust status

NHS England have published a draft Advanced Foundation Trust (AFT) Programme – guide for applicants which is out for consultation until 11th January 2026. Advanced foundation trust (AFT) is the name for the 'new FTs' referred to in the 10-year health plan. NHFT, who we are in a Group model with, are included in the first cohort of Trusts who have been invited to apply for Advanced Foundation Trust status. We will work closely across Group to support NHFT in their application and share learning and best practice.

The draft guidance sets out the rationale for the programme and the proposed eligibility criteria and assessment process. It also sets out the proposed assessment process for readiness to hold an integrated health organisation (IHO) contract. An IHO contract is a contract that can be awarded by an ICB to an eligible Advanced Foundation Trust to hold responsibility, and the associated health budget, for improving health for a defined population.

This new model will support the shift to community-based and preventative models of care, and savings from the delivery of high-quality and efficient care can be reinvested into better population health and patient care.

A useful briefing can be found here: Next day briefing: advanced foundation trust programme – guide for applicants

Planning

We welcome the publication of the medium-term planning framework, which sets out key priorities for the next three years and the broader strategic aims that will guide five-year plans for each NHS organisation. The plan focuses on high-level priorities, giving clear direction on what the NHS must deliver while allowing flexibility for local needs.

There are a suite of supporting documents that sit alongside the medium-term plan to support commissioners and providers to develop 5 year plans that will start to implement the ambitions of the 10 Year Health Plan. These include the new Strategic Commissioning Framework, NHS Oversight Framework and the draft Advanced Foundation Trust (AFT) Programme.

We will be working with system partners as we begin to develop our five-year plan in response to this guidance.

Further information can be found here NHS England » Medium Term Planning Framework – delivering change together 2026/27 to 2028/29

Winter Vaccination Programme

As we brace ourselves for expected peak flu season, NHS teams across the country have now delivered more than 13 million flu vaccines since the rollout began. Flu vaccines are available for everyone aged 65 and over, under 65s in clinical risk groups, pregnant women, care home residents and carers, close contacts of those who are immunosuppressed, frontline social care workers, and health and social care staff as well as children.

Our staff are working hard to ensure that LPT's flu vaccination programme is rolled out to a variety of locations to make it as convenient as possible for our staff to get vaccinated and keep our population safe.

CQC Executive team

Dr Arun Chopra, Chief Inspector of Mental Health, has assumed the role of Interim Chief Executive following the departure of Sir Julian Hartley.

For further information please see here: Sir Julian Hartley steps down as Chief Executive of CQC - Care Quality Commission

The CQC has launched its *Better Regulation, Better Care* public consultation to improve how health and care services are assessed and rated. The proposals aim to create a clearer regulatory framework, which will be informed by extensive stakeholder engagement and external reviews.

The proposed changes will focus on developing frameworks and guidance for assessing providers and improving how we assess and rate providers. Key changes include reintroducing rating characteristics to clarify what each rating means, replacing quality statements with assessment questions, developing sector-specific frameworks, and simplifying content for consistency and clarity.

The consultation is open to all stakeholders until 11 December 2025 and we will be engaging with the process.

For further information please see here: CQC launches Better regulation, better care consultation - Care Quality Commission

Medical Training recommendations

NHSE has published the first phase of its Medical Training Review, led by Chief Medical Officer Professor Chris Whitty and former National Medical Director Professor Stephen Powis. The review, informed by over 8,000 responses from doctors, patients, and stakeholders, identifies gaps in the current postgraduate training system and sets out 11 recommendations, including four key priorities: making training more flexible, addressing damaging bottlenecks, building on excellence beyond formal routes, and creating inclusive team structures where all doctors feel valued. The next phase will involve collaboration with medical royal colleges, regulators, and patient groups to design a comprehensive reform package.

NHSE is already implementing measures to improve resident doctors' working lives and plans to expand postgraduate training places as part of its 10-year health strategy

For further information please see here: NHS England » England's leading doctors set out medical training recommendations

NHS Providers and NHS Confederation merger

NHS Providers and NHS Confederation have confirmed plans to merge, creating a single membership body to represent NHS organisations across England, Wales, and Northern Ireland from April 2026. This decision follows extensive engagement, with 85% of nearly 400 senior leaders supporting the move. The new organisation aims to provide a stronger, unified voice for NHS leaders, improve collaboration, and support better care and value for patients and taxpayers.

A transition committee will oversee preparations, including a new leadership structure and external recruitment for a chief executive. A new membership offer will launch in March 2026, ensuring the organisation is fully operational by April 2026.

For further information please see here: NHS Providers and NHS Confederation confirm merger

10 Year Workforce Plan

The Department of Health and Social Care has launched a call for evidence to shape the forthcoming 10-Year Workforce Plan, which will underpin the government's wider health reform agenda.

We welcome the 10-Year Health Plan's ambition and strategic aims. Its emphasis on shifting care models, embracing digital innovation, and proactive population health resonates strongly with our local strategy. To deliver on this promise, we call for clear operational planning, capital and workforce investment, and a sustained focus on research, innovation, and health inequalities.

As a valued local partner, we stand ready to collaborate with NHS England, NHSE regional teams, and our ICS to co-design detailed delivery plans, support implementation, and track progress over the decade ahead.

Provider capability assessment

NHS England has issued guidance for Trust boards on assessing organisational capability as part of the NHS Oversight Framework. Boards were required to complete a self-assessment across six key areas: strategy, leadership and planning, quality of care, people and culture, access and delivery of services, productivity and value for money, and financial performance and oversight.

This process aims to strengthen board assurance and promote transparency.

Our self-assessment has been submitted, and we await feedback.

For further information see here NHS England » Assessing provider capability: guidance for NHS trust boards

Industrial Action

The British Medical Association has announced resident doctors will be undertaking industrial action from 6:59am on Friday 14 November until 6:59am on Wednesday 19 November.

As a Trust, we have plans in place to help minimise disruptions such as industrial action, where we can.

Local Developments

LPT welcomes new Interim Group Chair

I would like to take the opportunity to welcome Faisal Hussain into the Interim Group Chair role across NHFT/LPT and look forward to working alongside him in this new chapter.

We are also proud to share that Faisal was recently named as a rising star by the Health Service Journal (HSJ) in their recent most influential Black, Asian and minority ethnic people in health.

Leading conferences embedding THRIVE

We continue to embed our new vision, mission and strategy across the Group. We held two leadership conferences in November, one in Leicester and one in Northamptonshire, for our leaders to connect on the important topic of 'Every voice matters'. This combined Group approach saw over 200 delegates enhance their development around Freedom to speak up; Psychological safety, Belonging and inclusion and Healthy Communities. Further resources are being provided post-events to support leaders to embed the learning locally.

East Midlands Alliance Event

I recently attended our planned East Midlands Alliance annual event for Boards, held in Northampton. This event was open to all Board members of the East Midlands Alliance and was well attended. We took the opportunity to receive and share an update on the national context, our joint patient safety programme, the changing legal landscape, transformation in our children, adolescent mental health collaborative and an update on a pilot around adopting Open Dialogue approaches in services. The Alliance Plan for 2025/26 was shared and the group discussed future opportunities for collaboration

Celebrating Excellence

Our annual Celebrating Excellence awards ceremony took place at Leicester's Grand Hotel on September 26. Award winners nominated from 13 categories took to the stage to pick up trophies for embodying the Trust's values of compassion, respect, integrity and trust. It was great to celebrate achievements and successes with individuals and teams.

Charnwood Mill

We handed back Charnwood Mill, Barrow upon Soar, to NHS Property Services on November 10. The building has hosted a number of community and administrative teams over the past 20 years. Staff have relocated to existing LPT offices and units, saving around £400,000 a year in rent.

Short breaks engagement

We are engaging with affected families about a proposal to move our learning disabilities short breaks service. At present these breaks are provided at the Grange and the Gillivers bungalows on Farm Drive at the Glenfield Hospital site. The proposal is that the service is instead provided in vacant space within the Agnes Unit, a short distance away, while keeping the same level of service provision. The Agnes Unit is a fantastic, modern building with lots of specialist and bespoke facilities. We want to make sure it is used to its full potential to provide short and long term care and help people in the local community.

Find out more: https://www.leicspart.nhs.uk/involving-you/learning-disability-short-breaks-service-relocation-proposal/

While You Wait

We have created a 'While you wait' area on our Trust website to help the public, our patients, their families and carers find clinically-approved advice, support and guidance for their mental health; and specific advice for ADHD and CAMHS while waiting for a formal assessment or appointment. The area will be developed and enhanced, to include more information on the current three priority areas, and additional priority areas. https://www.leicspart.nhs.uk/while-you-wait/

Garden created for inpatients

We recently opened a new therapeutic sensory garden at the Bradgate Mental Health Unit. This space has been carefully designed to offer a calming, restorative environment where patients can reconnect with nature, find moments of peace, and support their recovery journey. Its £25,000 cost was met by sponsors following a Raising Health appeal.

More solar schemes

The government recently announced grants worth more than £400,000 to fund rooftop solar arrays at Coalville Community Hospital, the Herschel Prins Unit, the Evington Centre and Gwendolen House. All should be complete by the end of March 2026. This follows two other solar schemes installed this year at Hinckley and Bosworth Community Hospital and at Loughborough Hospital.

Hinckley Hub official opening

The Mayor of Hinckley and Leicester City FC's mascot Filbert Fox joined us at the official opening for our new base within the Hinckley Hub. It is expected to provide physiotherapy and occupational therapy for around 6,000 adult and child patients per year.

Sensory room at The Beacon

A new sensory room has been opened at The Beacon, our inpatient CAMHS facility. The room is equipped with a range of calming and interactive features, including an infinity tunnel, hurricane wall, soft safety padding, bean bags for comfortable seating, an interactive wall and floor projector, and a portable sensory trolley that can be taken to patients' bedrooms. It was funded through a Raising Health appeal.

Audiology centre opened

We have opened a new diagnostic hearing testing facility at Beaumont Leys Health Centre. It is fully sound-proofed and with its own separate observation suite and therefore provides a gold standard clinical testing environment.

Mutually Assured Resignation Scheme (MARS)

We offered the Mutually Agreed Resignation Scheme (MARS) to our employees over the summer. It attracted around 80 applications, of which 14 were eligible and have been accepted. We wish these employees well in their next chapter.

LLR MH Collaborative Away Day

We recently held a face-to-face LLR Mental Health Collaborative Away Day, where the group received and discussed updates on the implications of the NHS Long Term Plan. The session also explored health inequalities and the development of Neighbourhood Health for our population. It was highly encouraging to see such a wide range of partners working together to meet the needs of our communities.

Relevant External Meetings attended since last Trust Board meeting

October 2025	November 2025
Weekly Urgent & Emergency Care	Weekly Urgent & Emergency Care
Local Resilience Forum Executive Board	Monthly Urgent & Emergency Care Collaborative Transformation Group
Monthly Urgent & Emergency Care Collaborative Transformation Group	Midlands COO/MD/DoN monthly
NHSE COO Leadership Event	Remembrance Service Event
LPT & Healthwatch	Group Strategic Executive Board with NHFT
Trust legal team	ICB Mental Health Partners Forum Meeting
Urgent & Emergency Care SRO meeting	CEO at St Andrew's Healthcare
Group Accountability Framework discussion	Mental Health Network Sector Scope
LLR UEC SRO and UEC Operational Group	CQC/NHSP Trust well led reference group
Group Strategic Executive Board	CEO Mersey Care NHS Foundation Trust
Joint Governance & Risk Leadership Group	CQC Engagement Meeting
LNR Health Partners' Executive	UHN / LLR / UHL CEOs
ICB and Trust CEOs discussion on Medium Term Planning Framework	Director of System Architecture NHSE
Introduction meeting with UHL Acting COO	NHS Providers Conference
Midlands COO/MD/DoN monthly	CEO at St Andrew's Healthcare
LLR QIG	Mental Health Network Sector Scope
ICB/NHSE/LPT Core Standards Confirm and Challenge	*Joint Board Development Workshop with NHPT
East Midlands Alliance Annual Event for Boards	*Midlands and East Mental Health CEO Network
QIG expectations oversight	*CEO Nottinghamshire Healthcare NHS Foundation Trust

LLR & Northamptonshire Quarterly System Review	* Northamptonshire & LLR ICB CEO
East Midlands Alliance Annual Event for Boards	*LLR Urgent & Emergency Care Collaborative
UHN / LLR / UHL CEOs	*Joint Board Development Workshop
Roundtable: Future Models of Provider Integration and IHOs	*Joint Together Against Racism Workforce Group
East Midlands Alliance Lead	*Midlands and East Mental Health CEO Network
Mental Health Trusts Chief Executives meeting with Regional Leads and SROs	*Joint CQC Workshop
Group Strategic Executive Board with NHFT	*LLR Local Health Resilience Partnership
Together Against Racism Group with NHFT	*LPT Quality Improvement Group
Midlands NHS Leadership Meeting	*LNR Health Partners' Executive
LNR Health Partners' Executive Meeting	*Joint CQC Workshop with NHFT
East Midlands Alliance CEO Meeting	*LLR ICB and NICB Board development session
CEO at St Andrew's Healthcare	*Northamptonshire & LLR ICB CEO
Community Network	*Northamptonshire & LLR ICB Chair
REACH Network Leads with NHFT	*Northamptonshire & LLR ICB CFO
Midlands CEOs with Regional Director, NHS Midlands	
CEO South West London and St George's Mental Health NHS Trust	

*Indicates meeting scheduled but has not taken place at time of drafting the report.

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

LPT= Leicestershire Partnership Trust

MD = Managing Director

MH = Mental Health

NHFT = Northamptonshire Healthcare NHS Foundation Trust

NHSE = NHS England

QIG =

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

Briefing – no decision required

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 of Directors
Paper sponsored by:	Angela Hillery, Chief Executive
Paper authored by:	Sinead Ellis-Austin, Head of Chair/CEO Office
Date submitted:	November 2025
Name and date of other committee / forum at which this report / issue was considered:	None
Level of assurance gained if considered elsewhere	☐Assured ☐ Partially assured ☐ Not assured
Date of next report:	January 2026
THRIVE strategic alignment:	☒ **T**echnology ☒ **H**ealthy communities ☒ **R**esponsive ☒ **I**ncluding everyone ☒ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	
Is the decision required consistent with LPT's risk appetite:	Yes
False or 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

Public Trust Board 25 November 2025

Board Assurance Framework

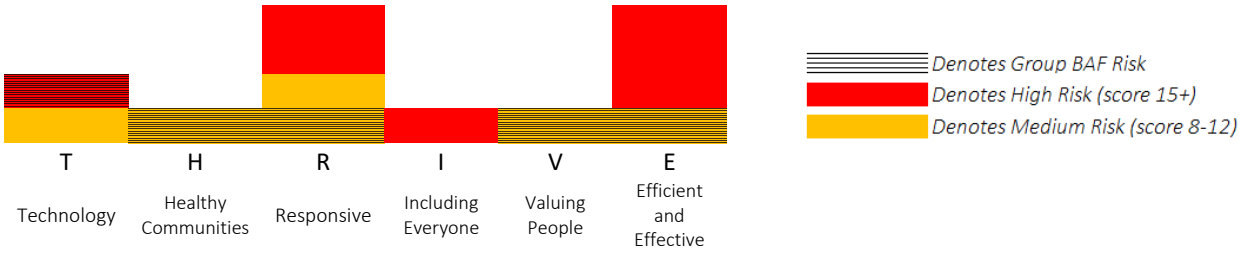
Purpose of the Report

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.

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



- There are eight strategic risks for Leicestershire Partnership NHS Trust (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 mostly 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

There are no significant changes to the board assurance framework to report this month.

Decision Required

Discussion – no decision required

T H R I V E

Governance Table

For Board and Board Committees:	Trust Board 25 November 2025
Paper sponsored by:	Kate Dyer Director of Governance and Risk
Paper authored by:	Kate Dyer Director of Governance and Risk
Date submitted:	17 November 2025
Name and date of other committee / forum at which this report / issue was considered:	The BAF is reviewed monthly at the Strategic Executive Board. It is also reviewed bi-monthly by the relevant level 1 Committee.
Level of assurance gained if considered elsewhere	☒Assured ☐ Partially assured ☐ Not assured
Date of next report:	SEB 12 December 2025
THRIVE strategic alignment:	☒ **T**echnology ☒ **H**ealthy communities ☒ **R**esponsive ☒ **I**ncluding everyone ☒ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	ALL
Is the decision required consistent with LPT's risk appetite:	Yes
False or 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

November 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.	10
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 14.11.2025
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	• Capital funding for digital including infrastructure and solutions to improve data & productivity • Capacity and resources • Challenges in recruiting and retaining Digital workforce. • Availability and quality of data for reporting & analysis	**1st Line:** The Information Management & Technology/ Digital Data & Technology Groups Capital planning committee **2nd Line:** Finance & Performance Committees **3rd Line:** NHS England Digital Maturity Assessment System oversight		• Group Digital Transformation plan – timelines – 1.1.26 - **Chief Information Officer (as SRO)** • Gap analysis of capacity to deliver plan to be scoped **- Chief Information Officer 1.1.26** • Group Digital Plan to be drafted – Group SEB October – draft to Group SEB Oct – final 1.1.26 **Chief Information Officer** • Governance review underway – 1.1.26 - **Chief Information Officer**	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	• Digital engagement	**1st Line** Digital prioritisation Process ensures that the most impactful initiatives receive the focus and resources required.. **2nd Line** Digital prioritisation regularly reported to the Transformation Committee **3rd Line** Clinical Focus and Engagement in decision making to be an essential element of its governance arrangements.	Lack of clinical leadership at times	Options to improve clinical leadership in digital decision making to be developed **Chief Information Officer** – October 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 14.11.2025
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					
• Qualified Cyber security experts with 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 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 • Access to the ICB CISO for advice • MFA enabled on user accounts • VPN are monitored and restricted • Cyber Security assess all software that is required to be installed / DPIAs	• Constrained capital • No Security Information and Event Management solution • No pro-active management of security outside core business hours (no cyber on call) • 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 Information Management & Technology/ Digital Data & Technology Groups Capital planning committee		• Implement InTune as the new Trust MDM – **31.3.26 – CIO** • Collaboration with cyber security teams across LLR - **31.3.26 – CIO** • Adoption and deployment of strategic cyber security solutions **31.3.26 – CIO**	• Pillar under the new Digital Transformation Group in place to review Cyber opportunities • Mobile phone replacement programme being started along with rollout of InTune • Windows 11 70% complete.
		2nd Line: DSPT Compliance and quarterly audit and penetration test with executive summary to the Data Privacy group. LHIS is ISO27001 accredited which provides assurance that the Information Security Management System (ISMS) operates effectively. Audited twice yearly. Routine reporting, review and escalation of cyber security threat/risk through Data Privacy Group (DPG). Incident reporting to DPG, including root cause and lessons-learned reviews. NHSE monitoring of our environment and MDE reporting	Assurance of security posture/compliance from core IT service suppliers.		
		3rd Line: Training is provided to staff to raise cyber awareness as well as regular communications and events. NHSE Board level cyber training provided by external provider Feb 2024 SIRO, Deputy SIRO and CDIO all undertaken SIRO training via NHSE Small number of CSOs who manage clinical safety Cyber Group formed across LLR/NICB	Impact of training and phishing campaigns		
Effect: unable to access electronic systems which are fit for purpose					
• Data Privacy Group • Trust CDIO/ LHIS Cyber team • NHSE best practice (DMA) to have NED assigned as the cyber lead • DTAC Process exists to ensure suppliers meet certain cyber and clinical safety standards to safeguard the Trust.	• 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 focused on areas of high and medium impact		DTAC Process needs to be reviewed and consistently applied by Procurement Team to help manage the risk of our supply chain – **31.3.26 – Director of Finance**	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.
		2nd Line Capital has been obtained from NHSE for key cyber security requirements as well as the new ICB CISO role. Chair of the FPC receives annual update as part of committee workplan.			
		3rd Line Systems monitored by LHIS and NHSE teams via MDE, MDM and secure boundary services LHIS re-accreditation of secure email system [ISO27000] and Cyber Essentials Consultancy			

GROUP BAF **2**	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 17.11.2025
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 – complete 10.11.25** 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 - complete**	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 – 1.12.25**	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 23rd October 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 • 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 **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 NHS IMPACT Self Assessment 2025 June 2025 **3rd Line:** University Led Non-Executive Director - LPT	Assurance over uptake and PRES survey outcomes Assurance over success rate for attracting high quality commercial trials	• 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 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 - approved by Royal college 6.11.25 – recruitment to commence	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
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 **2nd Line** LPT QI and Transformation Committee AAA report to Finance and Performance Committees and the Strategic Executive Boards	Impact of learning from research into service redesign	• 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.

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 18th November 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– 1.12.25** • 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 – remains ongoing – 1.1.26** • Clinical task and finish group workplan established with priorities agreed; a set of actions; workplan to Jan 26; Board Development session planned for Oct 25 - **Director of Nursing & Medical Director Jan 2026**	
Effect: **Clinical Outcomes**					
• Reducing Harm Whilst Waiting Policy & compliance oversight • Clinical Outcome performance measures • Incident reporting & learning from incidents	- Challenge of identifying harm whilst waiting –no national definitions of harm for Community Mental Health Trusts - Data insight & reporting on harm whilst waiting - Clinical Harm – no overarching Trust policy but local processes in place – usage and consistency	**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** Annual feedback from Community & Mental Health Survey	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 inpatient 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 from June 25. Phase 2 to consider additional metrics to support patient safety. • Quality & Safety Dashboard Report (Trust wide data) to QSC & QF • 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 Quality Forum & Safety Forum Dec 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 23rd October 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**	**2**	**10**
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 • Psychological Safety Workstream • Complex Case Huddle • System and process learning shared through governance meetings	Thematic Reviews timeliness & opportunity for learning	**1st Line:** Service level oversight; Executive Service Visits & feedback; NED Board Walks; Compliance Team visits; PSIRF	Consistent alignment between complex cases that involve safeguarding, patient safety & patient experience	• PSIRF priorities agreed at EMB Oct 25 • Suicide prevention work & training **Medical Director, update Dec 25**	• Staff booked onto STORM training
		2nd Line: EMB, SEB, Q&S Committee, Safety Forum. Policy compliance oversight	• Suicide prevention training		
		3rd Line: External reporting (ICB); HOSCs; CQC Visits & outcomes; MHA Visits & reports, 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 • Trust wide Discharge Policy	Effective use of technology to support data analysis	**1st Line:** Directorate oversight of local quality & safety systems and processes.	Comprehensive oversight of quality measures	• Quality Dashboard – phase 1 complete, phase 2 underway **Director of Nursing ongoing 2025/26**	Phase 1 complete with minimal viable product complete
		2nd Line: Horizon scanning & national leaning			
		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 16.10.25
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 November 2025 - complete** • 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 & received full assurance received on the 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 • LPT fully compliant against the EPRR Core Standards 25-26	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 – complete – full assurance received	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 23rd October 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 • Progressing NHSE letter & actions set out within regarding tackling racism including antisemitism	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 – signed off Group SEB Sept 25 – development plans under way 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: • LPT Internal Audit Freedom To Speak Up October 2023 significant assurance • LPT Internal Audit Fit and Proper Persons Test due Q2 2024/25 • LPT 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 2025 • Every Voice Matters Leadership Conference 3 & 10 No 25
		2nd Line • Mental Health and Wellbeing Support • Health and wellbeing champions and wellbeing NED role • Health and Wellbeing Lead • People and Culture Committee			
		• **3rd Line** • CQC inspection findings • Looking after our people systems H&WB support	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 23rd October 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 • Nursing Recruitment & Retention High Impact Actions • LLR AHP faculty & Council • L2 Committee Workforce Development Group in place • Benchmarking against workforce metrics • Jobtrain Effectiveness review • Vacancy Control	• High vacancies with supply issues • Link to transformation planning	**1st Line:** Operational risk profile for staffing – oversight at AFM and EMB/SEB; 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 • Actions resulting from recent staff survey findings when available • 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 – approved – to be published • Reviewing rostering policy in line Internal Audit Report • Workforce operational plan in development for 25-26 and beyond	Engagement with the NHSE price cap work for medical agency costs commenced Feb 2025 - ongoing People Dashboard launched through PCC Jobtrain/time to recruit reviewed Aug 25
Effect: **High Agency Usage**					
• Agency Reduction Plan • Jobtrain implemented	Nurse vacancies	**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)	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 use to EMB Oct 25 – ongoing monitoring	• No off-framework usage outside of break glass • THP numbers reducing • Benefits realisation of Jobtrain

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 14.11.25
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 • Green Plan 2026 - 29 • Estates Strategy and Delivery Plan • Partnerships Manager as resource for Green Plan oversight • Group Sustainability Forum	• 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		• Gap analysis of available funding and impact of any resource gap on delivery of the revised green plan. **Chief Finance Officer 1.1.26** • Green Plan going to September LPT TB for sign off - **Chief Finance Officer - complete** • Green Plan signed off July NHFT TB - **Chief Finance Officer - complete**	• Funding secured for LPT solar panel installations at Hinkley & Bosworth and Loughborough plus 4 more • Trust Green ambitions approved by SEB October 2025
		2nd Line: Finance & Performance Committees Group SEB			
		3rd Line: CQC feedback NHSE oversight of green plans	• 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			
		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 14.11.2025
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 • Space Utilisation Study Complete	• 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 – 1.8.26** • Medical Directorate rep at relevant Estates meetings to be identified – **Medical Director**	
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 – ongoing – 1.8.26**	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 – 1.11.25 **complete** • Annual Estates Plan approved – 1.11.25 **complete** • Escalation of Health & Safety issues **– 1.11.25 complete – process in place** • Oversight of estates risks on Ulysses – 1.11.25 **complete** • Review building compliance standards with DoN **Chief Finance Officer – 1.1.26**	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 14.11.25
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 – potential topslice of capital funds in 2026/27	• Policy compliance audit and oversight **Director of Finance and Performance.** • Escalated to NHSE in capital review meeting 15/09/25; Requested deferral of £1.8m to 26/27 **Director of Finance and Performance.** • External audit of 25/26 accounts **31.3.26 Director of Finance and Performance.**	Waiting for NHSE approval
		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 **30.12.25** 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 31.3.25**	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 14.11.25
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 – now BAU** • additional recovery actions implementation **ALL** • Enhanced cash reporting • External audit of 25/26 accounts **Director of Finance and Performance 31.3.26**	BAU In place
		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 31.3.26** • Deep dive reporting **Director of Finance and Performance ongoing** • DoF/service financial escalation meetings**-31.3.26**	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 / December 25**	
		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 26/27 & medium term financial plan **DoF** Dec 25 • Manage delivery of 2025/26 financial plan **DoF / March 26**	In progress
		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: Quality and Safety Committee
Meeting Chair & Report Author: Josie Spencer Non-Executive Director
Meeting Date: 21st October 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	There continues to be an alert from the Access delivery group around the number of waits over 52 weeks, predominantly in regard to neurodevelopmental pathway and this is being discussed at the Board Development Day on the 28th October 2025. A key issue identified is the functionality of our Electronic Patient Record and a need to amend processes. Updates to the Access policy as a result of the PTL work is ongoing. Keeping safe whilst waiting task and finish progressing.	3.2		
ADVISE: Advise the Board of areas subject to on-going monitoring or development or where there is negative assurance						
5. Executive Environmental Scan Director of Nursing Update Quality Assurance and CQC update Report	Item 5.1	James Mullins	The committee was briefed on the current position following the CQC Inspection to LPT services in May 2025. Draft reports with proposed ratings for CMHTs have been received and are currently subject to a factual accuracy process prior to publication. LPT has been part of a pilot process using a new CQC portal for submission. The draft reports for the crisis team and health-based place of safety core service visits are awaited. The committee received assurance that the process for completing actions which remain outstanding from the draft CQC report are monitored by the Compliance team and by the DMH Directorate with robust Executive oversight, with learning outcomes reported to the Executive Management Board (EMB) and Strategic Executive Board (SEB). The Committee requested specific assurance against the actions and will consider a timeframe for this outside of the meeting.	3.3		

5.2 Medical Director update	Item 5.2	Dr Bhanu Chadalavada	A Quality Visit was undertaken by Leicester Medical school and the overall findings were positive, however some issues were highlighted around broadening the teaching experience to include locum staff. A further issue highlighted was around the capacity and infrastructure of the Clinical Education centre as a temporary venue and this is being worked through with support from the Medical Education team.			
5.3 Themes from Freedom to Speak up	Item 5.3	Kate Dyer	The committee was advised that currently the process for escalating issues relating to Freedom to Speak up which have been raised at People and Culture Committee to the Quality and Safety Committee (QSC) is verbally by the QSC Chair because she attends both Committees. However, conversations have recently taken place about how to formalise this. It was agreed to add an action to the QSC action log to track progress.	3.3		
Accountability Framework Meeting (AFM) AAA report	Item 7	Jean Knight	The is a concern, previously reported in August 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.	3.3		
Quality and Safety Dashboard	Item 9	James Mullins	The committee were advised that the complaints performance (sign off within 40 working days) remains a key focus and the data for June 2025 (reported in arrears) confirmed compliance is at 73%, which is an improving position. The complaints team continues to work towards a target of achieving 90% compliance by December 2025. There has evidence of excellent collaborative working with directorate colleagues around complaints management particularly with services in FYPCLDA.	3.3		
Level 2 Quality Forum AAA reports (June and July 2025)	Item 10	James Mullins	The committee received an alert from the September 2025 Quality Forum about the use of CoPilot and staff understanding and interpreting guidance around AI. There has been an increase in clinicians using co-pilot, there is a concern that some of the current guidance could also be open to interpretation and about the scale and pace of delivery of our AI implementation. The Executive Management Board are aware, and the	3.3		

			committee were advised that pilots are being arranged through Health Innovation East Midlands and approval and guidance is awaited, in addition a CoPilot trial is being undertaken with NHFT to ascertain the efficiency, qualitative and financial benefits realised during the trial period.			
Safety Assurance report	Item 15	James Mullins	The Trust is responding to the recommendations from an independent report by Penny Dash, who was commissioned by the Secretary of State for Social Care to look at 'Patient Safety Across Health and Care' and actions will come through EMB and QSC. A further update will be brought to the December 2025 Committee.	3.3		
Staying safe from suicide NHSE guidance	Item 16	Dr Bhanu Chadalavada	The committee received an update on the progress of LPT against the Staying Safe from Suicide Guidance which was introduced to support the Government's work to reduce suicide and improve mental health, promoting a shift towards a more holistic approach and moving away from the use of suicide prediction tools and stratification of risk. The guidance identifies ten key principles of the approach. Following engagement in research around suicide prevention, the trust had identified a five key actions, progress and compliance will be reported to LPT Suicide Prevention Group and escalated accordingly. The committee would like evidence of the outcomes and impact of changes, and how LPT is assured about improvements in the time since the guidance was published. It was agreed that committee receives an update in April 2026, possibly using a deep dive approach, to further explore the actions, impact and outcomes (both in LPT and wider).	3.3		
Safeguarding Committee AAA Report	Item 18	James Mullins	Previously reported as an alert, the committee was received an update on the Safeguarding Children's Reforms Bill. There is LPT membership on the Childrens Reform Board and relevant subgroups and a specific Health Subgroup to focus on health's role in the new children's teams proposed. There is good progress against the actions against the Quality Improvement Plan, which is dynamic with new actions being added where required. A new pathway for pregnant young people who are open to CAMHS and Looked after Children is being established to ensure there is a clear robust process to follow. The Looked after Children (LAC) Named Nurse and Family Service Manager attended the September Safeguarding Committee to provide an overview of the LAC Service and Key Performance Indicator (KPI) data for NHSE around LAC	3.3		

			and this was very well received and acknowledgement of the improvements in this area.			
Equality and Quality Impact Assessments of CIPs	Item 21	James Mullins / Dr Bhanu Chadalavada	The committee were assured that the Medical and Nursing Director were working collaboratively and closely with Project Management office and finance colleagues and there is a robust process in place for discussion and sign off of all schemes. Monitoring is in place for the high-risk schemes. There is an updated EQIA policy which will go to the Transformation and Quality Improvement group in November 2025. The committee will now consider what it wishes to receive going forward, in order to be assured of the ongoing monitoring and mitigations of high-risk schemes.	3.3		
ASSURE: Inform the Board where positive assurance has been received						
Policies approved/ extensions granted:			Nil			
CMH Survey results 2023 to 2024	Item 12	Tanya Hibbert	The committee received for assurance an overview of the results from the 2023-24 Community Mental Health Survey, which is open to all patients aged 16 and above. LPT performed above national average in five of the seven domains. Of the areas where the Trust performed below national average, it is anticipated that some of the work aligned to the Community transformation work will improve outcomes and results in the current survey. This includes work with community connectors, voluntary sector links through cafes, the Joy application and neighbourhood teams. It was agreed that there needs to be consideration of the appropriate timing of future reporting to the committee.			
Level 2 Safety Forum AAA Reports	Item 14	Dr Bhanu Chadalavada	The August report highlighted the need for a suicide prevention lead post to take forward some aspects of suicide prevention work, in particular self-harm training. This post has now been appointed to.			
Infection Prevention and Control six-month report	Item 20	James Mullins	The committee received the report for the period April to September 2025. In terms of reportable infections, there is an increasing trend for Clostridium difficile infection (CDI) which is aligned to a national rise and there are local learning and prevention actions in progress. LPT is compliant with Sterilisation of equipment requirements and retains 5-star compliance under National Standards of Healthcare Cleanliness. The 2024 PLACE scores for cleanliness were 100% and LPT was the highest scoring mental health trust in the country. Work is ongoing to upgrade water and ventilation systems across the Trust. In terms of antimicrobial stewardship, monitoring shows increased			

			co-amoxiclav use in community hospitals. This is being closely reviewed and managed. The Trust exceeds the NHSE waste compliance targets, and this supports our sustainability and cost reduction agenda. The committee was assured by the contents of the report which demonstrated compliance with the Health and Social Care Act 2008 (updated July 2015).			
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding						
Executive Environmental Scan – Director of Nursing Update	Item 5	James Mullins	The Local Area Special Educational Needs and Disabilities (SEND) Inspection concluded in September 2025. LPT attained a positive outcome, achieving Level 2, and surpassing the national trend. The committee commended the outcome of this and thanked all concerned.			
Accountability Framework Meeting (AFM) AAA report	Item 7	Jean Knight	There were a number of areas of excellence highlighted in the report. One example was the soft launch of Frenotomy Service, 28 procedures have been completed with 100% positive feedback from parents			
Level 2 Quality Forum AAA reports (June and July 2025)	Item 10	James Mullins	There were a number of areas of excellence highlighted in the report, of particular note were: • The PIER team have completed a quality improvement about cervical screening and have managed to increase the number of patients being screened by 22%. • A pilot study has been completed using coloured crockery (blue plate scheme) that has had positive impact on amount of food consumed and reduced food waste.			

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Leicestershire Partnership NHS Trust

Trust Board Committee – 25 November 2025

Safe Staffing Monthly Report – September 2025

Purpose of the Report

This report provides a full overview of nursing safe staffing during the month of September 2025, including a summary/update of AHP and medical vacancies, new staffing areas to note, potential risks, and actions to mitigate the risks to ensure that safety and care quality are maintained (table on page 4). This report triangulates workforce metrics; fill rates, Care Hours Per Patient Day (CHPPD), Nurse Sensitive Indicators (NSI's) and patient experience feedback. (Scorecard, page 4&5).

Background

The Trust is required to undertake bi-annual review of workforce safeguards in line with National Health Service England (NHSE) requirements. The workforce safeguards review considers the efficiencies of the workforce in terms of activity and acuity, thereby ensuring that appropriate workforce planning is in place that meets operational demand, whilst working within the appropriate financial control. The Trust assesses compliance using a triangulated approach to deciding staffing requirements described in National Quality Board's guidance. This includes the use of evidence-based tools, professional judgement, and outcomes to ensure the right staff with the right skills are in the right place at the right time.

The Trust is required to demonstrate its position regarding mandatory submission of fill rates required by the Department of Health via UNIFY and paying attention to any variance below 80% and above 110%. The upload of these figures to UNIFY occurs on the 15th of each month following review and sign off by the Chief Nurse or designated deputy.

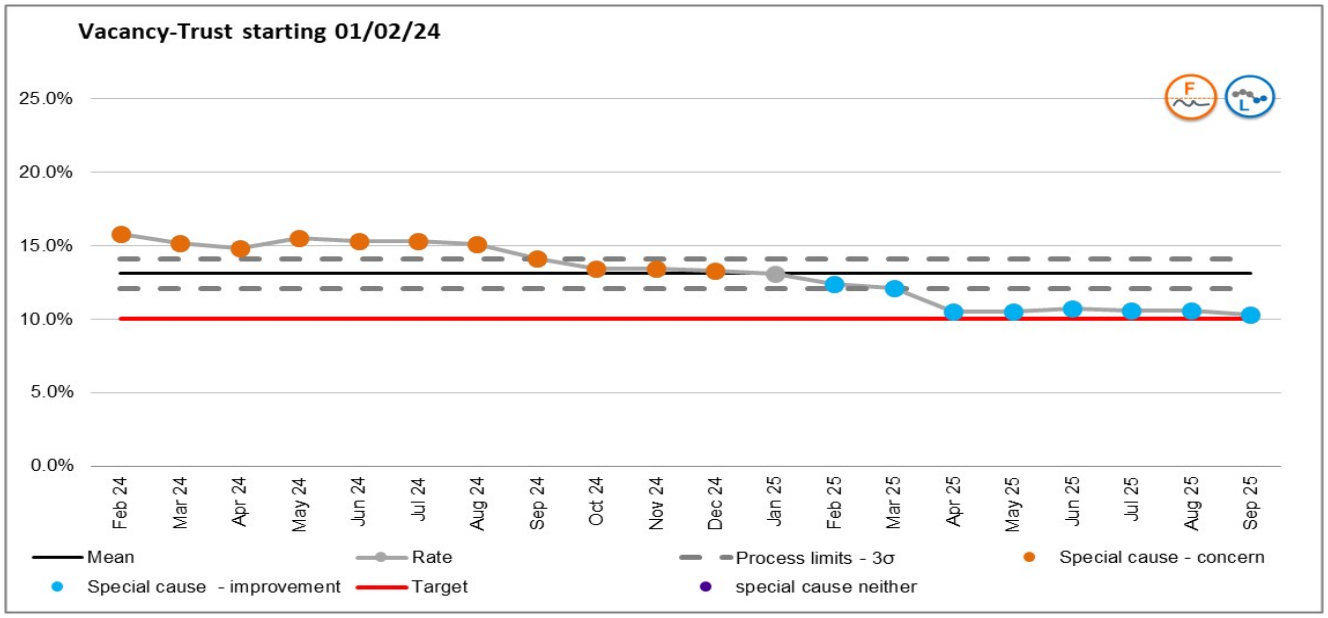
Analysis of the issue

Right Staff

- Temporary worker utilisation rate decreased this month by 1.62% reported at 24.1% overall, of this Trust wide agency usage increased this month by 0.38% to 1.49% overall.

Trust overall vacancy rate

For September 2025, the Trust vacancy rate was 10.3%. During 2025-26 our workforce plan shows a reduction/ special cause improvement 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.



- Registered Nurses
  - Vacancy position is at 257.3 Whole Time Equivalent (WTE) with a 12.9% vacancy rate, an increase of 0.1% since August 2025.
  - Turnover for nurses is at 5.3% which is below the trusts target of 10%.
  - Sickness reported at 6.3% which is an increase of 0.6% since August 2025.
  - A total of 17.7 WTE nursing staff (bands 5 to 8a) were appointed in September 2025.

- HCSW
  - Vacancy position is at 158.8 WTE with an 14.7% vacancy rate, increase of 1.8% since August 2025.
  - Turnover rate is at 7.1%. which is below our internal target of no more than 10% turnover.
  - Sickness reported at 8.4% which is a decrease of 0.5% since August 2025.
  - A total of 8.7 WTE HCSW were appointed in September 2025.

Allied Health Professionals (AHP)

- Vacancy position is at 81.7 WTE with an 8.8% vacancy rate.

Medical

- Vacancy position is at 14.37 with a 5.9% vacancy rate.

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 11.2 CHPPD (national average 10.8) for September 2025 consistent with August 2025.

September 2025 scorecard is presented below.

September 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	% Temporary Workers (NURSING ONLY) – Bank	% Temporary Workers (NURSING ONLY) – Agency	Overall CHPPD (Nursing And AHP)	Medication Errors	Falls	Complaints	PU Category 2	PU Category 4
				>=80%	>=80%	>=80%	>=80%	-	-	<20%	<20%	<=6%						
CHS City	Beechwood Ward - BC03	24	23	100.3%	103.6%	100.3%	108.0%	100.0%	100.0%	20.2%	19.9%	0.3%	9.0	0	6	0	0	0
	Clarendon Ward - CW01	21	20	82.2%	105.8%	103.3%	101.5%	100.0%	100.0%	8.3%	8.2%	0.2%	9.0	2	2	0	0	0
CHS East	Rutland Ward - RURW	18	17	114.3%	111.5%	107.4%	175.5%	100.0%	100.0%	10.4%	8.7%	1.7%	9.0	3	1	1	0	0
	Ward 1 - SL1	20	18	92.3%	105.3%	99.9%	99.9%	100.0%	100.0%	24.5%	24.0%	0.5%	11.0	0	1	0	0	0
	Ward 3 - SL3	14	13	105.4%	147.6%	98.3%	146.6%	100.0%	100.0%	28.3%	28.3%	0.0%	12.0	0	0	0	0	0
CHS West	Charnwood Ward - LBCW	18	17	92.0%	118.7%	100.0%	130.0%	100.0%	100.0%	19.6%	19.3%	0.3%	11.0	1	3	0	1	0
	East Ward - HSEW	23	22	88.1%	102.7%	103.3%	107.5%	100.0%	100.0%	7.6%	6.9%	0.7%	9.0	2	6	0	0	0
	Ellistown Ward - CVEL	19	17	95.3%	98.4%	100.0%	107.6%	100.0%	100.0%	14.4%	13.9%	0.5%	11.0	2	2	0	0	0
	North Ward - HSNW	19	19	100.4%	103.0%	100.0%	108.9%	100.0%	100.0%	14.5%	14.1%	0.4%	9.0	1	1	0	0	1
	Snibston Ward - CVSN	19	18	102.0%	107.1%	100.3%	106.6%	100.0%	100.0%	21.9%	21.7%	0.2%	10.0	2	1	0	1	0
	Swithland Ward - LBSW	20	19	98.6%	104.6%	100.0%	108.9%	100.0%	100.0%	14.2%	14.2%	0.0%	9.0	0	3	0	0	0
	Ward 4 - CVW4	15	15	100.1%	100.2%	98.3%	113.3%	100.0%	100.0%	19.1%	19.1%	0.0%	11.0	4	2	0	0	0
DMH Bradgate	Ashby	14	14	90.6%	137.3%	100.0%	133.0%		100.0%	37.5%	33.0%	4.5%	9.0	2	4	0	0	0
	Aston	17	17	74.1%	92.8%	98.4%	101.7%		100.0%	17.9%	15.3%	2.7%	7.0	0	1	0	0	0
	Beaumont	22	21	88.1%	96.2%	100.7%	100.8%		100.0%	29.4%	27.3%	2.2%	7.0	1	4	0	1	0
	Belvoir Unit	10	10	104.5%	138.3%	102.7%	144.7%		100.0%	33.8%	31.2%	2.6%	21.0	1	1	1	0	0
	Bosworth	14	13	84.9%	124.4%	100.0%	103.4%		100.0%	31.8%	30.6%	1.2%	8.0	0	1	0	0	0
	Griffin - Herschel Prins	6	6	106.9%	96.0%	98.5%	105.0%		100.0%	30.9%	29.9%	1.0%	24.0	0	2	0	0	0
	Heather	18	18	90.6%	125.3%	99.5%	115.6%		100.0%	41.1%	36.4%	4.8%	8.0	0	0	0	0	0
	Watermead	20	20	96.8%	97.0%	100.0%	102.2%		100.0%	39.8%	36.9%	2.9%	7.0	0	1	0	0	0
DMH Other	Coleman	18	17	88.8%	151.5%	100.1%	194.3%	100.0%	100.0%	38.3%	36.4%	1.9%	20.0	1	24	0	0	0
	Gwendolen	19	11	72.2%	100.3%	100.0%	117.2%		100.0%	21.1%	19.1%	1.9%	18.0	2	12	0	0	0
	Kirby	23	22	97.2%	146.9%	86.8%	189.4%	100.0%	100.0%	34.3%	34.1%	0.2%	10.0	1	6	0	0	0
	Langley (MHSOP)	19	16	88.7%	125.8%	100.0%	113.2%			22.4%	21.8%	0.7%	9.0	0	3	0	0	0
	Mill Lodge	14	11	93.0%	91.9%	100.3%	136.6%		100.0%	35.1%	32.9%	2.2%	15.0	0	0	0	0	0
	Phoenix - Herschel Prins	12	12	90.4%	101.2%	104.2%	97.8%		100.0%	20.1%	19.5%	0.5%	11.0	1	0	0	0	0
	Skye Wing - Stewart House	30	29	97.4%	100.1%	99.7%	104.0%		100.0%	14.0%	13.8%	0.2%	5.0	1	3	0	0	0
	Willows	9	9	103.7%	101.7%	97.2%	103.3%		100.0%	13.9%	13.8%	0.1%	11.0	2	1	1	0	0
FYPC	CAMHS Beacon Ward - Inpatient Adolescent	17	6	73.2%	130.5%	100.0%	114.2%			47.2%	42.7%	4.5%	34.0	1	0	0	0	0
	Welford (ED)	15	14	98.3%	211.6%	100.1%	178.3%	100.0%	100.0%	32.9%	31.2%	1.7%	15.0	1	1	0	0	0
LD	1 The Grange	2	1	55.6%	76.5%	53.8%	70.0%			5.5%	5.5%	0.0%	63.0	0	0	0	0	0

	Agnes Unit	1	1	91.1%	109.9%	78.5%	100.6%			35.1%	28.6%	6.5%	112.0	0	0	0	0	0
	Gillivers	3	2	106.4%	58.0%	107.2%	79.4%			7.8%	7.8%	0.0%	33.0	0	0	0	0	0

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.				

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

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 3 St Lukes 28.3%, Ward 1 St Lukes 24.5%, Snibston at 21.9% and Beechwood at 20.2% 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 continues to meet planned safe staffing where there is sickness.	**Amber**
	Fill rate: Fill rate above 110% of RN on day shifts on Rutland. No wards had a fill rate of over 110% for RNs at night. Fill rate above 110% of HCA day shifts and night shifts on Rutland, ward 3 St Lukes and Charnwood. HCA night shifts only ward 4 Coalville.	**Fill rate:** Only one ward reporting RN fill rate of over 110% this improved position continues. Rutland ward RN increased fill rate was due to additional RN from Dalgleish ward (remains closed due to estates work) working day shifts. For wards using over 110% fill rate of HCSW this was due to increased patient acuity and dependency, increased enhanced care and impact of patient transfers from acute providers. This is an improved position, with a continued focus reducing the number of wards to four compared to previous months. A robust Dynamic Risk Assessment (DRA) process is followed for additional staffing requests (above planned staffing) causing an increase in the fill rate above 110%. The process is closely managed and monitored ensuring patient safety.	
	Nurse Sensitive Indicators A review of the NSIs has identified a decrease in the number of falls incidents from 34 in August to 28 in September 2025. Ward areas to note with the highest number of falls are Beechwood and East ward. The number of medication incidents has decreased from 19 in August to 17 in September 2025. Ward area to note	**Nurse Sensitive Indicators** **<u>Falls</u>** The majority of the 28 falls resulted in low or no harm. The weekly falls meeting continues across all areas discussing themes and improvements in care. All falls discussed at monthly Quality Leads meeting. Falls link training days are planned to include learning from themes across all wards, supported by the patient safety team. **<u>Medication incidents</u>**	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
	with the highest number of medication incidents is ward 4 Coalville and Rutland. The number of category 2 pressure ulcers developed or deteriorated in our care has decreased from 3 in August to 2 in September 2025. 1 category 4 pressure ulcer developed or deteriorated in LPT inpatient care in September 2025.	The main themes were medication unavailable, discrepancy in counting and failure to follow policy. 16 of the incidents reported as no harm, and 1 incident reported as low harm. Wards continue to use safety crosses, whilst carrying out senior reviews and reflections. A daily report is shared with all leads reflecting omissions, which is showing improvement. Focus work has also commenced on controlled medication and will be captured in the new CHS medication group. **Pressure Ulcers** Pressure Ulcers category 2 developed in our care across 2 wards. One pressure ulcer category 4 developed on North ward. An ISMR was completed recognising no gaps in care and positive care was provided. CHS Pressure ulcer improvement work continues, led by the Deputy Head of Nursing and pressure ulcer link Matron, supported by the Community Hospitals Tissue Viability Nurse. The new Quality Account project to reduce moisture damage in care to patients continues, working closely with continence specialist teams and an additional 3-month workstream commenced focused on unstageable pressure ulcers. **Staffing Related Incidents** The number of safe staffing related incidents has increased from 6 in August to 7 in September 2025 across 6 wards relating to, staff shortages, a reduction in staffing due to last minute temporary worker cancellations, patient acuity requiring enhanced/one to one care and shifts unfilled. Baseline planned staffing was maintained.	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
DMH In-patients	**Staffing:** High percentage of temporary workforce to meet planned staffing for Heather at 41.1%, Watermead, Coleman and Ashby all above 35% temporary workforce. **AHP Staffing:** Limited Speech and Language Therapy (SALT) capacity in Rehabilitation and Huntingdon's Disease (HD) service, reduction in Technical Instructor (TI) posts in MHSOP due to sickness and vacancies. Long term sickness in Occupational Therapy (OT) in rehabilitation and MHSOP physiotherapy.	**Staffing:** Staffing is risk assessed daily through a staffing huddle across all DMH wards and staff moved to support safe staffing levels and skill mix, patient needs, acuity, and dependency and we use regular temporary staff who know the ward areas well and support continuity of patient care. High Utilisation of temporary workforce was due to a number of factors including increased patient acuity for patients with high-risk behaviours, increased therapeutic observations to manage both mental and physical health care needs, patient and hospital escorts due to deterioration in patients' physical health and staff sickness. **AHP** SALT referrals reduced into Rehabilitation and HD service. One band 7 OT lead and TI recruited into MHSOP with temporary workforce in place for physiotherapy and OT in Rehabilitation.	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
	Fill rate: Fill rate RN on day shifts below 80% on Aston and Gwendolen. Fill rate HCA day shifts and night shifts above 110% on Ashby, Belvoir, Heather, Coleman, Kirby and Langley and days shifts only on Bosworth. Fill rate HCA night shifts only above 110% on Gwendolen and Mill Lodge.	**Fill rate:** Aston ward had an average bed occupancy and acuity, there were 19 shifts that had 2 RNs on days, plus a supernumerary Registered Nurse Associate (RNA) the planned staffing is 3 RNs, on those days the reduced number of RN's was mitigated by a deputy ward sister (on management duties). On Gwendolen Ward there was a lower than normal bed occupancy during September 2025 there were 26-day shifts that had 2 RNs on days, the planned staffing is 3 RNs, on those days the reduced number of RNs was mitigated either by adjusting the skill mix to include a Medicines Administration Technician's (MAT) or backfilling with an additional HCSW (who are also utilised when there are 2 RNs on shift) ensuring safe/planned staffing was maintained. HCA fill rate above 110% was due to increased patient acuity and dependency requiring increased therapeutic observations to manage violence and aggression, management of falls and deterioration in mental and physical health needs, patient escorts and transfers to acute hospital.	
	Nurse Sensitive Indicators: A review of the NSI's has identified a decrease in the number of falls incidents from 65 in August to 63 in September 2025.	**Nurse Sensitive Indicators:** **<u>Falls</u>** **AFPICU –** 14 reported falls incidents occurred in Acute, Forensic and PICU services (AFPICU) in September 2025. There were no falls in this period reported as moderate harm or above. **Rehabilitation** – 4 falls incidents reported and none of moderate harm. **MHSOP** – 45 falls incidents were reported in September 2025. Highest falls on Coleman (24) and Gwendolen (12). It is noted an	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
		increased number of patient falls whilst mobilising/standing and a high number of first and repeat unwitnessed falls. Staffing levels not identified as a contributing factor. 2 falls were reported as moderate harm, the patients were 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.	
	The number of medication incidents decreased from 19 in August to 12 in September 2025.	**Medication errors** 11 no harm medication incidents and 1 reported as low harm for AFPICU and MHSOP. Staffing levels not identified as a contributing factor.	
FYPC. LDA in-patient	**Staffing:** High Percentage of temporary workforce, key area to note – Beacon at 47.2%, Agnes and Welford ED above 30%.	**Staffing:** Beacon unit continue with reliance on high temporary workforce usage with an advance booking of staff to ensure continuity of care to meet safe planned staffing due to high levels of acuity, increased complexity of children and young people and vacancies. 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.	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
	Fill Rate: Fill rate below 80% for RNs on day shifts – Beacon and the Grange. Fill rate below 80% RN on night shifts – Agnes Unit and the Grange. Fill rate below 80% for HCA on day shifts and night shifts at the Grange and Gillivers. Fill rate above 110% for HCA on days and nights on Beacon and Welford ED.	**Fill rate:** Beacon unit planned staffing is 3 RNs (as per budgeted Establishment) the day shift, staffing levels were reviewed and adjusted according to patient acuity and bed occupancy. 2 RNs worked consistently on day shifts in September 2025 reducing the overall average RN fill rate for the month and within a safe staffing model. No incidents reported relating to staffing levels. Agnes unit planned staffing is 4 RNs on the night shift. Safe staffing is reviewed daily by charge nurse and matron, pods reduced from 3 to 2 and staffing levels were reviewed and adjusted due to fluctuation in patient acuity. 3 RNs worked consistently on the night shifts safely staffing patients on 2 pods reducing the overall average RN fill rate during September 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: The number of falls incidents decreased from 6 in August to 1 in September 2025.	**Nurse Sensitive Indicators:** **<u>Falls</u>** There was 1 fall on Welford ED reported as no harm. **<u>Medication errors</u>**	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
	The number of medication related incidents decreased from 3 in August to 2 in September 2025.	2 medication incidents were reported as low and no harm.	
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 linking with Community Nursing Safer Staffing Tool II (CNSST II) being implemented from September 2025.	
DMH Community	The next phase of the CMHT transformation continues. 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 continue 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 weekly 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 staffing model fluctuates in response to case load and clinical risk. A new agency identified to support the service. 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. Recruitment challenges continue into Mental Health Practitioner (MHP) posts however successful recruitment to 3 posts made in MHLS and recruitment progressing for additional 3 MHPs. Challenges in Mental Health Urgent Care Hub with MHP vacancies	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
		being backfilled with additional hours/temporary workforce. Recruitment continues with planned interviews. **<u>MHSOP Community</u>** No change this month, temporary workforce being utilised across City East, South Leicester, Melton, Rutland and Harborough to manage long term sickness, absence, maternity leave RN and AHP vacancies across MHSOP community teams. Vacancies are starting to be filled and recruitment checks commenced.	
FYPC. LDA Community	key areas to note, LD Community Forensic team and Access, Dynamic Support Pathway and Discharge hub. No change to Mental Health School Team (MHST) a number of City and County Healthy Together and School Nursing teams and LD physiotherapy. 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, other areas of LD service offering additional input to patients on caseload and ensuring high risk patients continue to receive care and support. Mitigation and plans in place for the Access team. Dynamic Support pathway and Discharge hub staffing reduced due to sickness and absence, prioritisation model in place and support being provided from other LDA group to minimise the impact. MHST continue to cover across localities and review of referral and allocation processes to support capacity. The Triage and Navigation referral route is now live. Healthy Together utilise a safer staffing model reviewed monthly by service leads and CTLs. The safer staffing model is based on	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
		percentages of staff in work. Actions are then taken to mitigate any clinical impact. LD Physiotherapy Clinical Lead now in post.	

Challenges/Risks

- Considering the triangulated review of workforce metrics, nurse sensitive indicators, patient feedback and outcomes in September 2025, staffing challenges continue with key areas noted and clear actions in place to mitigate risks. There is a slight decrease in agency usage and significant reduction in temporary workforce usage overall.
- CNSST II revised implementation starting in 2 Community Nursing Hubs in September 2025.
- Annual Establishment Inpatient Review and data collection to commence 1-30 October 2025.

Proposal

This report is presented for discussion, the report provides assurance to the board that we are reporting in line with National Quality Board and Developing Workforce Safeguards guidance.

Decision required – Please indicate:

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

Governance table

For Board and Board Committees: Paper sponsored by:	Trust Board Linda Chibuzor Group Chief Nurse/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 25 November 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	

J

Leicestershire Partnership NHS Trust

Public Trust Board - November 2025

Patient Safety & Learning Assurance Report for September/October 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 September/October 2025, there were 3384 patient safety incidents reported that were classified as "incidents attributable to LPT" and "Incidents affecting patients". The top five reported incidents account for 60.99% of all patient incidents reported during this period and are explored in

order and in more detail below. This equates to an average of 1692 incidents per month during September and October 2025.

Top 5 reported patient safety incidents September and October 2025

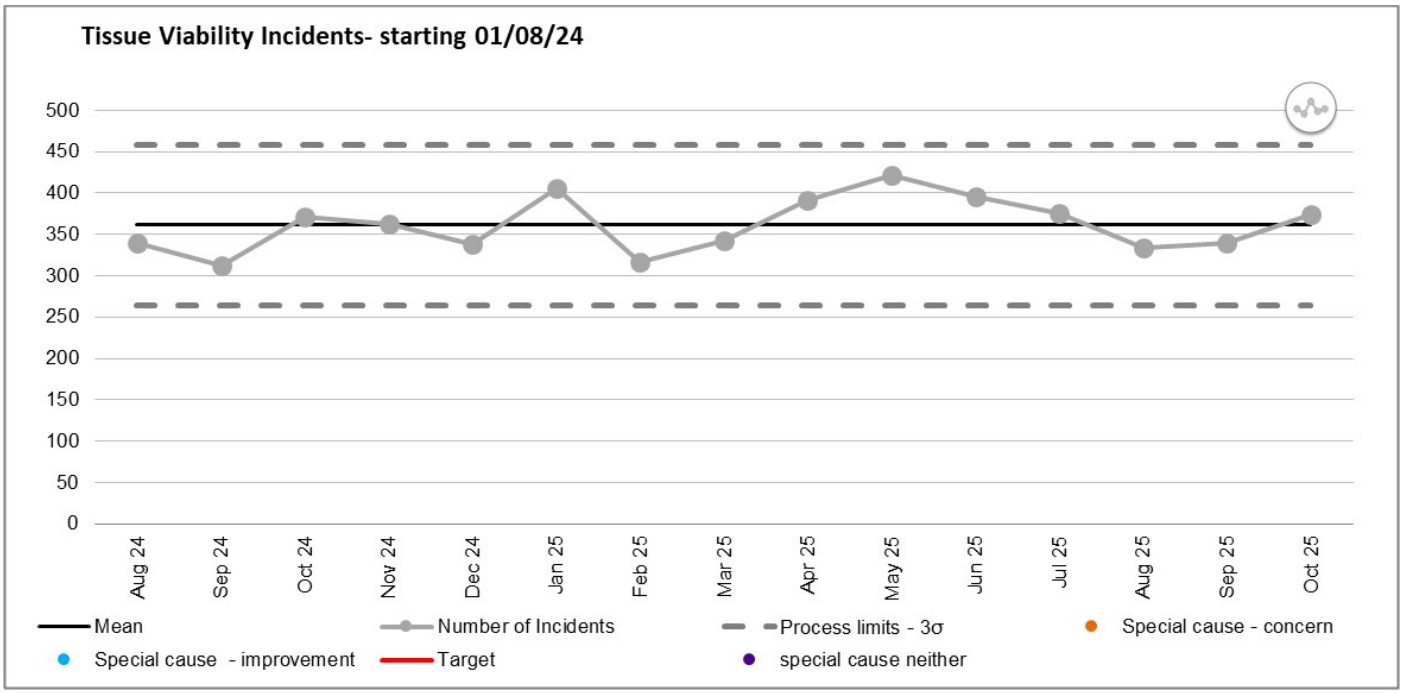
Category	Number of incidents	Directorate with highest % of the total reported
1. Tissue Viability	714	CHS (98.04%)
2. Self-Harm	567	DMH (72.31%)
3. Violence and Assault	266	DMH (79.32%)
4. Falls	260	DMH (63.84%)
5. Care/Treatment Under Restraint	257	DMH (52.53%)

Degree of harm recorded for all patient safety incidents for September and October 2025

Reported degree of harm	Number	% of total incidents reported
No Harm	1869	55.23%
Minor/Low Harm	1439	42.52%
Moderate Harm	45	1.33%
Severe Harm	2	0.06%
Death	29	0.86%

NB: these incidents were reported in September and October 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



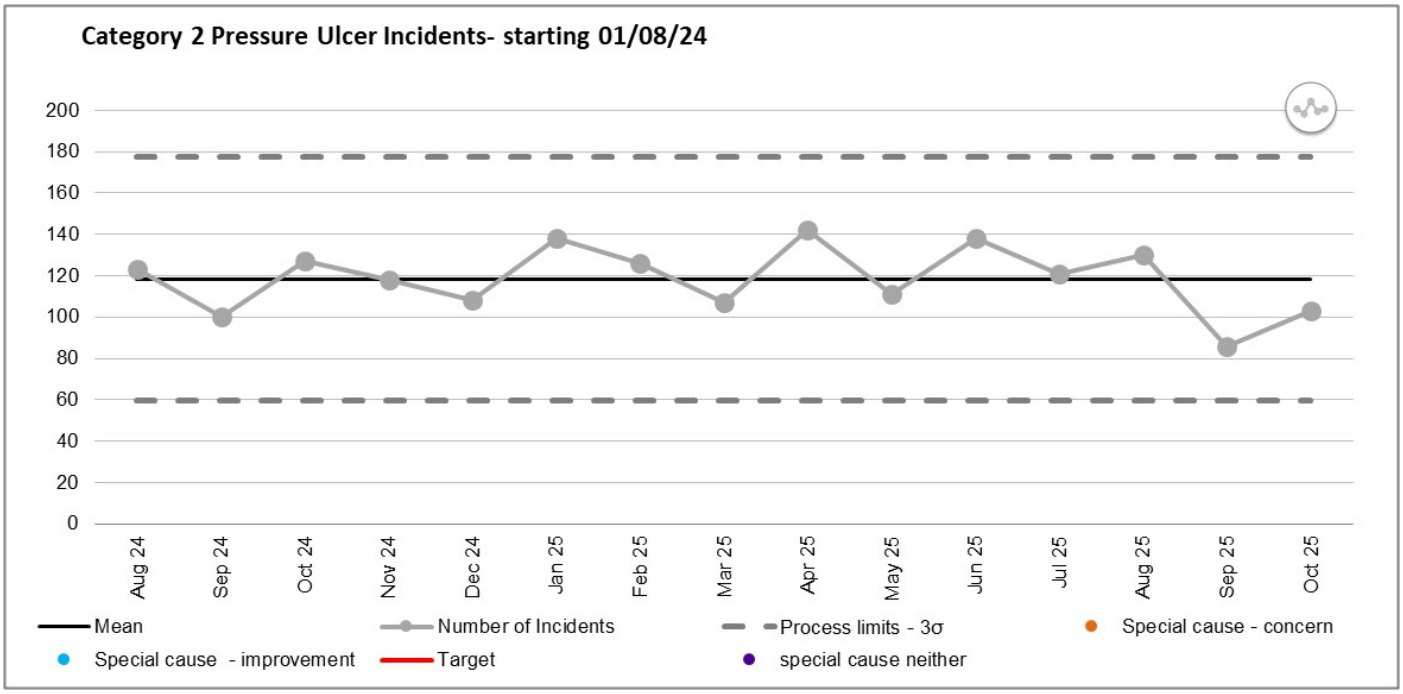
21.10% of all patient safety incidents reported relate to 'Tissue Viability' during September and October 2025; this equates to 714 incidents. This category includes pressure ulcers on admission, developed or deteriorated in our care, skin tears, scalds, wounds, and moisture associated skin damage. As Pressure ulcers (category 2,3,4 and unstageable) represent 63.31% of these, we will focus on this aspect of patient harm.

In September and October 2025, there were 452 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 11.20% decrease in pressure ulcers reported in comparison to the previous 2 months reporting.

During this period, 433 (95.80%) were reported in CHS community nursing services and 13 (2.88%) were reported in community hospitals (inpatients).

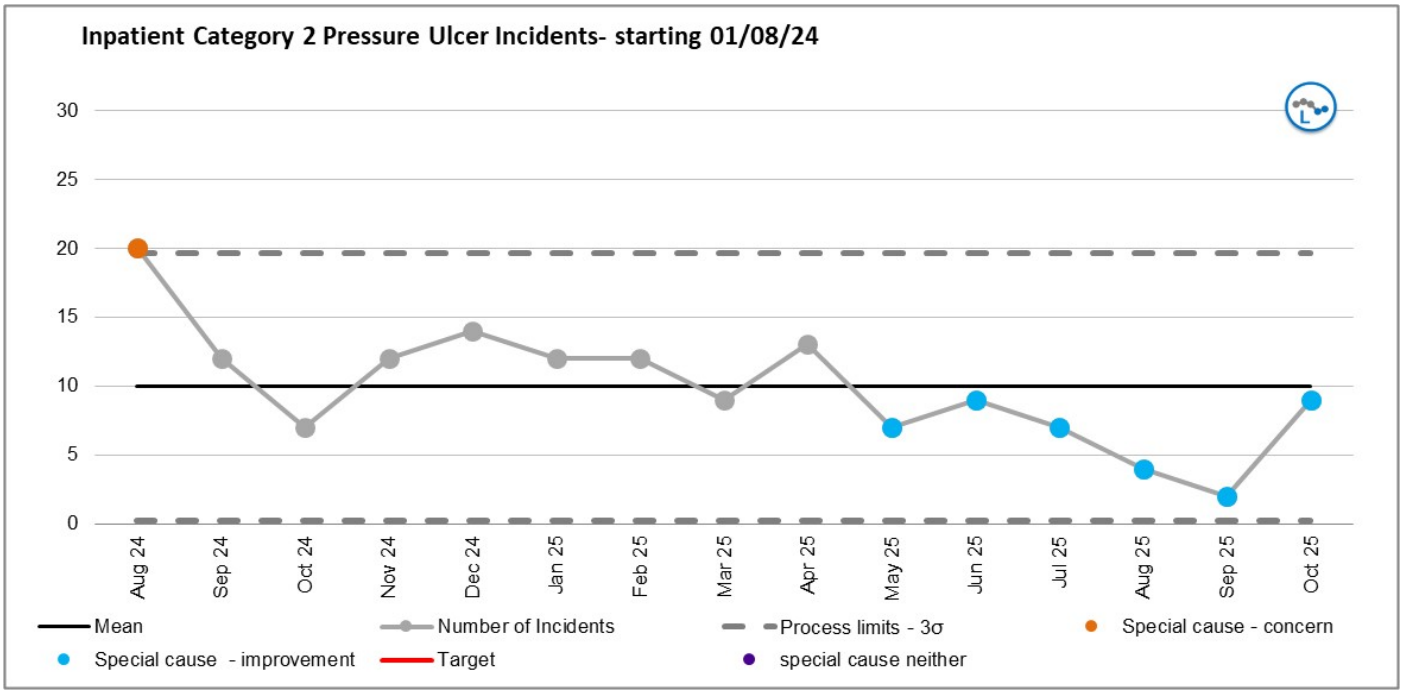
Of the remaining 6 incidents (1.33%), 5 were reported in FYPCLDA, which had four Category 2 Pressure Ulcers – one reported by each of Diana Service, FYPC South Charnwood (HV), Children's PT, and Pod 1 – and one Unstageable Pressure Ulcer reported by Diana Service. DMH had one Category 2 Pressure Ulcer reported by Gwendolen Ward.

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



The SPC chart shows normal variation for Category 2 pressure ulcers developed or deteriorated in LPT care, Trust wide.

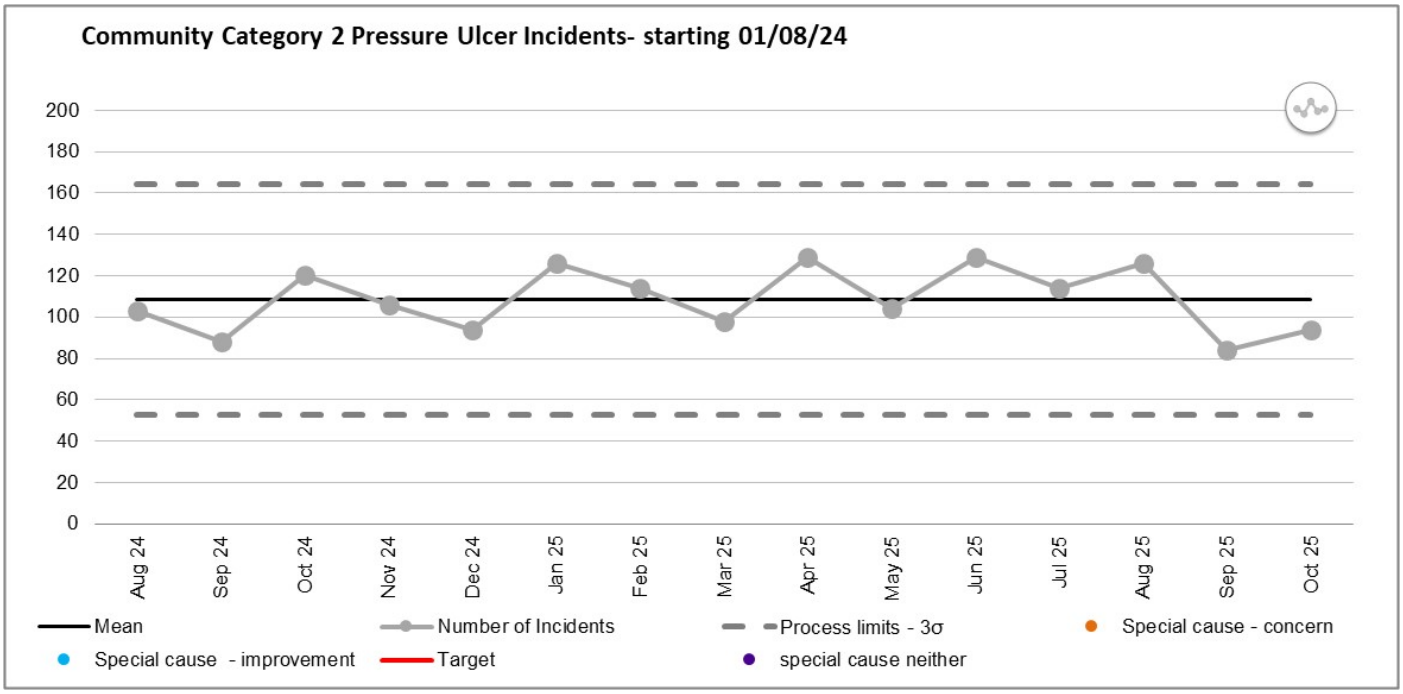
In-patient Category 2 pressure ulcers developed in LPT care.



The SPC chart shows special cause improvement in Cat 2 pressure ulcers developed in in-patient LPT care.

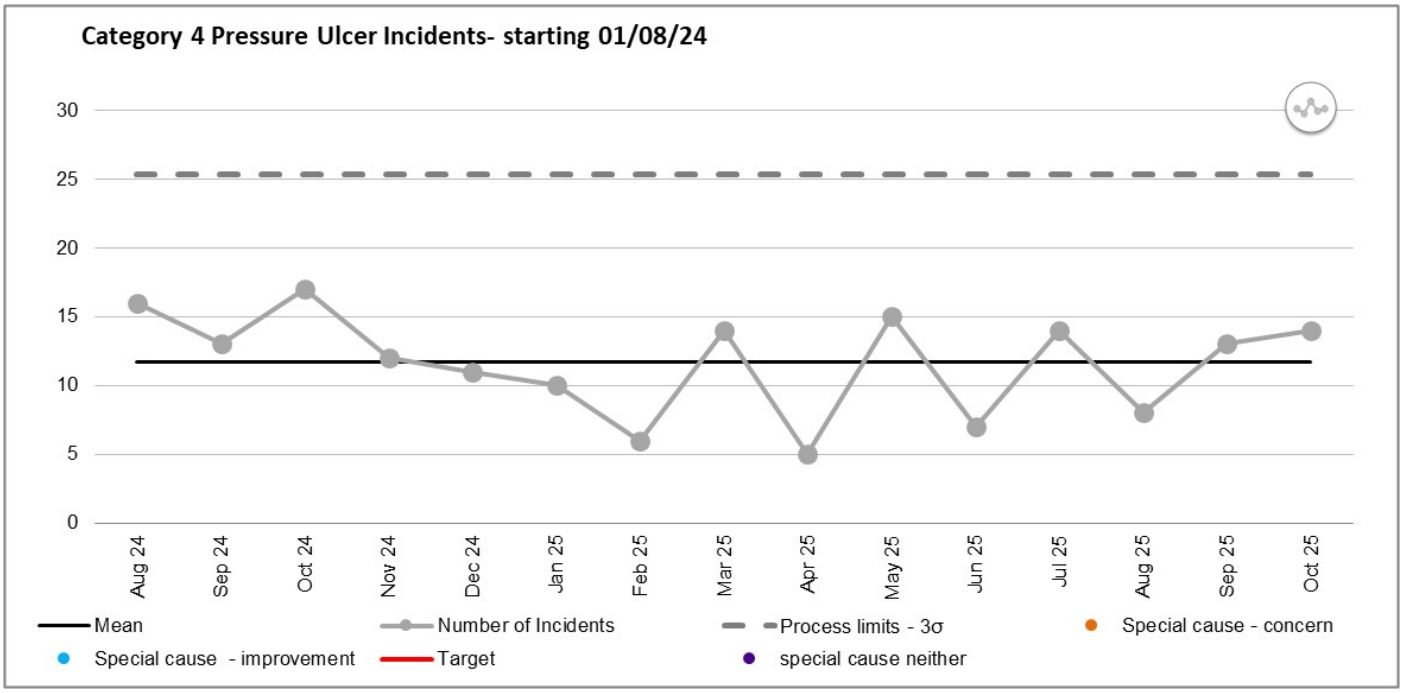
Community Hospital Category 2 pressure ulcers developed in our care.

CHS Community Hospital pressure ulcer improvement work continues, including the quality account project to reduce Moisture Associated Skin Damage. There is a pressure ulcer validation and learning meeting held weekly led by the senior nursing team. There is a downward trend of six data points demonstrating special cause improvement.



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.

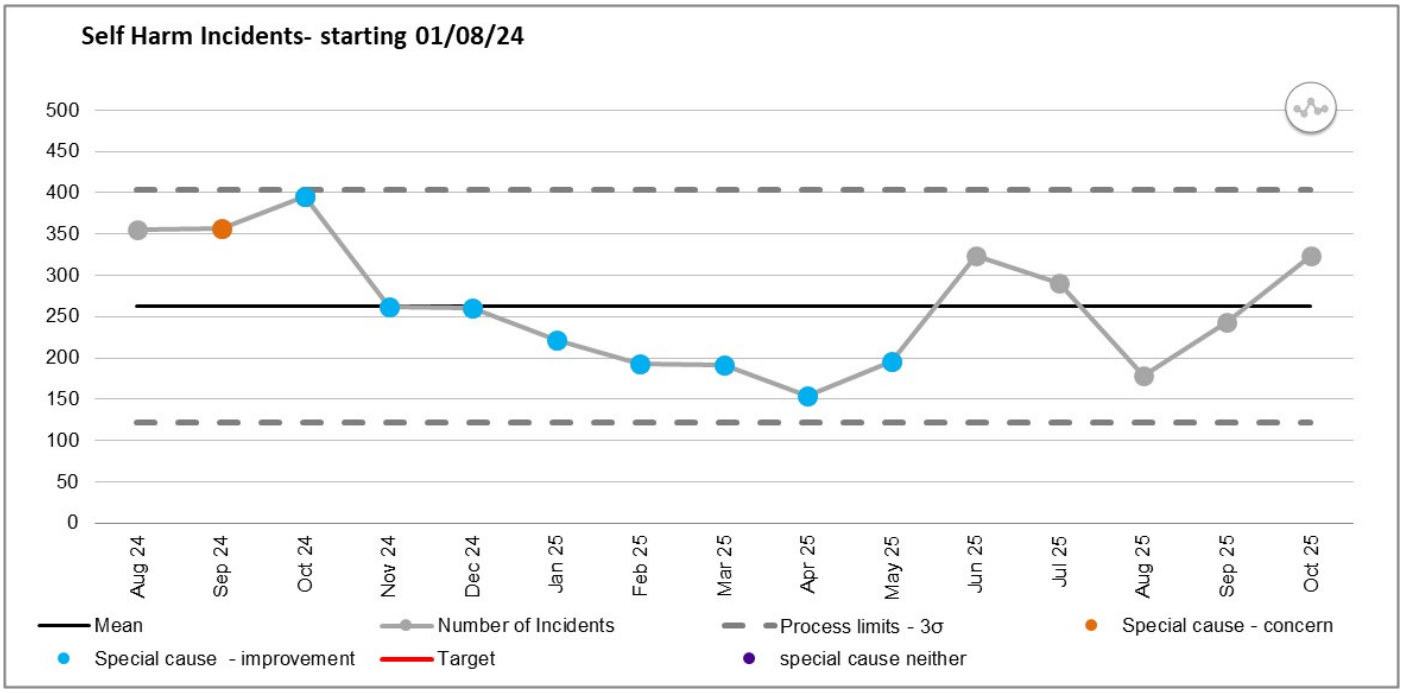


The SPC chart shows normal variation for Category 4 pressure ulcers developed or deteriorated in our care.

The CHS pressure ulcer delivery group continue to implement improvement work around moisture associated skin damage, repositioning, exploring the use of handheld devices for recording repositioning in care home settings, general equipment processes and patient experiences with pressure relieving equipment and patient choice.

A Trust wide pressure ulcer conference – Stop the Pressure Ulcer Day is being held on the 20th November 2025 led by the Tissue Viability Nursing (TVN) team in CHS as part of National Stop the Pressure Week.

2. Self-Harm – inpatient and community


Self Harm Incidents- starting 01/08/24
500
450
400
350
300
250
200
150
100
50
0
Aug 24
Sep 24
Oct 24
Nov 24
Dec 24
Jan 25
Feb 25
Mar 25
Apr 25
May 25
Jun 25
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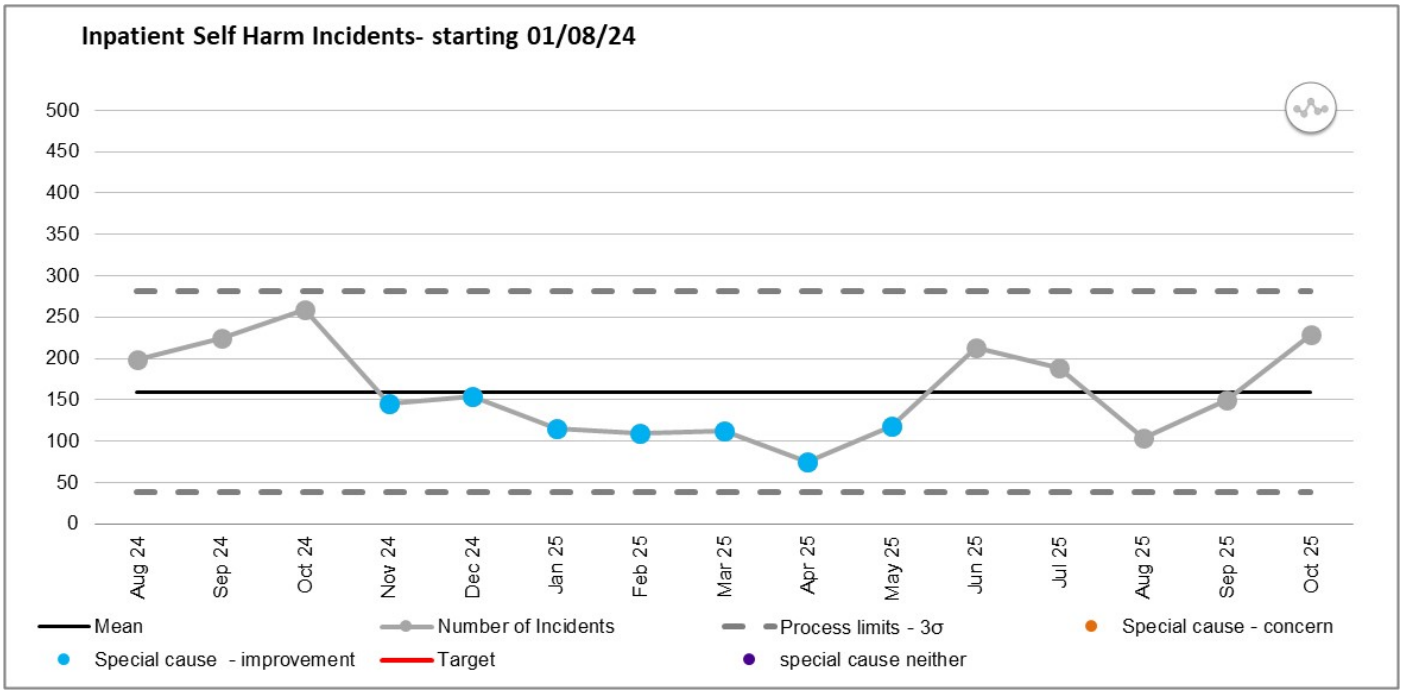
Sep 25
Oct 25
Mean
Number of Incidents
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
special cause neither


Inpatient Self Harm Incidents- starting 01/08/24
500
450
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100
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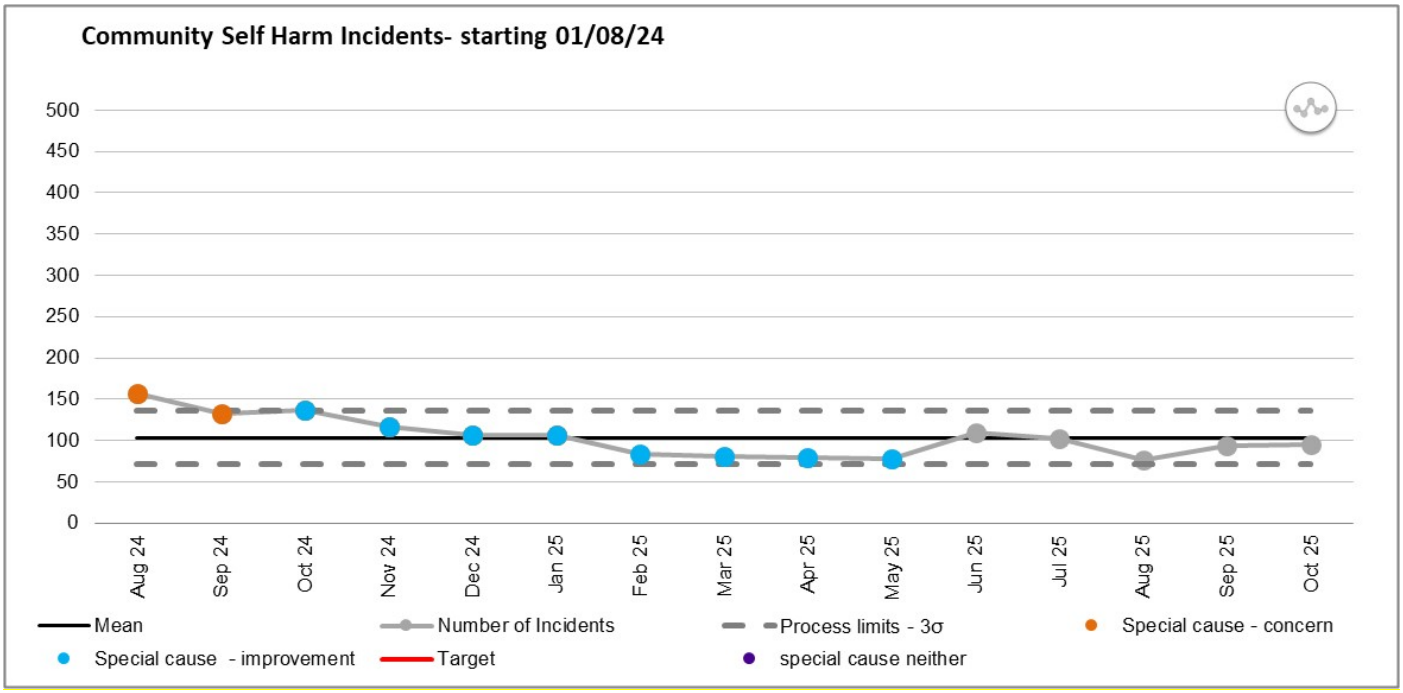
Aug 24
Sep 24
Oct 24
Nov 24
Dec 24
Jan 25
Feb 25
Mar 25
Apr 25
May 25
Jun 25
Jul 25
Aug 25
Sep 25
Oct 25
Mean
Number of Incidents
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
special cause neither



There were 567 patient self-harm incidents reported during September and October 2025, this equates to 16.76% of all reported patient safety incidents during this period. Of the 567 incidents reported as patient self-harm, 378 were inpatient incidents and 189 were community incidents.

During the previous reporting period, there were 470 self-harm incidents reported across both inpatient and community settings, this shows an increase of 20.64% during the current reporting period. This increase is mainly in patient incidents.

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 (567) of such incidents reported:

- CAMHS Beacon – 118 incidents (20.81%) This figure involves 6 patients; this is an increase from 29 total incidents reported in the previous reporting period.
- Heather Ward – 106 incidents (18.69%) This figure involves 10 patients; this is an increase from 62 total incidents reported in the previous reporting period.
- Beaumont Ward – 62 incidents (10.93%) This figure involves 10 patients; this is an increase from 8 total incidents reported in the previous reporting period.

CAMHS Beacon

In September and October 2025 there was an increase in self-harm and need for use of safety interventions, these all involve the same 3 young people who are very unwell. These incidents are all considered to ensure that the least restrictive approach is used balancing the patient's risk with their safety.

Beaumont Ward

Beaumont ward - again has a cohort of patients with repeat self-harm, one with a large proportion of incidents despite observations/ interventions in place. Low/ no harm incidents due to staff being alerted to incidents and intervening.

Heather Ward

Heather ward - has had cohorts of patients with multiple incidents of self-harm where staff have been alerted to these at an early stage and able to intervene to prevent harm from escalating through observation and other interventions.

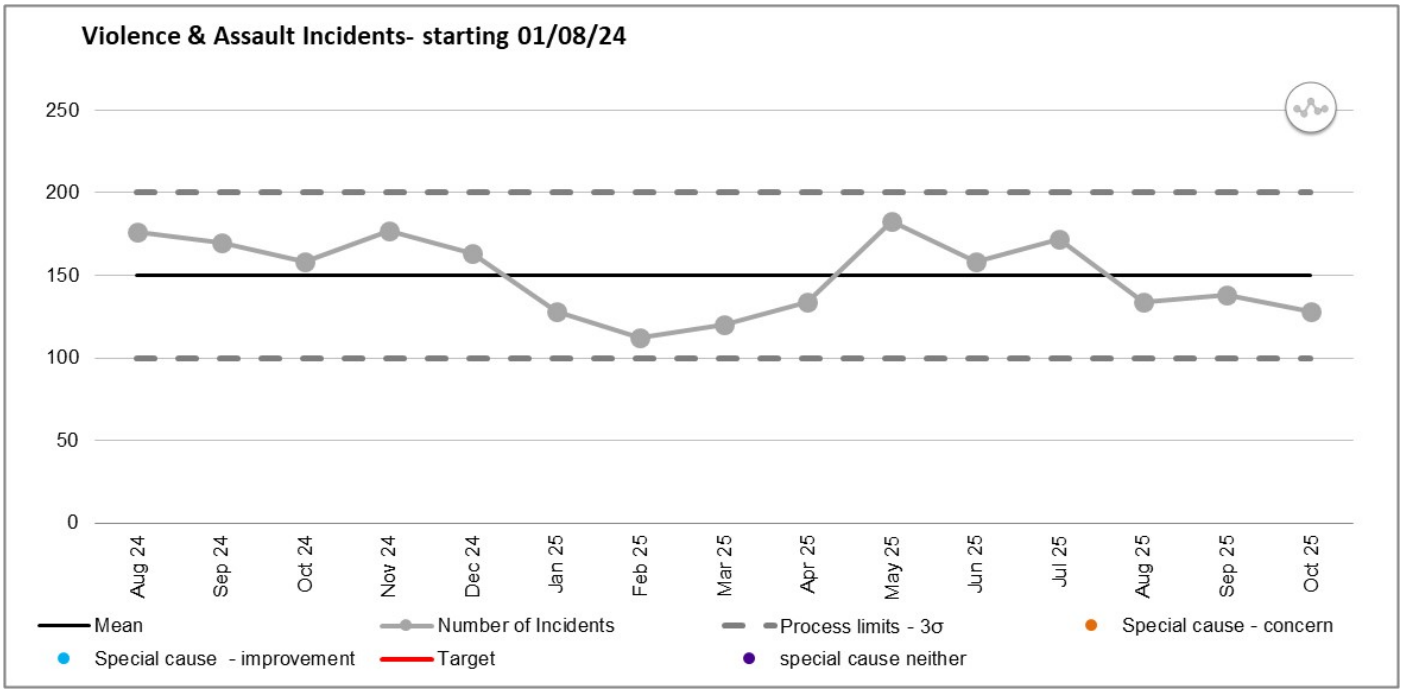
For both wards it is anticipated that risks will fluctuate dependent on the nature and diagnosis/ needs of the admitted cohorts. However, a deeper dive is being discussed to consider further improvements following recent QI work.

Harm Levels

Within the 3 areas of CAMHS Beacon, Heather Ward, and Beaumont Ward, there has been 1 incident reported as catastrophic/death –this is being reviewed as a PSII. There were 3 incidents reported as moderate harm. Of the 118 incidents reported by CAMHS Beacon, 1 (0.85%) was recorded as moderate harm, 65 (55.08%) were recorded as minor/low harm, with the remaining 52 (44.07%) being reported as no harm. Of the 106 incidents reported by Heather Ward, 1 (0.94%) was recorded as catastrophic/death, 2 (1.89%) were recorded as moderate harm, 70 (66.04%) were recorded as minor/low harm, with the remaining 33 (31.13%) being recorded as no harm. Of the 62 incidents reported by Beaumont Ward, 35 (56.45%) were recorded as minor/low harm, with the remaining 27 (43.55%) being recorded as no harm.

Overall, of the 567 total reported self-harm incidents, 1 (0.18%) has been recorded as catastrophic/death, 8 (1.41%) have been recorded as moderate harm which are all being reviewed individually, 304 (53.62%) have been recorded as minor/low harm, with the remaining 254 (44.80%) incident being recorded as no harm.

3. Violence/Assault



There were 266 incidents of violence and assault reported during September and October 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 7.86% of all reported patient safety incidents. During the previous reporting period, there were 305 violence and assault incidents reported, this shows a decrease of 12.79% during the current reporting period.

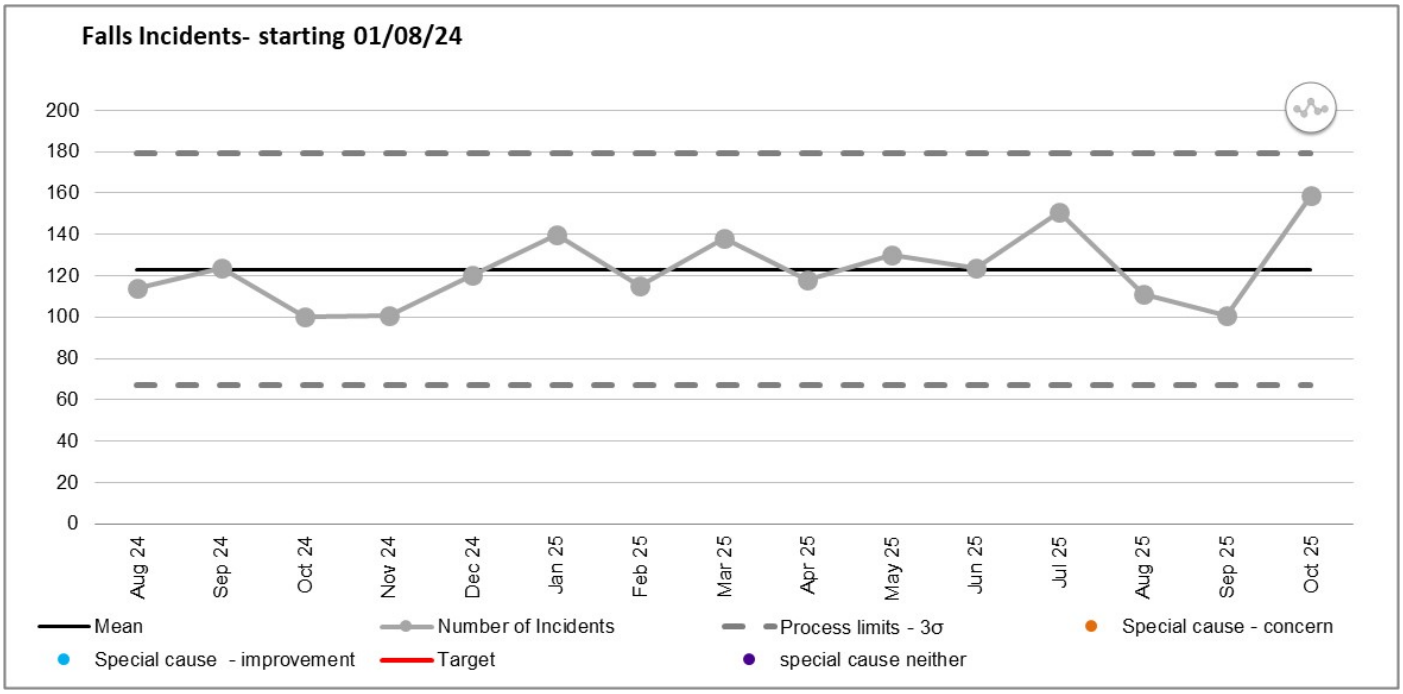
The numbers of violence and assault incidents has been analysed and over the reporting period, there are two areas with the highest number of incidents reported relative to the total number (266) of violence and assault incidents, those being the male and female Psychiatric Intensive Care Units (PICU), Belvoir Ward with 27 (10.15%) incidents, and Griffin Ward with 24 (9.02%) incidents. Of these 266 incidents, 130 (48.87%) were reported as physical disruptive behaviour.

Of the 266 incidents reported as Violence and Assault, 1 (0.38%) was recorded as Severe harm, this incident is the retrospective reporting of an incident that happened two years ago that we have just become aware of – this has been reviewed at IRLM and there was no further investigation required.

84 (31.58%) were recorded as minor/low harm, and 181 (68.05%) were recorded as no harm.

There were no incidents of violence and assault requiring review at IRLM during this reporting period.

4. Patient Falls, Slips and Trips



There were 260 falls during September and October 2025 representing 7.68% of all reported patient safety incidents. During the previous reporting period there were 262 Falls incidents reported, this shows a decrease of 0.76% during the current reporting period.

DMH

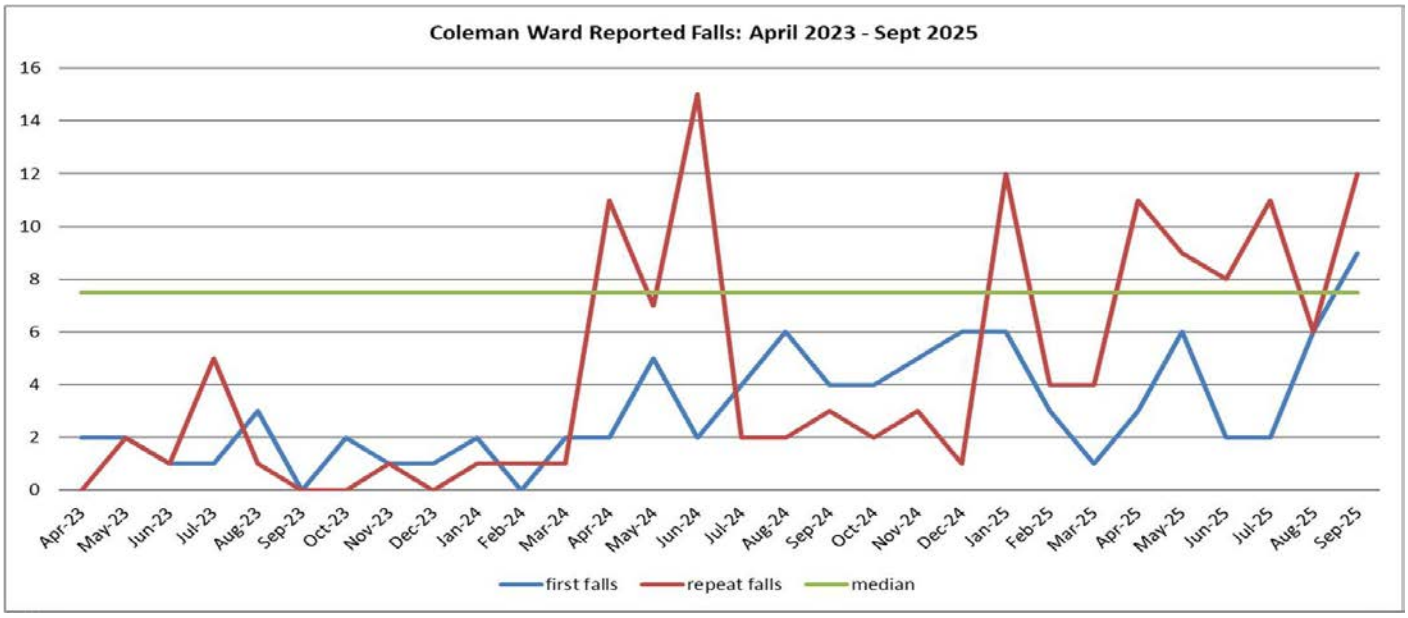
Numbers of falls have been analysed and over the reporting period, out of the 260 reported falls incidents, Coleman Ward at the Evington Centre reported 50 (19.23%) incidents, Gwendolen Ward at the Evington Centre reported 30 (11.54%) incidents, and Kirby Ward at the Bennion Centre reported 20 (7.69%) incidents.

Of the 260 reported Falls incidents, 3 (1.15%) were recorded as moderate harm, 95 (36.54%) were recorded as 'minor/low harm', 162 (62.31%) were recorded as no harm.

In the September and October Falls Steering groups the retrospective data from August and September was discussed. October's data will be discussed in the meeting on 17th November.

DMH

An increase in first falls and repeat falls was noted on Coleman Ward in September with 24 falls. (June-10, July-15, Aug- 14). 17 of those falls had occurred between 8pm and 7am and 7 were attributed to one patient. The team are undertaking a retrospective review to determine any themes.



Moderate harms, both on Gwendolen entailed facial injuries after falling in the bedrooms.

DMH engaging with ward staff and Falls Champions are rolling falls training out.

FYPC/LDA

FYPC/LDA report quarterly into September into Falls Steering Group quarterly as so few falls. In September it was reported there had been 19 Falls including 6 occasions when the patient placed themselves on the floor.

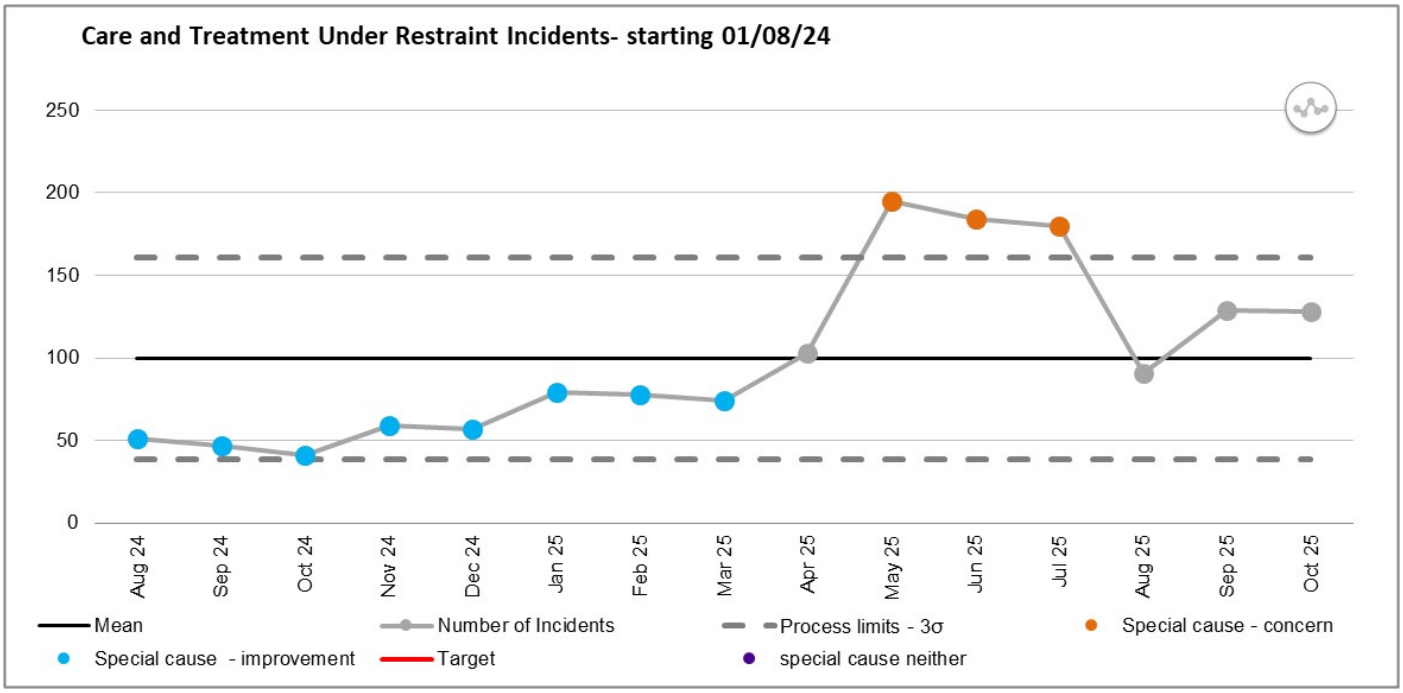
- Agnes Unit – 9 (7 related to the same patient who had physical health problems during this period)
- Welford – 2
- LD Community – 8 (4 repeat falls)

Ongoing work with improving compliance with falls risk assessment and care planning across the directorate is taking place.

CHS

3 moderate harm falls in this period and awaiting outcome of investigation however currently decreasing trends in unwitnessed falls and first and repeat falls.

5. Care & Treatment Under Restraint



There were 257 incidents where restraint holds were used to support care delivery during September and October 2025, representing 7.59% of all reported patient safety incidents during this period. During the previous reporting period, there were 270 incidents reported where restraint was utilised, therefore this shows a decrease of 4.81% 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 feeding regimes or personal care – washing and changing incontinence wear. The Least Restrictive Practice Group is scoping if new training for 'clinical holding' will support these care activities and is reviewing the categories on the Ulysses system to allow the categories to be separately reported; it is anticipated this will be available at the end of quarter 4 (2025) and no later than quarter 1 (2026).

The analysis of incidents where restraint has been used to deliver care shows that over the reporting period, there have been 2 areas with a significant number of incidents reported relative to the total number (257) incidents; those being CAMHS Beacon with 115 (44.75%) incidents compared to 97 during the last reporting period, and Mill Lodge with 92 (35.80%) incidents. Compared to 91 during the last reporting period.

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.

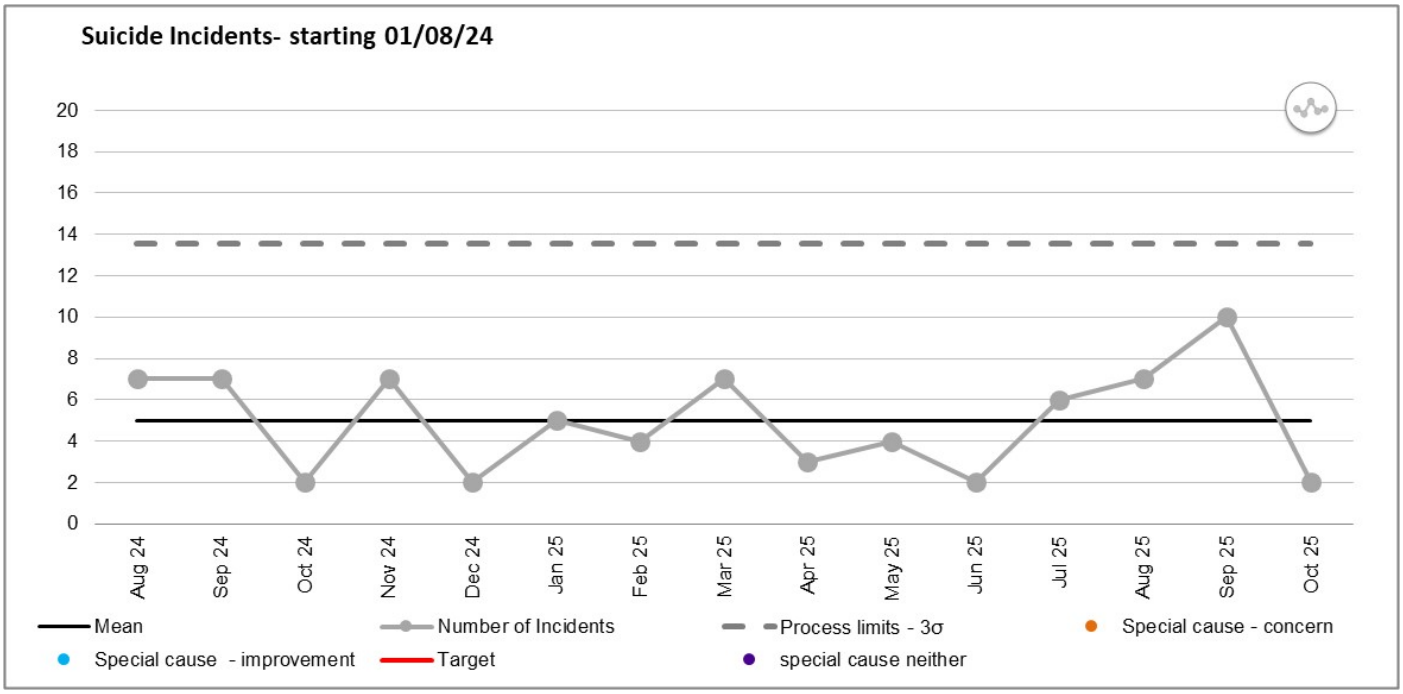
CAMHS Beacon

These incidents are part of the young people's care and treatment. Balancing least restrictive practice with the need to keep them safe including feeding regimes.

Overall, of the 257 incidents reported where restraint was utilised, 81 (31.52%) were reported as minor/low harm, and 176 (68.48%) were reported as no harm.

Suicide Prevention

While suicide does not feature in the top five reported incidents, we review every suicide for learning, themes, and trends. We also assess our services and actions against National learning from National Confidential Inquiry into Suicide and Safety in Mental Health (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.

The learning from deaths group have completed their review of the policy and are working to ensure that screening processes are robust o identify deaths that need further review.

LeDeR

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

- There were 8 notifications made by LPT staff to LeDeR related to patients with a known learning disability or autism and who have died for Sept (5) 2025 and Oct (3) 2025.
- For City and Countywide reviews, there were 8 patient death notifications in Sept 2025 and 2 patient death notifications in Oct 2025.
- Of the total 19 notifications,11 are focused and 8 are initial reviews.

Specific Learning for LPT FYPC/LDA as reported in the yearly review for 2024/25

The significant increase in the number of people with a LD and autistic people receiving an annual review of their psychotropic medication, increasing from 735 during 22/23 to 2355 for 24/25 is an incredible achievement. The outcome data received also confirms that an increasing percentage of people are having ineffective, or inappropriate, medication stopped because of their annual review. Maintenance of prescribing rates for people with a LD, prescribing below national rates and against the trend of increasing antidepressant prescribing and have particularly low benzodiazepine prescribing in children. Our Lived Experience Partner has worked with the Autism Space Team to create accessible information and further raise awareness regarding STOMP/STAMP. A guidance document created for GPs and practice staff regarding medication reviews, outlining the importance of making all reasonable adjustments to support people to attend their medication review.

The LD Physical Health Pathway launched in response to concerns around the deteriorating patient. A Physical Health Lead Matron appointed delivering on this project, the key aims: Physical Health Competency framework; Training Needs Analysis & Programme Development; Strengthen processes to support the identification of the deteriorating patient.

The Leicestershire Aspiration Pneumonia Protection Plan (LAPPP) is a 1-page risk profile to support decision making around aspiration pneumonia diagnosis and treatment and enable people with this diagnosis to have personalised care, reasonable adjustments, identify higher risks and potentially identify appropriate treatment in a more holistic way. It is now in the pilot stage of the

process prior to implementation and evaluation. The LAPPP has been accepted for oral presentation at the RCN International Nursing Research Conference in the Autumn of 2025.

LPT Outstanding patient safety reviews:

As of end of October 2025.

The table below shows the total number of learning responses overdue with the current position and numbers with percentage of those that are overdue below the table.

Overdue learning response stage	CHS	DMH	FYPC	Corporate
Allocation	0	0	0	0
Information Gathering	0	0	0	0
Report Drafting	0	1	0	0
Awaiting specialist review	0	0	0	2
SMART Action Planning	0	0	0	0
Directorate Sign off Stages	0	0	0	4
Right to Reply	3	0	2	2
Submission to CPST	0	0	0	0
Exec Review	0	0	1	0
With ICB	0	0	0	0
Directorate Post Exec Review	0	0	0	0
Total Learning Responses Overdue	**3**	**1**	**3**	**8**

Current Position

- As of 22nd October 2025, there were 59 open investigations. 13 DMH, 20 Corporate, 16 CHS and 8 FYPC/LDA.
- 16 of these overdue and 6 of these are in right to reply with patient or family.
- 1 DMH (6.25%) is overdue
- 8 Corporate (34.78%) are overdue all are within the various phases of sign off
- 3 CHS (11.76%) are overdue
- 3 FYPC/LDA (37.50 %) are overdue

Of these, 1 ‘Serious Incident Investigation (SI) from under the previous framework remains overdue. The investigators were able to meet recently with the patient in secure provision and the investigation report is now being updated with the information they shared.

The Deputy Director of Nursing and Quality chairs a weekly PSII tracker meeting with the patient safety team and directorates to manage the overdue reports and those in the pipeline.

Whilst there are reports that are overdue this is an improving position and those delayed are all in final stages of the review process.

Improving Collaborative Care for Mental Health Inpatients in Acute Settings

We are pleased to share a significant improvement initiative that enhances the care of patients with mental health needs who require physical health treatment at University Hospitals of Leicester (UHL), while under the care of Leicestershire Partnership NHS Trust (LPT).

Patients with mental health conditions sometimes require admission to UHL for physical health needs. In such cases, LPT may be asked to provide an escort to support the patient’s mental health during their stay. Historically, this process has been challenged by unclear communication pathways and role ambiguity between the two trusts.

Learning from Incidents

Through incident reviews and the application of the Systems Engineering Initiative for Patient Safety (SEIPS) framework, we identified key areas for improvement:

• Lack of clarity around decision-making for escort provision

• Inconsistent communication between LPT and UHL teams

• Limited guidance and support for escorting staff

In response, a collaborative effort between LPT and UHL led to the development of a strengthened policy and support framework, including:

• Clear criteria for when an escort is required

• Comprehensive guidance and preparatory information for escorts

• Defined communication pathways between both organisations

• Bespoke documentation to ensure consistent and safe patient care

To further support staff, a short training video has been developed. This resource outlines:

• The expectations of the escort role

• Key safety considerations

• How and where to access support during the patient's stay

We have also implemented a feedback mechanism for both escorts and UHL colleagues to share their experiences. This will enable ongoing refinement of the process and ensure we continue to learn and improve.

Duty of Candour

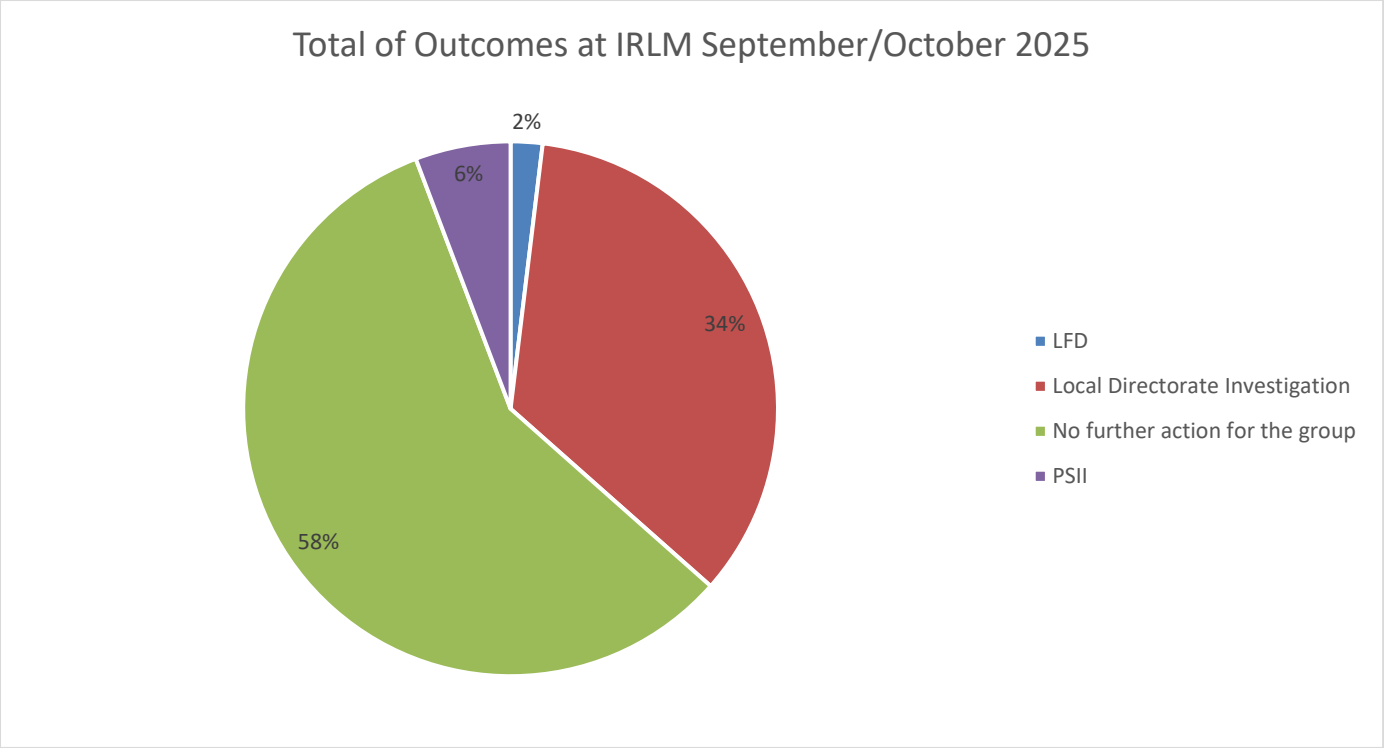
There was no statutory duty of candour breaches during this period. We continue to follow 'being open' which is inbuilt in PSIRF principles of compassionate and positive engagement with patients/families.

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)

52 cases were reviewed at IRLM during September and October 2025. 3 (6%) Patient Safety Incident Investigations (PSII) was declared during this reporting period. 30 (58%) were identified as having already identified any learning and actions put in place. There were 18 (34%) 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.

Prevention of Future Deaths (PfD/Regulation 28)

Following completion of the Inquest on 27th August 2025 into the death of a patient under a CMHT in November 2023 the coroner issued a preventing future deaths report to LPT.

The coroner heard evidence that staff were not clear around any formal guidance for the viewing of recordings taken of patients by relatives or friends.

The prevention of future deaths report requires the trust to provide guidance on the extent to which staff should consider evidence provided in alternative formats such as video evidence and what checks are in place to ensure carers are equipped to support patients in their home environment.

The response was shared with HM Coroner ahead of the 31st October 2025 deadline. The action plan will be monitored to completion by PSIG and progress shared with Safety Forum

Patient Safety Strategy

Training: SEIPS approach to investigation training.

During September and October 2025, 33 staff had been trained bringing the total so far to 171 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	84	71
CHS	36	27
FYPC/LDA	49	22
Enabling	2	0
TOTAL	**171**	**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
Sept- 2025	199	12	211
Oct-2025	173	4	177
Total	7505	178	7683

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 Linda Chibuzor, Group Chief Nurse/ Executive Director of Nursing, Allied Health Professionals (AHPs) and 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	Tracy Ward, Head of Patient Safety; Patient Safety Specialist 17/11/2025 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:	

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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: 23 October 2025 Quorate: Yes

Agenda Item:	Minute Reference:	Lead:	Description:	BAF Ref:
ALERT:				
No items to alert the Board of				
ADVISE:				
Beacon Unit – in Year and Long Term Proposals	FPC/25/121	Chief Finance Officer	Final arrangements were now being put in place on a pilot to provide a CAMHS day service run by LPT. Non-recurrent funding for 2025/26 had been agreed but any further non-recurrent support for this year was still being considered. Agreement was also still required on what LPT could deliver operationally. The timeline for decision making and operational implementation was progressing but still carried some risk.	BAF 5.3
Finance Report Month 6 2025/26	FPC/25/123	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 as well as of the risks for the 2026/27 financial year. The key points to note were; • At month 6 of 2025/26 the Trust was reporting a £1.8m deficit which was in line with plan. The actual deficit was £2m which was being offset by equivalent non-recurrent and short term underspends in central reserves. Planned monthly run rates needed to move to surpluses from month 7 to achieve the planned £300k surplus at year end. • The Trust was currently reporting a £5.4m risk to forecast, being tightly managed and an estimated underlying income and expenditure deficit of £12.6m, 59% of which was directly linked to the underfunding of the pay award by the ICB over the past few years. • CIP delivery was on track and the gap had reduced from £1m last month to £90k this month but assumed delivery of the £2.5m worth of corporate schemes which had still not been identified.	BAF 5.3 BAF 5.4

Agenda Item:	Minute Reference:	Lead:	Description:	BAF Ref:
			• £5.5m of capital had been spent of a total £19.7m which was slightly below plan. A review of capital strategic estate schemes would be undertaken at the December FPC meeting. • FPC also noted the deferral of £1.8m capital budget to 2026/27, approval was awaited from NHS England.	
Accountability Framework Meeting	FPC/25/126	Director of Finance	The key discussion points to note were; • The upward trend of over 52 week waiters remained largely unaltered with reductions in some services offset by overall Neurodevelopmental levels. The total number in June was reported at 15,000 and there were also approximately 7,700 people waiting over 104 weeks. • Lack of progress on access to the Integrated Clinical Environment (ICE) system was being escalated to a number of Trust and system forums. It was a long standing issue affecting timely access to pathology and radiology bookings and results, LPT's executive team would continue to highlight the patient safety and risk aspects.	BAF 3.2 BAF 3.3
Board Performance Report M6 2025/26	FPC/25/127	Director of Finance	FPC reviewed highlights from this report and noted that the forthcoming Trust Board workshop on Waiting Lists and Waiting Well would enable a deep dive into the metrics and progress around waiting times. FPC also noted significant work was underway to address substantive staff numbers which were above plan, and continued pressure on out of area placements.	N/A
ASSURE:				
Board Assurance Framework	FPC/25/119	Director of Governance and Risk	Assurance was received that robust systems were in place to secure an effective risk framework. The Committee asked for a review of links between the BAF and the corporate and operational risks to provide greater clarity. Discussion focused on group BAF risk 1 (*digital transformation*) RAG rated red and BAF risk 1.2 (*digital disruption*) RAG rated amber in terms of whether they were scored at the correct level. FPC agreed that both risks should be reviewed and the narrative made more explicit around the risk of cyber attack and elements of emergency preparedness, resilience and response. A review would be carried out at	BAF 1.2 BAF 3.4

Agenda Item:	Minute Reference:	Lead:	Description:	BAF Ref:
			the next meeting. The Committee noted that the review of the Digital Plan later in the meeting contributed significant assurance.	
Transformation & QI Delivery Group Triple A Report	FPC/25/128	Director of Governance and Risk	FPC was assured by updates across a range of transformation and quality programmes including: • Work being undertaken to progress the Mental Health Transformation programme; • Progress being made on the Clinical Plan and its alignment to THRIVE; • Showcasing the Equality App to drive resources and support on equality issues; • The submission of the Trust Green plan for approval.	N/A
LPT Digital Plan	FPC/25/129	Group Chief Digital Information Officer / Director Digital Services	FPC received the Digital Plan and was assured by the breadth and depth of the plan to improve both staff and patient experience, noting the evolving references to business continuity and cyber defence.	BAF 1 BAF 1.2
Estates and Facilities Summary Report	FPC/25/131	Associate Director of Estates and Facilities	FPC was assured by the Estates and Facilities Service report and suggested a deeper dive into the occupancy survey results and strategic estates operating plan. The Committee noted in particular; • All national submissions were up to date including the new NHS England Digital Maturity Assessment. • Good progress was being made in terms of catering around new patient menus and food waste reduction. • Compliance for maintenance of medical devices was at 95% across all directorates and a system for disposing of old medical devices through British Medical Auctions was yielding a new modest income stream. • Approval had been given to capital funding for a further 4 LPT photovoltaic roof panels at Hinckley and Bosworth Community Hospital, Coalville Community Hospital, the Herschel Prins and Evington Centres.	BAF 5.2
CELEBRATING OUTSTANDING:				
Accountability Framework Meeting	FPC/25/125	Director of Finance	• The Right Care Right Person Group had been formally stepped down as system partners were working well in terms of handovers under section 136 of the Mental Health Act.	BAF 3.2

Agenda Item:	Minute Reference:	Lead:	Description:	BAF Ref:
			• The success of the QI project which sought to improve the quality and efficiency of health advice for statutory SEND EHCP assessment reports had resulted in a more efficient use of clinician time.	
Triple A Reports - Data Privacy Group	FPC/25/134	Director of Finance	All archived records had now been transferred from L&R to Iron Mountain. This had been a significant piece of work over a long period of time which was already delivering financial value for the Trust. Focus would now turn to reducing the volume of paper records generated by the Trust.	N/A
Transformation & QI Delivery Group Triple A Report	FPC/25/128	Director of Governance and Risk	• The CHS team had shared a range of positive updates showing real progress in improving services and supporting staff which included delivery of the Auto Planner project; a new Chat Health pilot launching in SALT and completion of a major review of compression therapy; and the team was also tackling health inequalities rolling out targeted projects across 7 services. • The TSPPD Service had introduced a waitlist initiative as part of enhanced operational planning in response to significant challenges and a peak in referrals. • The Perinatal Mental Health Service was selected by the ICB as1 of 3 services to undergo the Equality Delivery System review this year.	N/A

Leicestershire Partnership NHS Trust

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

For presentation at the **TRUST BOARD** **25 November 2025**

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4. Summary report of financial position

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D. Better Payment Practice Code performance
E. Capital programme update
F. Statement of Finance Position, cash and working capital
G. Directorate expenditure run-rates, forecast & actual
H. Risk adjusted forecast outturn scenarios
I. Underlying financial position

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 £1.75m at the end of October (in line with plan). The forecast year end position is currently a surplus of £0.3m, also in line with plan, but with £4.1m likely net risks	APPENDIX A
2. Remain within Capital Resource Limit (CRL).	G	G	The YTD capital spend for October is £6.1m, 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 October is in line with plan, as is the forecast year end surplus (but with £4.1m likely net risks)	SUMMARY REPORT
5. Achieve Efficiency Savings targets.	G	A	Savings at 31st October are £13.2m, on plan. The £28.4m target for the year is expected to be delivered, although this includes a significant number of high risk and non-recurrent schemes.	APPENDIX B
6. Manage agency staff spend in line with plan	G	G	YTD agency spend at the end of October is £6.5m, which is lower (£767k) than planned YTD spend. Forecast year end spend is £9.7m, £1.4m lower than plan.	APPENDIX C
7. Comply with Better Payment Practice Code (BPPC).	A	A	Cumulatively the Tust achieved 2 of the 4 BPPC targets, and in month, the Trust achieved 3 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 £23.1m at the end of October. This is £8.1m 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. October's cash level of £23.1m was 20 days.	APPENDIX F
10. Deliver capital investment in line with plan	G	G	YTD capital expenditure is £6.1m, which is £828k (12%) below planned levels for Month 7. See 'Capital Section' in summary report.	APPENDIX E

Summary report – financial position as at 31 October 2025

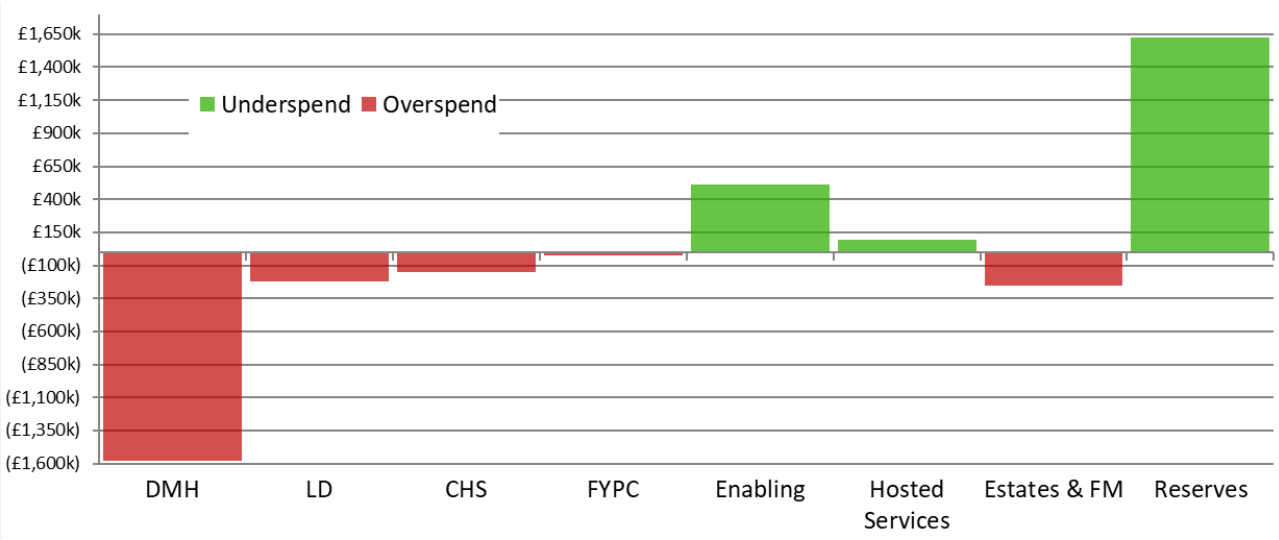
YEAR TO DATE POSITION

- The overall year-to-date income and expenditure plan (being a planned deficit of £1,752k) has been achieved at the end of October.

- Within the wider position, the collective operational budget position has improved significantly during October. At the end of September the operational budgets overspend was £2,002k reflecting an overspending trend of approximately £300k - £350k deficit monthly run-rate. For October, the operational run-rate was actually a surplus (for the first time this financial year) of £373k, thus reducing the year-to-date operational overspend to £1,629k. Of particular note is the DMH position, which had previously been overspending at a rate of c. £250k per month. For the month of October the directorate saw a very slight underspend marking a radical shift from the previous trend.

- Overall within the M7 position, initial operational overspends within all clinical services are currently being offset by equivalent non-recurrent and short term 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 £1,579k at the end of M7, reflecting a £13k improvement compared to the M6 overspend. Aside from negative budgets, high medical locum usage and out of area placements have been the key drivers of the overspend this financial year. However out of area placements have reduced significantly (and were at zero at the end of October) and this is primarily the cause of the improved financial performance.

- **The Community Health Service** is reporting an overall overspend of £152k for the first 7 months of the year, representing a favourable movement of £154k from the previous month. The improved position is a result of reducing the additional 5 beds at Hinckley and the full effect of the temporary Dalgliesh ward closure where staff have been deployed to other wards thus reducing the need of further temporary staff. This contributed to a bank and agency spend reduction of £140k compared to the previous month. Looking towards winter, it has been agreed as a system that we will open Gracedieu ward to support wider pressures. Approximately 68% of the estimated £888k cost has been funded by the ICB, the balance will be a pressure for LPT to manage.

- **The FYPC** financial position at month 7 is a £23k overspend, a further favourable movement compared to last month and in line with forecast out-turn. Agency costs reduced during the month partly down to a re-classification of costs, and medical locum costs ceased in the month. Non pay costs continued to be contained within budget although there was an increase in monthly spend through anticipated VPN costs to be recharged from HIS and Medical equipment within the Diana service. The income position improved in the month due to increased high occupancy on Welford ward and additional funds received from the Local Authorities. The actual CIP savings were below plan at month 7 however the plan for the year is still expected to be delivered.

- **The LDA** financial position at month 7 reported an overspend of £220k, an increase from last month although it is still forecast that the overspend will be capped at £200k by year end. The pay budget was overspent mainly related to negative budgets linked to the Agnes Unit and LDA management budget, and agency costs saw a small increase in the month. Non pay was reporting a small overspend at month 7, with income budgets broadly breaking even. The income position was reporting a virtual break-even position in the month. The CIP was showing under delivery for month 7 but full delivery for the year is forecast (albeit requiring non-recurrent savings to deliver the total target).

- **Enabling budgets** are underspent by £512k as at M7. This is a positive movement of £172k compared to M6 (£340k underspent). The impact of holding vacancies due to the enhanced vacancy controls has contributed towards the increased underspend.

- **Estates budgets** are overspent by £257k as at M7, on par with M6. Pay costs continue to show an overall favourable variance of £467k due to vacancies. This has helped offset overspends within non pay costs primarily relating to Patient food and Laundry Services and a shortfall in income recovery. Additional savings are expected to materialise in November following a review of catering services.

- **The Central Reserves position** is underspent by £1.6m. This is mainly due to the up-front release of balance sheet flexibility as per planning assumptions. The reserves underspend offsets the reserves overspend, enabling the delivery of the on-plan positions at the end of M7.

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 £1,752k planned deficit can be seen in M7. 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 £593K (from the M7 £91k reported surplus run-rate to the planned M12 run-rate of £684k) is still required to achieve the plan for the year. The table below also shows where the operational overspend varies from the planning assumption regarding overspends (blue cells).

	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	(150)	373						
ACTUAL operational cuml. YTD deficit	(538)	(1,078)	(1,594)	(1,980)	(1,852)	(2,002)	(1,629)						
Operational deficit in excess of plan - run-rate	63	(71)	(143)	(153)	269	(124)	282						
Operational deficit in excess of plan - cuml YTD	63	(8)	(151)	(304)	(35)	(159)	123						

- In the year end forecast, net likely risks total £4.0m (down from the £5.4m reported last month). Whilst this is clearly an improvement it suggests that delivery of the forecast £0.3m surplus is high risk and still requires 'best case' in key areas. Work continues to identify further mitigations to negate these risks, with a weekly tracker process now in place to monitor recovery actions.

ICS FINANCIAL POSITION

- The ICS financial position was reported as off plan in month 6 (the latest information available). The ICS position was £17.3m deficit and £5.9m adverse variance against plan (UHL £4.0m, ICB £1.9m).

- The system continues to forecast a year end deficit of £80.00m, before deficit 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. Organisations that are off plan will have deficit funding removed in year.

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

APPENDICES

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 31 Oct 2025	YTD Actual M7 £000	YTD Budget M7 £000	YTD Var. M7 £000
Revenue			
Total income	255,390	252,068	3,322
Operating expenses	(254,860)	(251,538)	(3,322)
Operating surplus (deficit)	**530**	**529**	**0**
Investment revenue	747	747	0
Other gains and (losses)	0	0	0
Finance costs	(1,152)	(1,152)	0
Surplus/(deficit) for the period	**125**	**124**	**0**
Public dividend capital dividends payable	(1,876)	(1,876)	0
I&E surplus/(deficit) for the period (before tech. adjs)	**(1,752)**	**(1,752)**	**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	**(1,752)**	**(1,752)**	**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:	**(1,752)**	**(1,752)**	**0**
Trust EBITDA £000	**7,646**	**7,793**	**(148)**
Trust EBITDA margin %	**3.0%**	**3.1%**	**-0.1%**

APPENDIX B – Efficiency savings performance

At the end of month 7, CIP performance is reported in line with plan which is delivery of £13.2m total savings. There are some year-to-date shortfalls within directorate targets, however the directorate position has improved since month 6. Individual shortfalls are being offset by Estates and Corporate schemes over-delivery. The Estates year-to-date over-delivery is caused by schemes in the original plan being phased towards the end of the year whereas actual savings are being achieved more equally across the year.

The corporate position includes the corporate cost reduction target (£1.5m) and the 'difficult decisions' target (£1.0m). The corporate cost reduction target was originally planned to be delivered through gross MARS pay bill savings, when NHSE had suggested that staff exit costs would be covered via national funding. Now that costs have to be borne by individual organisations, the potential MARS opportunity has been scaled back and no 25/26 in-year savings will be delivered. As such both the corporate £1.5m target and the £1.0m difficult decisions target have been covered via other fortuitous non-recurrent gains (including one-off balance sheet gains and capital charges savings). Note that the 25/26 MARS scheme does release £0.8m recurrent savings in 26/27.

Whilst the in-year 25/26 forecast outturn CIP position is expected to be achieved, the reliance on substantial non-recurrent savings results in a recurrent shortfall of almost £10m which will have to be addressed in the 26/27 financial plan.

CIP year-to-date performance and forecast by directorate

	M7 YTD PERFORMANCE (£'000			FORECAST OUTTURN (£'000)			FOT (£'000)	
Directorate	YTD plan	YTD actual	YTD variance	Annual Plan	FOT	Variance	Recurrent - actual	Non-recurrent actual
DMH	3,377	2,901	(476)	6,210	6,207	(3)	4,452	1,755
CHS	3,314	3,314	0	5,404	5,404	0	4,859	545
FYPCLDA	2,586	2,429	(157)	4,730	4,713	(17)	4,229	484
Estates	740	894	154	2,399	2,399	0	1,422	977
Enabling	1,042	1,049	7	1,779	1,779	0	1,503	276
Corporate	2,132	2,604	472	7,836	7,855	19	2,189	5,666
Unallocated								
Grand total CIPs	**13,192**	**13,192**	**0**	**28,358**	**28,358**	**0**	**18,654**	**9,704**

APPENDIX C – Agency expenditure

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 Actual	25/26 M7 £000s Actual	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	-255	-263	-268	-228	-248	-252	-239	-2,629	-3,864
Nursing - Qualified	-3,192	-266	-167	-123	-118	-126	-127	-103	-131	-124	-125	-125	-123	-121	-895	-1,513
Nursing - Unqualified	-144		-2	0	-4	-8	-3	-2	-8	-3	-4	-3	-2	-1	-27	-40
Other clinical staff costs	-145	-12	-11	-9	-15	17	0	-2	0	0	0	0	0	0	-19	-19
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**	**-362**	**-402**	*-395*	*-357*	*-376*	*-377*	*-361*	**-3,570**	*-5,436*
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	-2	-13	-2	-2	-2	-2	-2	-61	-71
Nursing - Unqualified	-36		0	0	-1	0	0	-1	-1	-1	-1	-1	-1	-1	-3	-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**	*-3*	**-14**	*-3*	*-3*	*-3*	*-3*	*-3*	**-64**	*-79*
Consultant Costs	-370	-31	-30	-16	-23	-24	-14	-26	-6	-8	-8	0	0	0	-139	-155
Nursing - Qualified	-7,723	-644	-358	-329	-264	-258	-225	-221	-217	-230	-230	-180	-165	-165	-1,872	-2,842
Nursing - Unqualified	-1,129		-31	-12	-7	-4	-2	-3	-4	-5	-11	-11	-5	-5	-63	-99
Other clinical staff costs	-326	-27	-27	3	-6	-3	-4	-9	-6	-4	-4	-4	-4	-4	-53	-72
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**	**-259**	**-232**	*-246*	*-253*	*-195*	*-173*	*-173*	**-2,126**	*-3,167*
RISK OF INCREASED AGENCY - GRACEDIEU WARD:											*-145*	*-260*	*-295*	*-188*	**0**	*-888*
FYPC																
Consultant Costs	-438	-37	-22	-22	-22	-22	-29	-18	-14	0	0	0	0	0	-149	-149
Nursing - Qualified	-1,406	-117	-94	-70	-76	-62	-22	-91	-40	-45	-35	-35	-35	-35	-456	-641
Nursing - Unqualified	-40		0	-1	-4	-3	-1	-6	-3	-3	-3	-2	-2	-2	-18	-30
Other clinical staff costs	-23	-2	-9	-14	-10	-9	6	-6	42	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 - FYPC	-1,907	-156	**-125**	**-108**	**-111**	**-96**	**-45**	**-120**	**-16**	*-48*	*-38*	*-37*	*-37*	*-37*	**-623**	*-820*
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	-14	0	0	0	0	0	0	-12	-12
Non clinical staff costs	-297	-25	-6	-4	-7	-10	-36	-19	-11	-13	-13	-13	-13	-13	-94	-159
Sub-total - Enab/Host	-202	-17	**-6**	**-5**	**-6**	**-10**	**-34**	**-33**	*-11*	*-13*	*-13*	*-13*	*-13*	*-13*	**-106**	*-171*
Consultant Costs	-5,983	-499	-488	-493	-456	-491	-407	-299	-283	-276	-236	-248	-252	-239	-2,917	-4,168
Nursing - Qualified	-12,868	-1,072	-628	-539	-475	-449	-376	-417	-401	-401	-392	-342	-325	-323	-3,284	-5,067
Nursing - Unqualified	-1,349	-112	-33	-13	-16	-14	-6	-12	-17	-12	-19	-17	-10	-9	-111	-177
Other clinical staff costs	-499	-42	-47	-20	-31	4	4	-30	36	-4	-4	-4	-4	-4	-84	-103
Non clinical staff costs	-297	-25	-6	-4	-7	-10	-36	-19	-11	-13	-13	-13	-13	-13	-94	-159
Total - excluding Gracedieu risk:	-20,996	-1,750	**-1,203**	**-1,069**	**-985**	**-960**	**-820**	**-777**	**-676**	*-705*	*-664*	*-624*	*-603*	*-587*	**-6,489**	*-9,673*
Total including Gracedieu risk:			**-1,203**	**-1,069**	**-985**	**-960**	**-820**	**-777**	**-676**	*-705*	*-809*	*-884*	*-898*	*-775*	**-6,489**	*-10,561*

Agency spend for October (month 7) is £0.68m. The average monthly agency spend last financial year was £1.75m.

YTD spend is £6.49m; this is lower (by £767k) than the planned YTD spend.

Agency spend for the year is forecast to be £9.7m, lower than the planned £11.1m.

The opening of Gracedieu ward to support system winter pressures may result in a significant additional agency requirement. If all additional staffing was made up of agency staff, this would increase the total initial year end forecast agency spend to £10.6m, which would still be below the £11.1m planned spend.

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. All 4 cumulative targets improved compared to last month's performance, and 3 of the 4 targets were met for October's in-month performance.

Better Payment Practice Code	October (Cumulative)		September (Cumulative	
	Number	£000's	Number	£000's
Total Non-NHS trade invoices paid in the year	22,293	56,244	19,013	50,617
Total Non-NHS trade invoices paid within target	20,663	54,229	17,461	48,768
% of Non-NHS trade invoices paid within target	**92.69%**	**96.42%**	**91.84%**	**96.35%**
Total NHS trade invoices paid in the year	534	45,031	475	39,570
Total NHS trade invoices paid within target	495	43,655	439	38,201
% of NHS trade invoices paid within target	**92.70%**	**96.94%**	**92.42%**	**96.54%**
Grand total trade invoices paid in the year	22,827	101,275	19,488	90,187
Grand total trade invoices paid within target	21,158	97,884	17,900	86,969
% of total trade invoices paid within target	**92.69%**	**96.65%**	**91.85%**	**96.43%**

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

The cumulative performance for the number of Non-NHS invoices for the first seven months of the year is 92.69%, however the position is improving (Month 6: 91.84%). The in-month performance for October was 97.62% (September was 97.04%).

Cumulatively, 90% of Non NHS invoices not paid within the target period are in the estates & facilities directorate, 1468 of the 1630 late invoices relate to catering and estates invoices not being approved and paid on time, with the majority relating to catering invoices. The Estates & Facilities position improved in Month 7: 50 invoices were paid late in October, compared to 95 invoices in September.

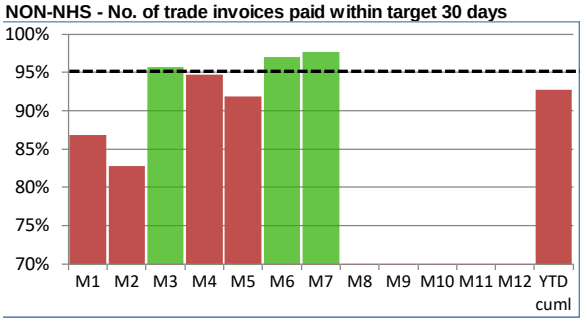
Non-compliant target – Number of NHS invoices:

The cumulative performance for the number of NHS invoices for the first seven months of the year is 92.70% This is an improvement compared to the previous month's performance of 92.42%. The in-month performance for October is 94.92% (September was 91.93%).

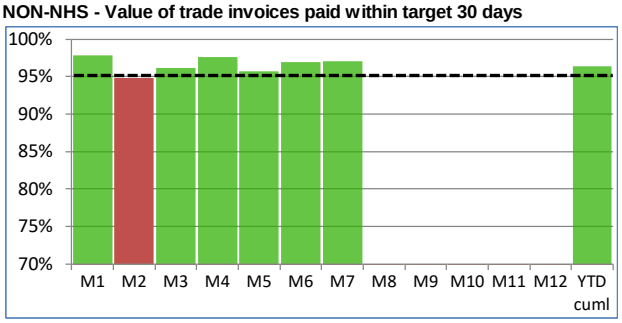
Due to the relatively low volume of NHS invoices paid during the year, only a small number of late invoices will make the performance non-compliant. So far this year, 534 NHS invoices have been paid in total, with 39 invoices being paid outside of the target period of 30 days. Only 3 of the 39 non-compliant invoices were paid late in October - the majority of these related to UHL recharges needing a sole-provider waiver to be approved before a purchase order could be raised, resulting in a delay in payment.

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

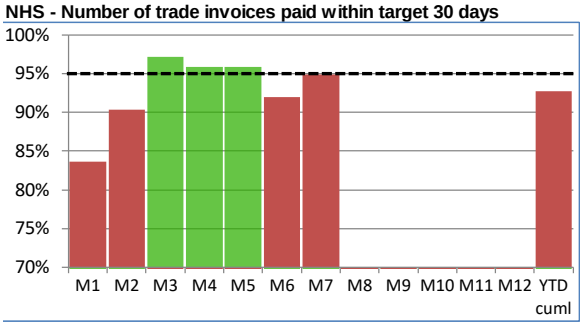
NON-NHS - No. of trade invoices paid within target 30 days



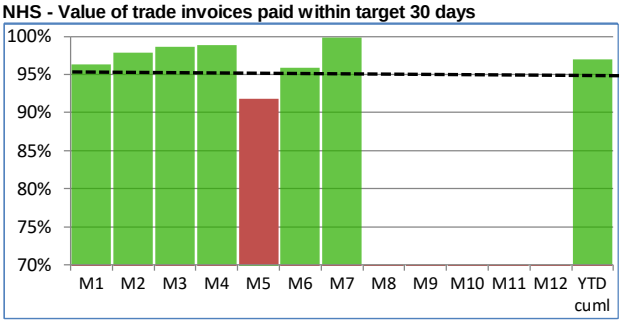
NON-NHS - Value of trade invoices paid within target 30 days



NHS - Number of trade invoices paid within target 30 days



NHS - Value of trade invoices paid within target 30 days



APPENDIX E - Capital Programme 2025/26 update

Trust Board approved an opening capital plan of £13.5m. In addition, the plan included £5m of PDC funding to support a number of national schemes detailed in the table below, bringing the total opening plan to £18.678m. £2.77m of the £5m national schemes relate to MH Out of Area Placements (OAPs). Due to capital works implications on service delivery, the Acacia and Thornton ward refurbishments won't now be completed in this financial year, resulting in £1.8m being carried forward into 2026/27. NHSE has confirmed that the £1.8m unused PDC funding can be deferred to support completion of the schemes next year.

During the year we have received additional GB Energy funding of £456k, £82k to support cyber security initiatives, and a further £315k clinical infrastructure risk funding was confirmed this month. Our System capital limit also increased by £492k, resulting a revised capital forecast of £18.223m.

	Annual Revised Plan	Oct Actual	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation	13,066	7,116	12,198	(868)
Cash reserves	2,840	(264)	4,197	1,357
Capital borrowings repayments	(4,447)	(2,579)	(4,444)	3
Total System operational capital	**11,459**	**4,273**	**11,951**	**492**
IFRS-16 new leases	**2,000**	**1,415**	**2,000**	**0**
MH OAPS - Acacia Ward Refurb	1,200	0	200	(1,000)
MH OAPS - Thornton Ward refurb	1,300	0	500	(800)
MH OAPS - Acute wards bathroom refurb	270	0	271	1
GB Energy	118	118	574	456
Estates Critical Infrastructure Risk (CIR)	2,129	148	2,443	314
Cyber security	0	0	82	82
National Programmes (PDC)	**5,017**	**266**	**4,070**	**(947)**
PFI capital lifecycle costs	**202**	**118**	**202**	**0**
Total Capital funds	**18,678**	**6,072**	**18,223**	**(455)**
Application of Funds				
Estates	**£'000**	**£'000**	**£'000**	**£'000**
Strategic schemes	(1,497)	(3)	(507)	990
Capital staffing	(567)	(303)	(567)	0
Estates backlog programme	(3,470)	(207)	(3,385)	85
Estates rolling programme	(2,107)	(616)	(2,377)	(270)
Medical devices	(170)	0	(170)	0
Directorate investment	(7,430)	(2,707)	(7,349)	81
PFI Agnes Unit capital lifecycle costs	(202)	(118)	(202)	0
	(15,443)	**(3,954)**	**(14,557)**	**886**
IM&T investment	**(1,235)**	**(703)**	**(1,666)**	**(431)**
Operational Capital	**(16,678)**	**(4,657)**	**(16,223)**	**455**
IFRS16 - Right of Use Leases	**(2,000)**	**(1,415)**	**(2,000)**	**0**
Total Capital Expenditure	**(18,678)**	**(6,072)**	**(18,223)**	**455**
(Over)/underspend	**0**	**0**	**0**	**0**

Capital expenditure to date:

Capital expenditure up to the end of October totals £6.072m, which is £828k (12%) below planned levels for Month 7. The majority of spend relates to the Belvoir Unit refurbishment, Hinckley Hub lease conversion costs and the capitalisation of the associated lease.

Capital changes since last month:

The total capital envelope has reduced by £1.435m since the previous month, as detailed below:

	Opening Plan	Changes	Revised Plan	Comments
	£'000	£'000	£'000	
M07 Position	**(19,708)**	**1,485**	**(18,223)**	£1.8m deferral from MH OAPs and CIR Estates fund phase 2
Changes to Plan over £100k				
MH OAPs schemes deferral		1,800	1,800	Scheme slippage agreed by NHSE for Acacia £1m and Thornton £800k - deferral to 26/27
CIR Estates Safety (phase 2)		(315)	(315)	Approved Phase 2 Safety fund - M07
Net allocation change in month		1,485		
DeMontfort and Langton repurpose		250	250	Adjust to forecast spend in year
Glenfield - new hospital (MH)		300	300	Adjust to forecast spend in year
H&S - Window replacement programme		298	298	No further window replacements in 25/26 - Stewart House on hold
IM&T Equipment - MaST (Management & Supervision Tool)		269	269	Amended value
New Finance & Procurement System		100	100	Upgrade only, value reduced
SystmOne patient portal (AirMid)		75	75	Revised spend in 25/26
Acacia Full Refurbishment - The Willows		(500)	(500)	adjust spend to forecast = £700
Thornton Ward Refurbishment		500	500	adjust spend to forecast = £0
PV (Solar Panels) Coalville, Hershel, Evington, Gwendolen		(144)	(144)	Additional enabling works - electrical, building
Agnes Unit & Short Breaks		(500)	(500)	To enable move from Winstanley and short breaks
Net Contingency / Slippage adj		(773)	(773)	Net adjustment - Contingency & slippage
		(125)	1,360	
Changes to Plan below £100k		125	125	
Net Change in month	**(19,708)**	**1,485**	**(18,223)**	

Capital forecasts

From Month 8 it is important to avoid significant movements in capital forecasts as it leaves little time nationally 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.

SoFP, cash and working capital

PERIOD: October 2025	2024/25 31/03/25 Audited £'000's	2025/26 31/10/25 October £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	132,331	132,110
Intangible assets	4,422	3,592
IFRS16 - Right of use (ROU) assets	18,538	18,699
Trade and other receivables	920	920
Total Non Current Assets	**156,211**	**155,321**
CURRENT ASSETS		
Inventories	436	462
Trade and other receivables	8,747	10,479
Short term investments	0	0
Cash and Cash Equivalents	19,547	23,111
Total Current Assets	**28,730**	**34,052**
Non current assets held for sale	**0**	**0**
TOTAL ASSETS	**184,942**	**189,373**
CURRENT LIABILITIES		
Trade and other payables	(28,128)	(31,760)
Borrowings	(4,481)	(4,576)
Provisions	(3,298)	(2,885)
Other liabilities	(6,755)	(10,146)
Total Current Liabilities	**(42,662)**	**(49,367)**
NET CURRENT ASSETS (LIABILITIES)	**(13,932)**	**(15,315)**
NON CURRENT LIABILITIES		
Borrowings	(39,939)	(39,418)
Provisions	(899)	(899)
Total Non Current Liabilities	**(40,838)**	**(40,317)**
TOTAL ASSETS EMPLOYED	**101,442**	**99,690**
TAXPAYERS' EQUITY		
Public Dividend Capital	108,228	108,228
Retained Earnings	(24,744)	(26,496)
Revaluation reserve	17,958	17,958
Other reserves	0	0
TOTAL TAXPAYERS EQUITY	**101,442**	**99,690**

Non-current assets

Property, plant, and equipment (PPE) amounts to £132m, and includes capital additions of £4.7m, offset by depreciation charges.

Right of Use (ROU) leased assets total £18.7m.

Current assets

Current assets of £34.1m mainly includes cash of £23.1m, and receivables of £10.5m.

Current Liabilities

Current liabilities amount to £49.4m with trade and other payables making up £31.8m of this balance.

Other liabilities of £10.1m 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.

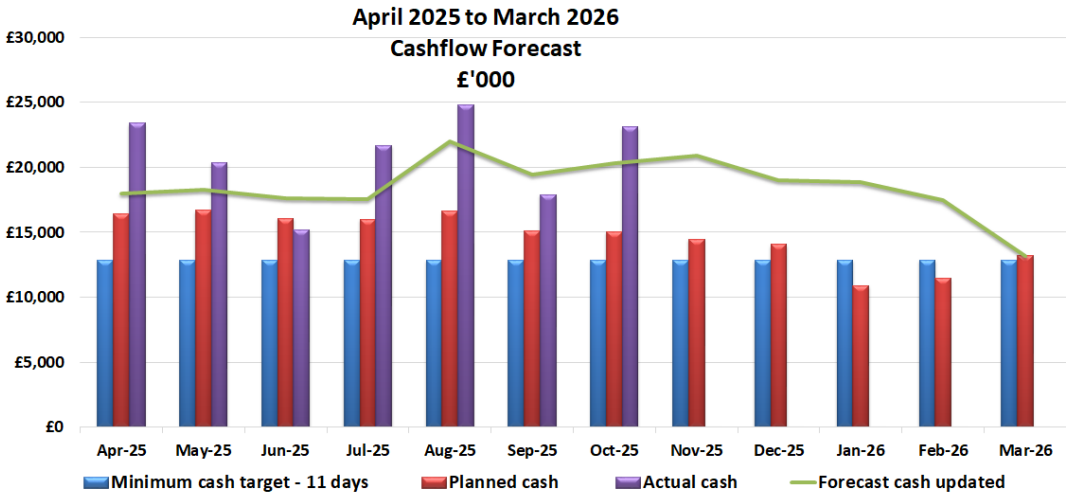
Taxpayers' Equity

October's deficit of £1.75m is reflected within retained earnings.

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

Cash

The closing cash balance at the end of October is £23.1m, an increase of £3.6m since the start of the financial year. This delivers 20 operating days cash, 7 days above the planned level of 13 days for October.



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).

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	20,280	20,896	18,994	18,835	17,441	13,172
Actual cash	23,383	20,358	15,205	21,682	24,806	17,885	23,111	-	-	-	-	-

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	17	18	16	16	15	11
Actual cash days	20	17	13	19	21	15	20	-	-	-	-	-

Receivables

Current receivables (debtors) total £10.5m, an increase of £1.7m since the start of the year. Most of this increase relates to outstanding contract recharges with other NHS providers.

Receivables	Current Month October 2025					
	NHS	Non	Emp's	Total	% Total	% Sales Ledger
	£'000	£'000	£'000	£'000		
Sales Ledger						
30 days or less	2,970	1,892	14	**4,876**	**42.78%**	**78.3%**
31 - 60 days	186	181	1	**368**	**3.23%**	**5.9%**
61 - 90 days	25	336	9	**370**	**3.25%**	**5.9%**
Over 90 days	0	415	200	**615**	**5.40%**	**9.9%**
	3,181	2,824	224	**6,229**	**54.65%**	**100.0%**
Non sales ledger	1,572	2,678	0	**4,250**	**37.28%**	
Total receivables current	**4,753**	**5,502**	**224**	**10,479**	**91.93%**	
Total receivables non current		920		920	**8.07%**	
Total	**4,753**	**6,422**	**224**	**11,399**	**100.00%**	**0.0%**

Debt greater than 90 days stands at £0.62m; this is an increase of £5k 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 7 is 5.40% (last month: 5.39%).

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 7).

Payables

The current payables position in month 7 is £31.8m – an increase of £3.6m since the start of the year. Other liabilities of £10.1m relate to deferred income. It mainly relates to income carried forward from previous years, for provider collaborative and Secure Digital Environment initiatives where LPT is acting as host for the funding and also in-year medical training income.

Borrowings

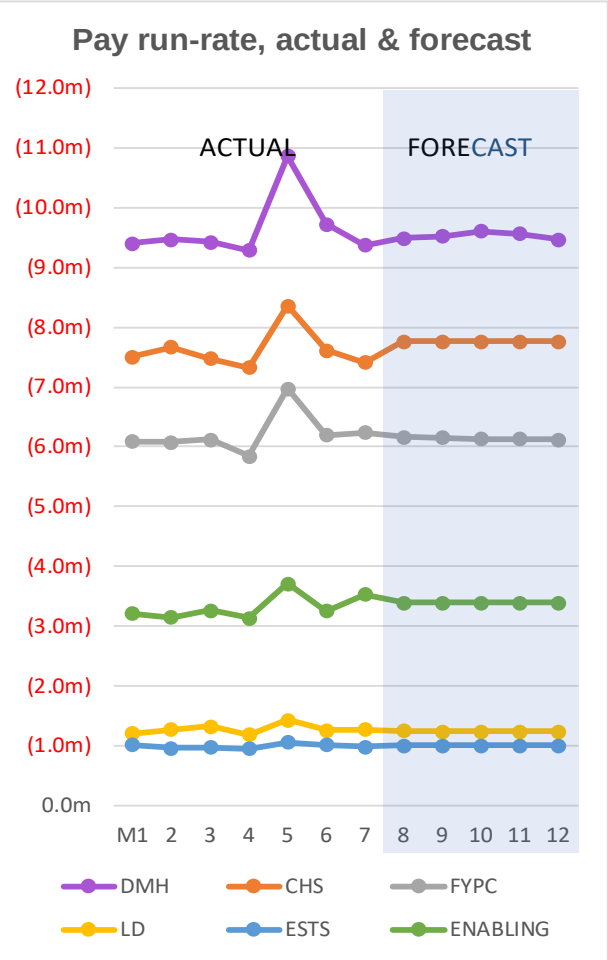
Current and non-current borrowings total £44m. PFI, property leases and the capital investment loan make up this balance, which reduces each month when corresponding payments are made or increases when new lease liabilities arise. The new Hinckley Hub lease is responsible for an increase in borrowings of £1.4m since the start of the year.

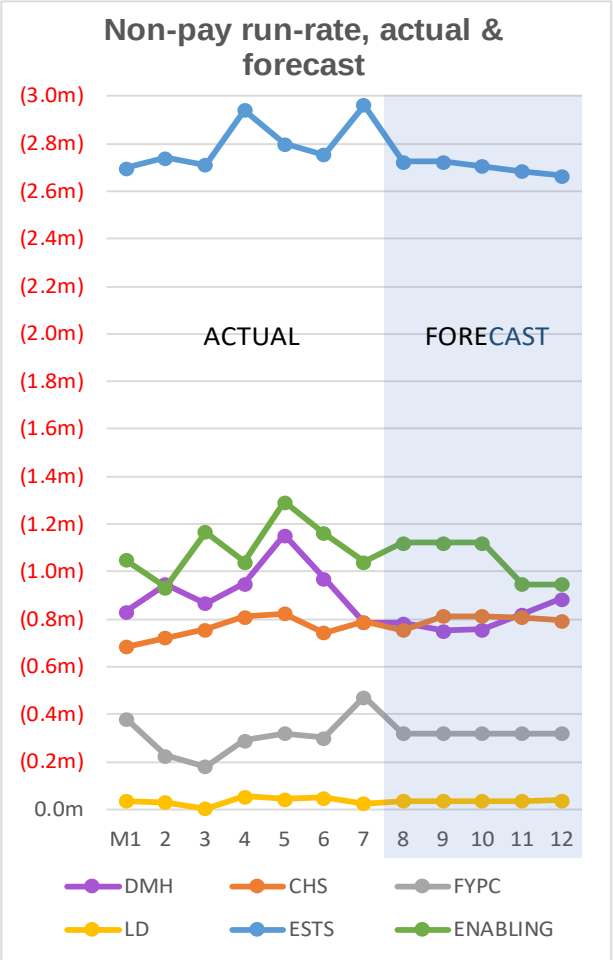
APPENDIX G – Directorate expenditure run-rates, forecast & actual

Monthly cost run-rates are shown in the graphs below, based on likely risk adjusted forecasts (see **appendix H**). Note that the run-rates do not reflect the best case scenarios which support the current risk adjusted best case forecast outturn. The embedding of financial escalation actions sees key components of best case scenarios moving into likely positions which is becoming evident in the run-rate forecasts.

Most directorate likely forecast outturns are based on a fairly static payroll position from month 7 although the DMH position anticipates some reduction in cost in the final quarter which is supporting their improved forecast. This can be evidenced in the graph below left. Note the 'spike' upwards in costs in month 5 which was caused by the pay award arrears.

Non-pay run-rate projections (graph below right) show the biggest change, particularly within Estates (due to the catering costs review). Within DMH the significant impact of actions to reduce out of area placement costs is already evident in month 6 and 7, and their forecast does allow for some seasonal increase early in the new calendar year.





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)	(1,640)	(1,640)	(1,867)
CHS (excluding Gracedieu pressure - see below)	0	0	(150)	(1,000)
FYPC	200	200	200	0
LD	(200)	(200)	(200)	(300)
ESTS	250	0	(18)	(218)
ENABLING	1,200	1,100	980	500
HOSTED	150	125	100	(100)
Opening of Gracedieu Ward to support system pressures (net cost - partially funded)	(200)	(300)	(300)	(400)
TOTAL DIRECTORATE FOT VARIANCE:	**157**	**(715)**	**(1,028)**	**(3,385)**

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:	1,074	874	434	200
£2m NON-REC INCOME TARGET:	1,200	440	0	(1,000)
DIFFICULT DECISIONS / FURTHER NON-RECURRENT TARGETS:	0	(480)	(976)	(976)
UNALLOCATED CIP TARGET	(977)	(977)	(977)	(977)
CORPORATE SERVICES RE-ALIGNMENT:	(1,688)	(1,688)	(1,688)	(1,688)
Sub-total - position re: original plan gap mitigations:	**665**	**(775)**	**(2,151)**	**(3,385)**
Other mitigation identified to date				
Interest receivable minor gain over budget:	252	226	200	100
Slippage on internal investments:	328	295	260	180
Sub-total 'mitigations' (reserves) position:	**1,245**	**(254)**	**(1,691)**	**(3,105)**
Pay award funding shortfall:	**(1,402)**	**(1,402)**	**(1,402)**	**(1,402)**
TOTAL CORPORATE PRESSURES / MITIGATIONS:	**(157)**	**(1,656)**	**(3,093)**	**(4,507)**
TOTAL TRUST	**0**	**(2,371)**	**(4,121)**	**(7,892)**

**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)*

APPENDIX I – Summary underlying position

Within the wider NHS, there is now much greater focus on organisations' underlying financial positions. Analysis of the underlying position provides further insight into the financial stability of an organisation beyond the current year, as it strips out any non-recurrent or one-off gains and pressures.

NHS England have released a Key Lines of Enquiry list and set of national reporting principles to NHS organisations to ensure that reporting of underlying positions is consistent across the sector (see separate paper on Confidential Trust Board agenda).

The Trust is currently reporting an estimated underlying income and expenditure deficit of £12.4m. The table below shows how the in-year forecast of £0.3m surplus moves to the £12.4m underlying deficit when the large value of non-recurrent gains are removed from the recurrent position.

CALCULATION OF HIGH LEVEL UNDERLYING POSITION 2025/26 - @ M7	£000
2025/26 Forecast outturn reported at M7:	**311**
FOT non-recurrent CIPs*	(9,704)
Net impact of recurrent CIP FYE offset by other non-recurrent gains	863
Confirmed shortfall in 25/26 pay award funding	(1,402)
Additional non-recurrent gains required to deliver 25/26 plan	(1,504)
Recurrent impact of ceasing temporary vacancy pause	(1,000)
FORECAST YEAR END UNDERLYING POSITION (deficit) at M6:	**(12,436)**

*Recurrently unmet CIP target substantially driven by prior and current year pay award funding shortfalls totalling £7.4m

The table above shows that the majority of the underlying deficit is caused by the removal of non-recurrent 25/26 efficiency savings.

The likely recurrent CIP shortfall was well understood at 25/26 planning stage due to the very high CIP target (6.6%) required to balance the 25/26 financial plan. The national CIP requirement levied via NHS contracts was 2.0%, meaning that the remaining 4.6% was required to offset local cost pressures. It is worth noting that in recent years, the most significant recurrent LPT cost pressure has been caused by the shortfall in national funding for pay awards. Following confirmation of the 25/26 funding allocation from the ICB, the cumulative recurrent shortfall has now increased to £7.4m. In effect therefore, £7.4m of the Trust's £12.6m underlying deficit (59% of the total) arises as a result of the pay award funding shortfall.

Governance Table

For Board and Board Committees:	Trust Board
Paper sponsored by:	Sharon Murphy, Executive Director of Finance & Performance
Paper authored by:	Chris Poyser - Head of Corporate Finance; Jackie Moore – Financial controller
Date submitted:	17th November 2025
Name and date of other committee / forum at which this report / issue was considered:	None
Level of assurance gained if considered elsewhere	☐ Assured ☐ Partially assured ☐ Not assured
Date of next report:	Trust Board standing agenda item
THRIVE strategic alignment:	☐ **T**echnology ☐ **H**ealthy communities ☐ **R**esponsive ☐ **I**ncluding everyone ☐ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	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
Is the decision required consistent with LPT's risk appetite:	Yes
False or Misleading Information (FOMI) considerations:	N/A
Positive confirmation that the content does not risk the safety of patients or the public:	Yes
Equality considerations:	None

M

Leicestershire Partnership NHS Trust

Trust Board – 25.11.25

Board Performance Report – October 2025 (Month 7)

Purpose of the report

To provide the Trust Board with an overview of Trust performance against an agreed set of KPI's for October 2025 (M7 of 2025/26).

Analysis of the issue

The report is presented to the Trust Board in advance of Accountability Framework Meeting due to the timing of meetings.

Proposal

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

- A new exception page has been generated for the 'Safe staffing - No. of wards not meeting >80% fill rate for RNs - Day' metric
- There is a known data quality issue with the longest waiter for the Dynamic Psychotherapy - Treatment Waits. This has resulted in a longer wait being reported. The patient's record is in the process of being updated.

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:

- Trends moving from *common cause* to *special cause improving with higher values*
    - CAMHS ED 4 weeks complete
- Trend moving from *common cause* to *special cause improving with lower values*
    - 52 Week Wait: All LD – Treatment Waits
    - 52 Weeks Wait: Adult Eating Disorders Community – Treatment Waits

    - No. of Medication Errors
- Trend moving from *common cause* to *special cause concerning with higher values*
    - Occupancy Rate – mental health beds (excluding leave)
    - No. of episodes of seclusions >2hrs
- Trend moving from *special cause concerning with higher values* to *common cause*
    - 52 Weeks Wait: Cognitive Behavioural Therapy - Treatment Waits
    - 52 Weeks Wait: CAMHS - Treatment Waits (excl ND)
    - No of concerns
    - Safe staffing - No. of wards not meeting >80% fill rate for RNs - Night

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:	17.11.25	
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	

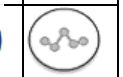
NHS
Leicestershire Partnership
NHS Trust

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%	Sep-25	50.5%	44.6%	F	
Memory Clinic (18 week Local RTT) - Incomplete pathway	>=92%	Sep-25	57.6%	55.1%	F	L
ADHD (18 week local RTT) - Incomplete pathway	>=92%	Sep-25	8.8%	8.4%	F	H
CINSS (6 weeks) - Incomplete Pathway	>=95%	Sep-25	40.2%	41.5%	F	L
Speech Therapy - Voice, Respiratory and Dysfluency - Routine (6 weeks) - Incomplete Pathway	>=95%	Sep-25	22.5%	23.2%	F	L
Community Paediatrics (18 weeks) - Incomplete pathway	>=92%	Sep-25	9.8%	10.2%	F	L
Childrens Audiology (6 week wait for diagnostic procedures) - Incomplete pathway	>=99%	Sep-25	32.0%	27.5%	F	H
Adult General Psychiatry - Community Mental Health Teams and Outpatients – Treatment waits - No of Waiters	0	Oct-25	34	37	F	L
Cognitive Behavioural Therapy - Treatment waits - No of waiters	0	Oct-25	46	52	F	
Dynamic Psychotherapy - Treatment waits - No of waiters	0	Oct-25	3	5	F	
Therapy Service for People with Personality Disorder - Treatment waits - No of waiters	0	Oct-25	162	194	F	
Medical/Neuropsychology - Treatment waits - No of Waiters	0	Oct-25	101	118	F	H
ADHD (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	Sep-25	6006	5833	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	Sep-25	5	9	F	L
Community Paediatrics - assessment waits over 52 weeks - No of waiters	0	Sep-25	6182	6067	F	H
Community Paediatrics Treatment (excl ND) - No of waiters	0	Oct-25	46	35	F	L
All Neurodevelopment (inc CAMHS, SALT, PAEDS) - Treatment waits - No of waiters	0	Oct-25	1597	0	F	H
CAMHS - Treatment waits (excl ND) - No of waiters	0	Oct-25	57	102	F	
All LD - Treatment waits - No of waiters	0	Oct-25	1	3	?	L
Children's SALT Communication & Dysphagia - No of waiters	0	Oct-25	1839	1845	F	H
Children's Physiotherapy - No of waiters	0	Oct-25	18	19	F	H
Adult Eating Disorders Community - Treatment waits - No of waiters	0	Oct-25	1	2	?	L
Safe staffing - No. of wards not meeting >80% fill rate for RNs - Day	0	Oct-25	4	4	F	H
Vacancy Rate	<=10%	Oct-25	10.3%	10.3%	F	L
Sickness Absence	<=5.0%	Sep-25	5.7%	5.4%	?	
Agency Costs	<=£922,333	Oct-25	£675,681	£776,941	F	L

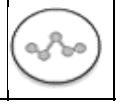
EXCEPTION REPORTS - Consistently Achieving Target						
Indicator	**Monthly Target**	**Data As At**	**Current Reporting**	**Previous Reporting**	**SPC Assurance**	**SPC Trend**
MRSA Infection Rate	**0**	**Oct-25**	**0**	**0**		
Clostridium difficile infection rate	**<=12**	**Oct-25**	**1**	**2**		
Normalised Workforce Turnover (Rolling previous 12 months)	**<=10%**	**Oct-25**	**7.1%**	**7.0%**		
Core Mandatory Training Compliance for substantive staff	**>=85%**	**Oct-25**	**98.4%**	**98.5%**		
Staff with a Completed Annual Appraisal	**>=80%**	**Oct-25**	**94.9%**	**95.2%**		
% of staff from a BME background	**>=22.5%**	**Oct-25**	**32.9%**	**32.7%**		
% of staff who have undertaken clinical supervision within the last 3 months	**>=85%**	**Oct-25**	**94.4%**	**94.5%**		

EXCEPTION REPORTS MATRIX SUMMARY

Variation/Trend		Assurance		
		Achieving Target 	**Inconsistently Achieving Target** 	**Not Achieving Target** 
	Special Cause - Improvement 	Normalised Workforce Turnover / Core Mandatory Training Compliance for substantive staff / % of staff from a BME background / % staff clinical supervision	LD 52 Wks Adult ED Community 52 wks	*Waiting Times* : ADHD / Children's Audiology / CMHT 52 Wks / TSPPD 52 wks / Community Paediatrics Treatment 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 / CBT 52 weeks / DPS 52 wks / MHSOP Memory Clinic 52 Wks / CAMHS - Treatment waits
	Special Cause - Concern 			*Waiting Times:* Stroke & Neuro / Speech Therapy / Memory Clinic / Community Paediatrics / Medical_Neuro 52 wks / ADHD 52 weeks / Community Paediatrics 52 wks assessment / All Neurodevelopment 52 Wks / Children's SALT Communication & Dysphagia 52 Wks / Children's Physiotherapy 52 wks Safe staffing - Day

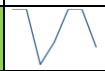
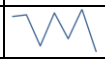
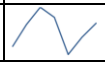
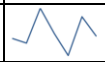
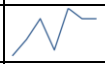
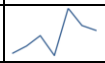
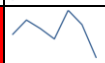
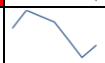
SUMMARY

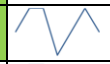
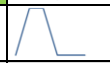
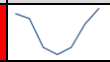
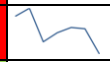
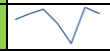
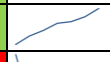
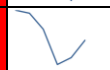
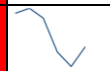
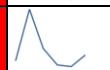
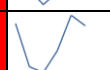
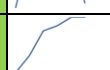
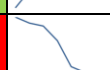
WORKFORCE						
Indicator	**Monthly Target**	**Data As At**	**Current Reporting Period**	**Previous Reporting Period**	**SPC Assurance**	**SPC Trend**
Normalised Workforce Turnover (Rolling previous 12 months)	**<=10%**	**Oct-25**	**7.1%**	**7.0%**		
Vacancy Rate	**<=10%**	**Oct-25**	**10.3%**	**10.3%**		
Sickness Absence (in arrears)	**<=5.0%**	**Sep-25**	**5.7%**	**5.4%**		
Agency Costs	**<=£922,333**	**Oct-25**	**£675,681**	**£776,941**		

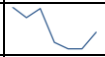
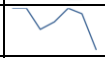
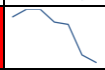
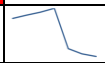
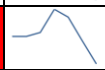
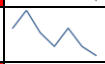
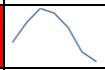
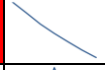
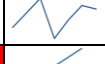
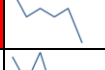
QUALITY & SAFETY						
Indicator	**Monthly Target**	**Data As At**	**Current Reporting Period**	**Previous Reporting Period**	**SPC Assurance**	**SPC Trend**
Safe staffing - No. of wards not meeting >80% fill rate for RNs - Day	**0**	**Oct-25**	**4**	**4**		
Safe staffing - No. of wards not meeting >80% fill rate for RNs - Night	**0**	**Oct-25**	**1**	**2**		

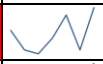
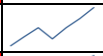
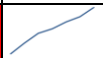
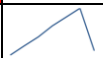
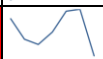
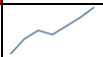
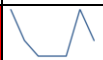
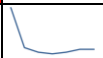
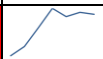
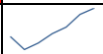
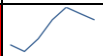
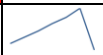
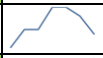
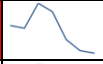
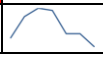
FINANCE (Metrics TBC)

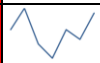
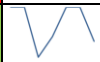
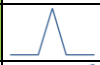
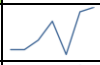
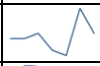
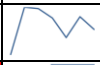
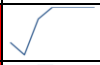
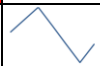
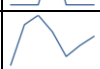
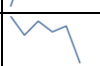
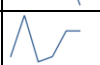
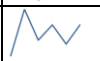
Board Performance Report
Summary Dashboard

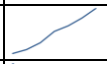
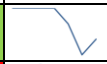
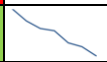
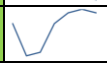
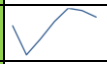
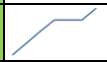
Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Quality Account	TRUST	Monthly	The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period	>=95%	Oct-25	98.5%	100.0%				
	TRUST	Yearly	The Trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period		24/25	6.6	6.3				
	TRUST	Monthly	The percentage of inpatients discharged with a subsequent inpatient admission within 30 days - 0-15 years		Oct-25	0.0%	0.0%				
	TRUST	Monthly	The percentage of inpatients discharged with a subsequent inpatient admission within 30 days - 16+ years		Oct-25	5.1%	7.4%				
	TRUST	Monthly	The number of patient safety incidents reported within the Trust during the reporting period		Oct-25	1902	1750				
	TRUST	Monthly	The rate of patient safety incidents reported within the Trust during the reporting period		Oct-25	68.1%	69.7%				
	TRUST	Monthly	The number of such patient safety incidents that resulted in severe harm or death		Oct-25	15	15				
	TRUST	Monthly	The percentage of such patient safety incidents that resulted in severe harm or death		Oct-25	0.8%	0.9%				
	MHSDS	Monthly (a quarter in arrears)	72 hour Follow Up after discharge (Aligned with national published data)	>=80%	Aug-25	88.0%	92.0%				
NHS Oversight	TRUST	Monthly	2-hour urgent response activity	>=70%	Oct-25	85.1%	85.0%				
	TRUST	Monthly	Daily discharges as % of patients who no longer meet the criteria to reside in hospital		Oct-25	23.6%	26.3%				
	TRUST	Monthly	Out of Area Placement - Inappropriate Bed Days	0	Oct-25	52	270				
	ICB	Monthly	Reliance on specialist inpatient care for adults with a learning disability and/or autism		Oct-25	25	23				
	ICB	Monthly	Reliance on specialist inpatient care for children with a learning disability and/or autism		Oct-25	3	2				
		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		Oct-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	Oct-25	0	0				
	TRUST	Monthly	Clostridium difficile infection rate	<=12	Oct-25	1	2				
	UHL	Monthly (In Arrears)	E.coli bloodstream infections		Sep-25	0	0				
	GOV	Monthly (YTD)	Percentage of people aged 65 and over who received a flu vaccination								
			VTE Risk Assessment								
Operational Planning	TRUST	Monthly (3 month rolling)	Average Length of Stay in Adult Acute MH Beds	<=54.5	Oct-25	69.0	64.9				
	TRUST	Monthly	Average Length of stay - Community Hospitals	<=23.5	Oct-25	22.4	24.3				
	TRUST	Monthly	Community Care Contacts - CHS	Plan=85468	Oct-25	89732	86465				
	TRUST	Monthly	Community Care Contacts - FYPC	Plan=11098	Oct-25	10810	11196				
	TRUST	Monthly	Community Services Waiting List over 52 weeks	Target =0 Plan=6587	Oct-25	6380	6182				
Access Waiting Times - DMH	TRUST	Monthly (In Arrears)	Adult CMHT Access (6 weeks routine) - Incomplete pathway	>=95%	Sep-25	50.5%	44.6%				
	TRUST	Monthly (In Arrears)	Memory Clinic (18 week Local RTT) - Incomplete pathway	>=92%	Sep-25	57.6%	55.1%				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - Incomplete pathway	>=92%	Sep-25	8.8%	8.4%				
	TRUST	Monthly (In Arrears)	Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral - complete pathway	>=60%	Sep-25	65.4%	59.1%				
Access Waiting Times - CHS	TRUST	Monthly (In Arrears)	CINSS (6 weeks) - Incomplete Pathway	>=95%	Sep-25	40.2%	41.5%				
	TRUST	Monthly (In Arrears)	Speech Therapy - Voice, Respiratory and Dysfluency - Routine (6 weeks) - Incomplete Pathway	>=95%	Sep-25	22.5%	23.2%				
Access Waiting Times - FYPCLDA	TRUST	Monthly (In Arrears)	CAMHS Eating Disorder (one week) - Complete pathway	>=95%	Sep-25	50.0%	100.0%				
	TRUST	Monthly (In Arrears)	CAMHS Eating Disorder (four weeks) - Complete pathway	>=95%	Sep-25	100.0%	100.0%				
	TRUST	Monthly (In Arrears)	Community Paediatrics (18 weeks) - Incomplete pathway	>=92%	Sep-25	9.8%	10.2%				
	TRUST	Monthly (In Arrears)	Childrens Audiology (6 week wait for diagnostic procedures) - Incomplete pathway	>=99%	Sep-25	32.0%	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)		Oct-25	6.7%	0.0%				
	TRUST	Monthly	(5-18yrs) Percent of RHAs sent to LA in month within 12 months of previous assessment (City/County/Rutland)		Oct-25	91.8%	98.9%				
	TRUST	Monthly	(0-4yrs) Percent of RHAs sent to LA in month within 6 months of previous assessment (City/County/Rutland)		Oct-25	96.9%	95.7%				
52 Week Waits - DMH	TRUST	Monthly	Adult General Psychiatry - Community Mental Health Teams and Outpatients – Treatment waits - No of Waiters	0	Oct-25	34	37				
	TRUST	Monthly	Adult General Psychiatry - Community Mental Health Teams and Outpatients – Treatment waits - Longest Waiter		Oct-25	131	134				
	TRUST	Monthly	Cognitive Behavioural Therapy - Treatment waits - No of waiters	0	Oct-25	46	52				
	TRUST	Monthly	Cognitive Behavioural Therapy- Treatment waits - Longest waiter (weeks)		Oct-25	79	81				
	TRUST	Monthly	Dynamic Psychotherapy - Treatment waits - No of waiters	0	Oct-25	3	5				
	TRUST	Monthly	Dynamic Psychotherapy - Treatment waits - Longest waiter (weeks)		Oct-25	101	68				
	TRUST	Monthly	Therapy Service for People with Personality Disorder - Treatment waits - No of waiters	0	Oct-25	162	194				
	TRUST	Monthly	Therapy Service for People with Personality Disorder - Treatment waits - Longest waiter (weeks)		Oct-25	194	189				
	TRUST	Monthly	Medical/Neuropsychology - Treatment waits - No of Waiters	0	Oct-25	101	118				
	TRUST	Monthly	Medical/Neuropsychology- Treatment waits - Longest Waiter		Oct-25	151	152				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	Sep-25	6006	5833				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - assessment waits over 52 weeks - Longest waiter (weeks)		Sep-25	346	342				
	TRUST	Monthly (In Arrears)	MHSOP Memory Clinics (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	Sep-25	5	9				
	TRUST	Monthly (In Arrears)	MHSOP Memory Clinics (18 week local RTT) - assessment waits over 52 weeks -Longest waiter (weeks)		Sep-25	66	71				

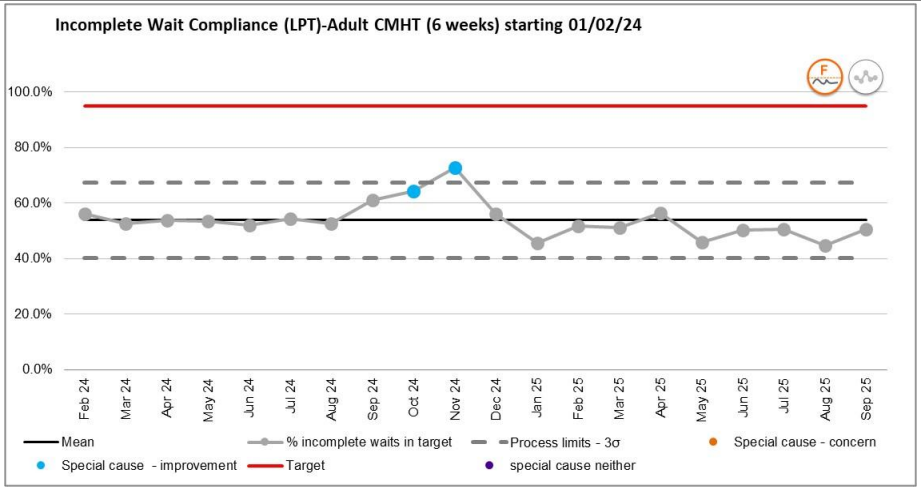
Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
52 Week Waits - FYPCLDA	TRUST	Monthly (In Arrears)	Community Paediatrics - assessment waits over 52 weeks - No of waiters	0	Sep-25	6182	6067				
	TRUST	Monthly (In Arrears)	Community Paediatrics - assessment waits over 52 weeks - Longest waiter (weeks)		Sep-25	193	189				
	TRUST	Monthly	Community Paediatrics Treatment (excl ND) - No of waiters	0	Oct-25	46	35				
	TRUST	Monthly	Community Paediatrics Treatment (excl ND) - Longest waiter		Oct-25	150	145				
	TRUST	Monthly	All Neurodevelopment (inc CAMHS, SALT, PAEDS) - Treatment waits - No of waiters	0	Oct-25	1597	1518				
	TRUST	Monthly	All Neurodevelopment (inc CAMHS, SALT, PAEDS) - Treatment waits - Longest waiter (weeks)		Oct-25	239	258				
	TRUST	Monthly	CAMHS - Treatment waits (excl ND) - No of waiters	0	Oct-25	57	102				
	TRUST	Monthly	CAMHS - Treatment waits (excl ND) - Longest waiter (weeks)		Oct-25	90	85				
	TRUST	Monthly	All LD - Treatment waits - No of waiters	0	Oct-25	1	3				
	TRUST	Monthly	All LD - Treatment waits - Longest waiter (weeks)		Oct-25	53	53				
	TRUST	Monthly	Children's SALT Communication & Dysphagia - No of waiters	0	Oct-25	1839	1845				
	TRUST	Monthly	Children's SALT Communication & Dysphagia - Longest waiter		Oct-25	123	121				
	TRUST	Monthly	Children's Physiotherapy - No of waiters	0	Oct-25	18	19				
	TRUST	Monthly	Children's Physiotherapy - Longest waiter		Oct-25	98	125				
	TRUST	Monthly	Children's Continence - No of waiters	0	Oct-25	0	0				
	TRUST	Monthly	Children's Continence - Longest waiter		Oct-25	19	23				
	TRUST	Monthly	Audiology - No of waiters	0	Oct-25	1	0				
	TRUST	Monthly	Audiology - Longest waiter		Oct-25	52	47				
	TRUST	Monthly	Adult Eating Disorders Community - Treatment waits - No of waiters	0	Oct-25	1	2				
	TRUST	Monthly	Adult Eating Disorders Community - Treatment waits - Longest waiter (weeks)		Oct-25	63	69				

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%	Oct-25	88.0%	88.3%				
	TRUST	Monthly	Occupancy Rate - Community Beds (excluding leave)	>=93%	Oct-25	93.5%	92.6%				
	TRUST	Monthly	Delayed Transfers of Care	<=3.5%	Oct-25	6.4%	5.3%				
	TRUST	Monthly	Gatekeeping	>=95%	Oct-25	98.5%	100.0%				
	TRUST	Monthly	Admissions to adult facilities of patients under 18 years old	0	Oct-25	0	0				
Quality & Safety	TRUST	Monthly	No. of Complaints		Oct-25	30	29				
	TRUST	Monthly	No. of Concerns		Oct-25	47	62				
	TRUST	Monthly	No. of Compliments		Oct-25	181	200				
	TRUST	Monthly	Safe staffing - No. of wards not meeting >80% fill rate for RNs - Day	0	Oct-25	4	4				
	TRUST	Monthly	Safe staffing - No. of wards not meeting >80% fill rate for RNs - Night	0	Oct-25	1	2				
	TRUST	Monthly	Care Hours per patient day		Oct-25	11.5	11.2				
	TRUST	Monthly	No. of Long term Segregations		Oct-25	2	2				
	TRUST	Monthly	No. of episodes of seclusions >2hrs		Oct-25	17	15				
	TRUST	Monthly	No. of episodes of prone (Supported) restraint		Oct-25	1	0				
	TRUST	Monthly	No. of episodes of prone (Unsupported) restraint		Oct-25	0	0				
	TRUST	Monthly	Total number of Restrictive Practices		Oct-25	261	227				
	TRUST	Monthly (In Arrears)	No. of Category 2 pressure ulcers developed or deteriorated in LPT care		Sep-25	86	131				
	TRUST	Monthly (In Arrears)	No. of Category 3 pressure ulcers developed or deteriorated in LPT care		Sep-25	19	19				
	TRUST	Monthly (In Arrears)	No. of Category 4 pressure ulcers developed or deteriorated in LPT care		Sep-25	12	7				
	TRUST	Monthly (In Arrears)	No. of repeat falls		Sep-25	38	51				

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		Oct-25	94	87				
	TRUST	Monthly	LD Annual Health Checks completed - YTD		Oct-25	39.8%	32.0%				
	TRUST	Monthly	LeDeR Reviews completed within timeframe - Allocated		Oct-25	10	9				
	TRUST	Monthly	LeDeR Reviews completed within timeframe - Awaiting Allocation		Oct-25	12	12				
	TRUST	Monthly	LeDeR Reviews completed within timeframe - On Hold		Oct-25	15	12				
HR Workforce	TRUST	Monthly	Normalised Workforce Turnover (Rolling previous 12 months)	<=10%	Oct-25	7.1%	7.0%				
	TRUST	Monthly	Vacancy Rate	<=10%	Oct-25	10.3%	10.3%				
	TRUST	Monthly (In Arrears)	Sickness Absence	<=5.0%	Sep-25	5.7%	5.4%				
	TRUST	Monthly (In Arrears)	Sickness Absence Costs		Sep-25	£1,188,327	£1,098,029				
	TRUST	Monthly (In Arrears)	Sickness Absence - YTD	<=5.0%	Sep-25	5.3%	5.2%				
	TRUST	Monthly	Agency Costs	<=£922,333	Oct-25	£675,681	£776,941				
	TRUST	Monthly	Core Mandatory Training Compliance for substantive staff	>=85%	Oct-25	98.4%	98.5%				
	TRUST	Monthly	Staff with a Completed Annual Appraisal	>=80%	Oct-25	94.9%	95.2%				
	TRUST	Monthly	% of staff from a BME background	>=22.5%	Oct-25	32.9%	32.7%				
	TRUST	Monthly	Staff flu vaccination rate (frontline healthcare workers)		Oct-25	31.3%					
	TRUST	Monthly	% of staff who have undertaken clinical supervision within the last 3 months	>=85%	Oct-25	94.4%	94.5%				

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

DMH	Target	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
	>=95%	64.4%	72.8%	56.1%	45.6%	51.7%	51.1%	56.4%	45.9%	50.2%	50.5%	44.6%	50.5%
No of Referrals		342	442	319	251	310	338	413	348	314	448	344	439



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
53.8%	40.0%	67.0%

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

Daily huddles in place in all 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 completed with CAP backlog of routine referrals cleared. Routine referrals now sent directly to MDT Front Door as business as usual for all Neighbourhood teams.

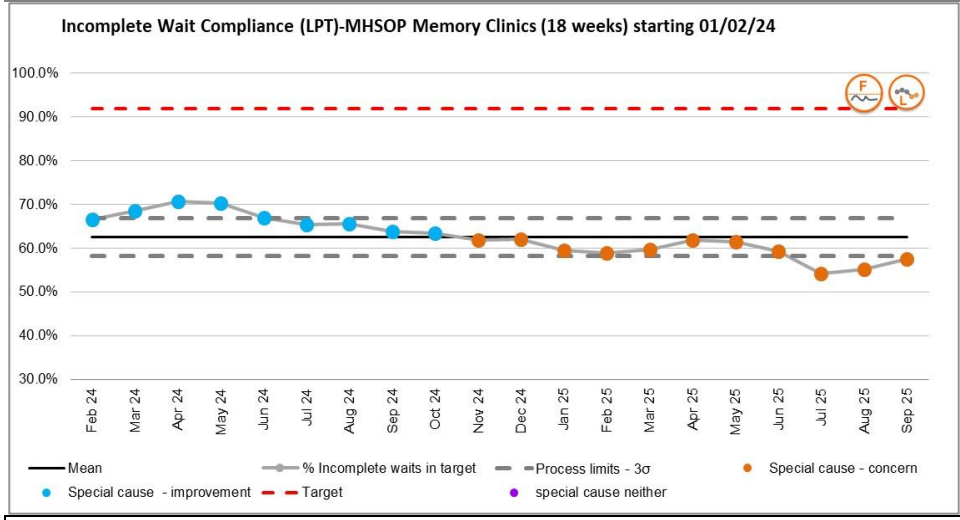
Work continues to progress caseloads review programme. Medical workforce transformation plan workstreams will review caseload and patient cohorts in outpatient clinics with the expected outcome of reduced consultant caseloads, bringing these within agreed thresholds, and supporting increased retention 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.

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

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

DMH	Target	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
	>=92%	63.4%	61.9%	62.1%	59.4%	58.9%	59.7%	61.9%	61.5%	59.2%	54.1%	55.1%	57.6%
No of Referrals		239	191	197	184	196	253	218	207	240	184	203	279



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
62.6%	58.0%	67.0%

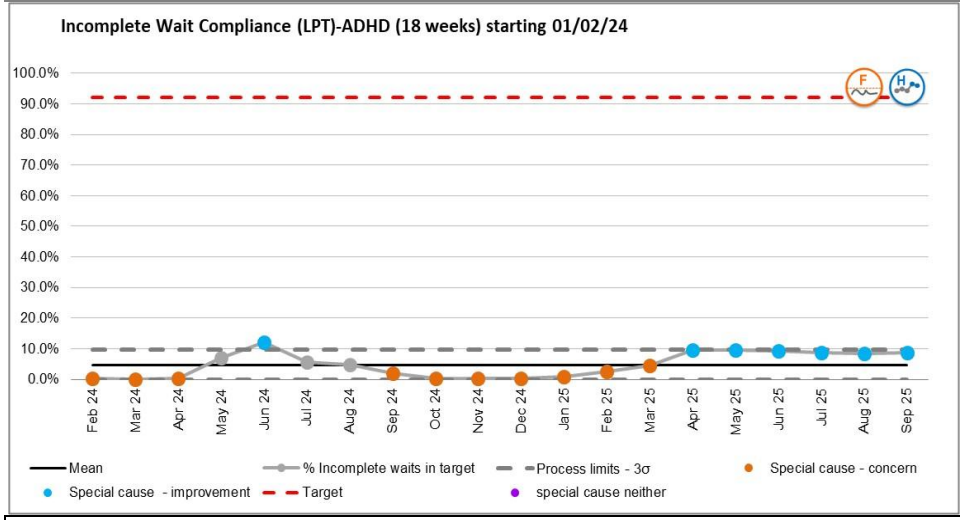
Operational Commentary (e.g. referring to risk, finance, workforce)

Implementation of One Stop Clinic pilot (rapid access clinics) commenced March 2025 with noted improvement in numbers waiting and length of wait where patients are seen and diagnosed in clinic. Has enabled assessment and diagnosis on-the-day. Advanced pathway clinics running as a pilot from June 2025, for patients over 85 and where there is a high suspicion of dementia. 200 patients identified from a review of the waiting list with 54 patients assessed and 43 diagnosed on the same day between June and September 20205. A review of both models to take place in Q4 to assess effectiveness in improving the patient experience and waiting times.

All patients waiting receive wellbeing calls following 8 week waits and then every 8 weeks thereafter, support workers provide these calls following a clear script to check risks, support network available and signpost to support available. Any escalating or unmanaged risks are referred to a clinician for review and call back if needed.

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

DMH	Target	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
	>=92%	0.2%	0.4%	0.3%	0.9%	2.5%	4.5%	9.5%	9.6%	9.4%	8.7%	8.4%	8.8%
No of Referrals		391	329	258	314	292	311	247	216	268	266	239	299



Analytical Commentary

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

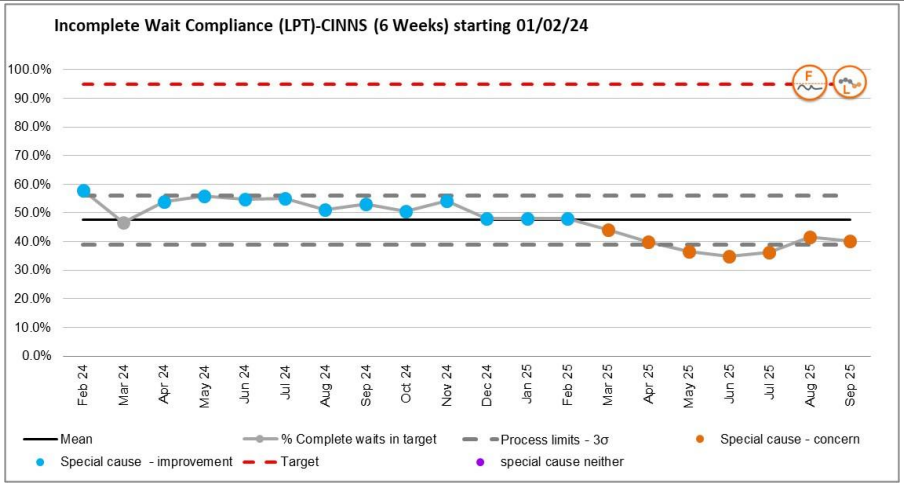
Mean	Lower Process Limit	Upper Process Limit
4.8%	0.0%	10.0%

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

Following ICB and EMB agreement, work has commenced to develop a more efficient pathway with shorter waits for assessment and treatment and ensure patients are signposted to the service most appropriate to their needs. A group co-chaired by DMH Exec Director and ICB Associate Director oversees workstreams to progress Adult ADHD pathway transformation. This includes increasing productivity, reviewing best practice elsewhere, potential for 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 and implementation of replacement of ADHD Solutions for psychological/psychoeducational support for patients waiting. The service working closely with the Communications Team to develop waiting well support pages on the LPT website, these are now live with further work progressing to continue to enhance.

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

CHS	Target	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
	>=95%	50.5%	54.1%	48.0%	48.1%	47.9%	44.0%	39.9%	36.6%	34.9%	36.3%	41.5%	40.2%
No of Referrals		209	203	170	222	174	210	203	219	180	189	205	165



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
47.5%	39.0%	56.0%

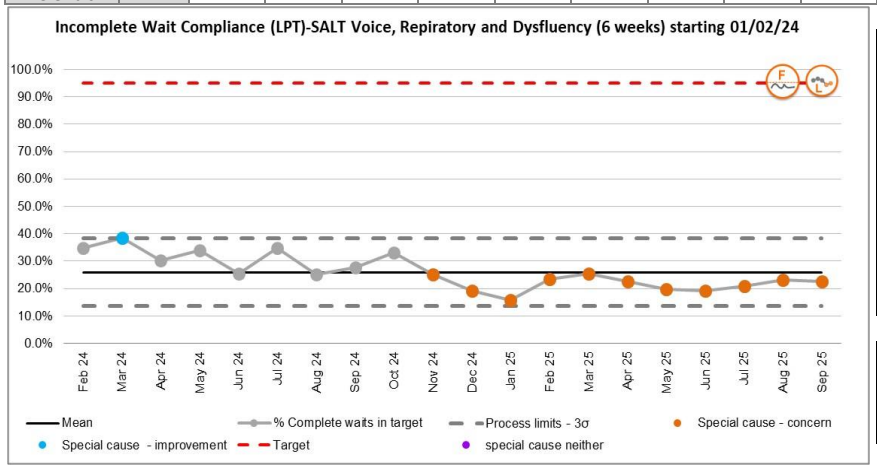
Operational Commentary (e.g. referring to risk, finance, workforce)

Ongoing actions:
- Weekly monitoring of new patient appointments completed and prospective bookings to support assurance service is on track to meet waiting list trajectory.
- Senior oversight at every PTL. PTL efficiencies and process improvements made to maximise available slots; minimises risk of empty slots and patients booked in a minimum of 6 weeks in advance.
- Monthly monitoring against 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) to demonstrate improvement and reduction in numbers waiting. October data shows the service has over achieved its trajectory to reduce the number of patients waiting. N.B. Complete compliance will deteriorate prior to improvement as the longest waiters who have already breached the target will be seen first unless there is a clinical prioritisation reason to see a patient sooner.

Next steps:
- Embed new internal service referral process; will ensure that new slots not prioritised for internal service referrals between CINSS allied health professionals i.e. OTs and Physios. To be completed end of October.
- Review job plans after 3 months to identify and consider potential further productivity gains. To be completed end of November.
- OT Memory Group to commence November 2025; anticipate will increase throughput of patients - up to 28 patients on the current waiting list may be suitable for the group.
- 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	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
	>=95%	33.0%	25.1%	19.2%	15.7%	23.4%	25.4%	22.6%	19.7%	19.3%	20.8%	23.2%	22.5%
No of Referrals		120	83	67	68	78	100	72	73	58	63	81	81



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
26.0%	14.0%	38.0%

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

ONGOING ACTIONS:

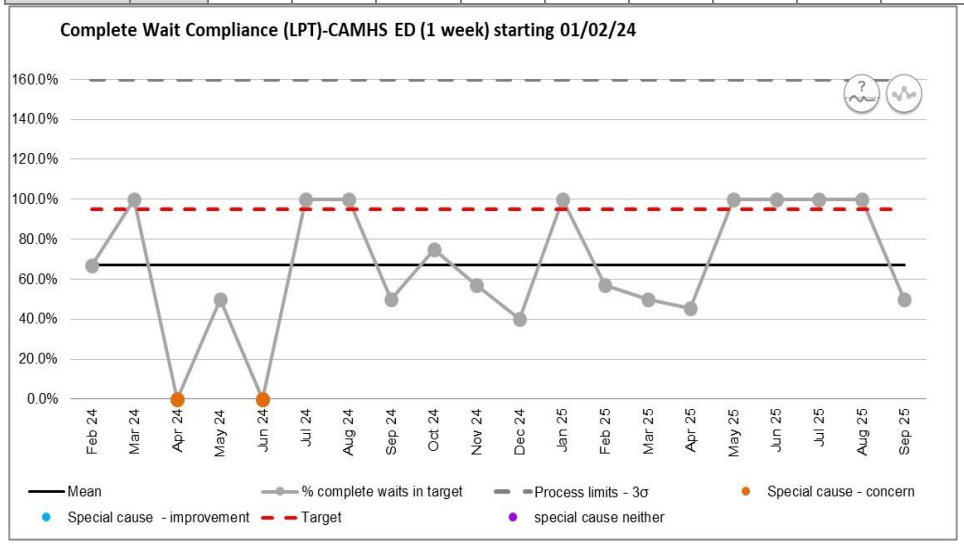
- Weekly monitoring of new patient appointments completed and prospective appointments booked, to support service to increase the number of new patients being seen and reduce numbers waiting.
- Opt-in letters being sent to the longest waiters on the Voice waiting list in staggered batches. Are working age adults and SBAR & EQIA completed to ensure effective risk management. Anticipate c40% will be discharged.
- PTL process changes to strengthen waiting list management

NEXT STEPS:

- Increase admin support to book patients into appointments in a timely manner; will ensure all capacity utilised, reduce number s and lenght of wait. Monitored via DMT using SPC to support evidence of impact.
- Produce trajectory to demonstrate reduction in the number of patients waiting against plan, providing assurance on delivery. Expected to be in place by end of November 2025.
- Review opt in process results for Voice and consider rolling out to other patient cohorts if successful, will ensure patients waiting still want to be seen. Expected to be in place by end of December 2025
- Consider move to increased use of digital communication for appointment offers, self-help, service information. Scope of options with the Business Team to be complete by end of November 2025.
- Review practice against DNA / cancellation policy and ensure service is complaint. To be completed by end of November 2025.
- Consider increasing use of video and telephone follow-ups to reduce cancellations / non-attendance and increase productivity. To be completed by end of December 2025.

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

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



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.

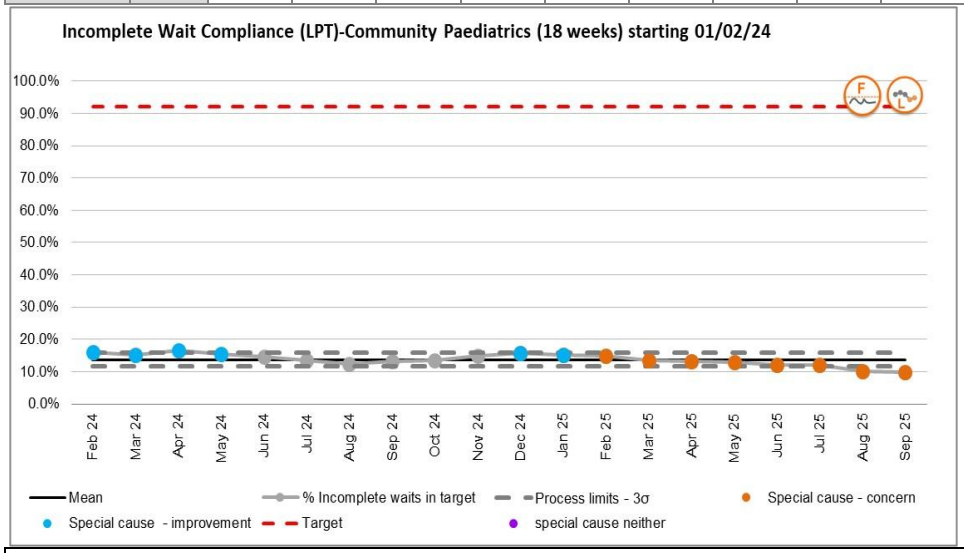
Mean	Lower Process Limit	Upper Process Limit
67.1%	-26.0%	160.0%

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

Of the patients not being seen within the target this was due to patient choice and one was not offered an appointment within the timeframe. Service processes and escalation plans when slots are not available within the KPI timeframe to be strengthened.

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

FYPCLDA	Target	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
	>=92%	13.2%	13.4%	14.8%	15.6%	15.2%	15.0%	13.6%	13.2%	13.0%	12.0%	10.2%	9.8%
No of Referrals		334	325	300	366	318	345	271	269	286	290	137	215



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.

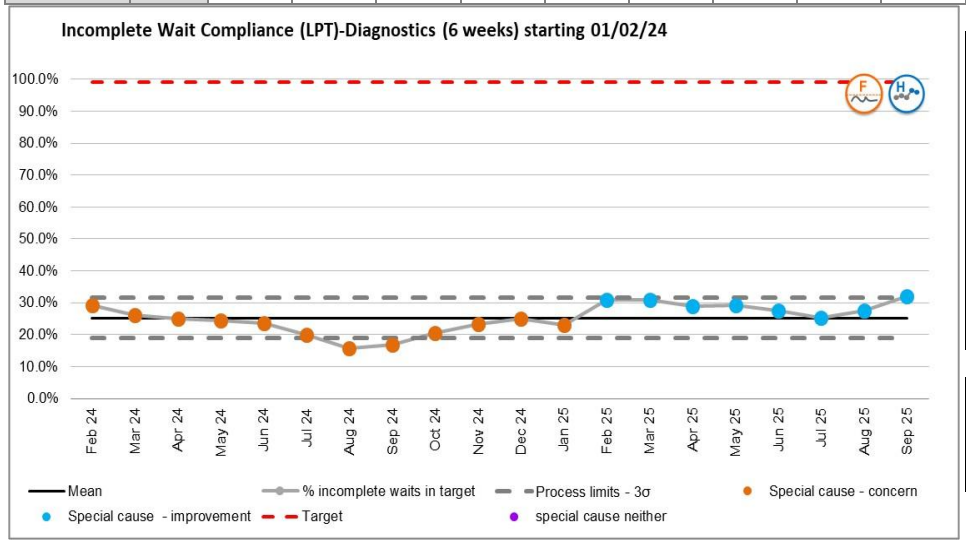
Mean	Lower Process Limit	Upper Process Limit
13.7%	12.0%	16.0%

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. Majority of CYP waiting are for neurodevelopmental assessment, the service continues to prioritise referrals at triage as urgent or routine with urgent patients offered appointments within 18 weeks. 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 shared with ICB and NHSE - positively received and working towards delivery by end of February 2026. Review of SBARs for Foetal Alcohol Syndrome and genetic testing pathways at CYP Partnership Meeting with agreed actions to be undertaken by LPT and system partners. Service has completed action to streamline and expedite diagnostic process for children under 5 years of age for Autism Spectrum Disorder Assessment, next step is to audit to establish impact of the change, due to be completed in Q1of 2026/27.

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

FYPCLDA	Target	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
	>=99%	20.4%	23.3%	24.9%	23.0%	31.0%	30.8%	29.0%	29.2%	27.5%	25.3%	27.5%	32.0%
No of Referrals		354	332	282	333	302	310	310	293	243	206	201	246



Analytical Commentary

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

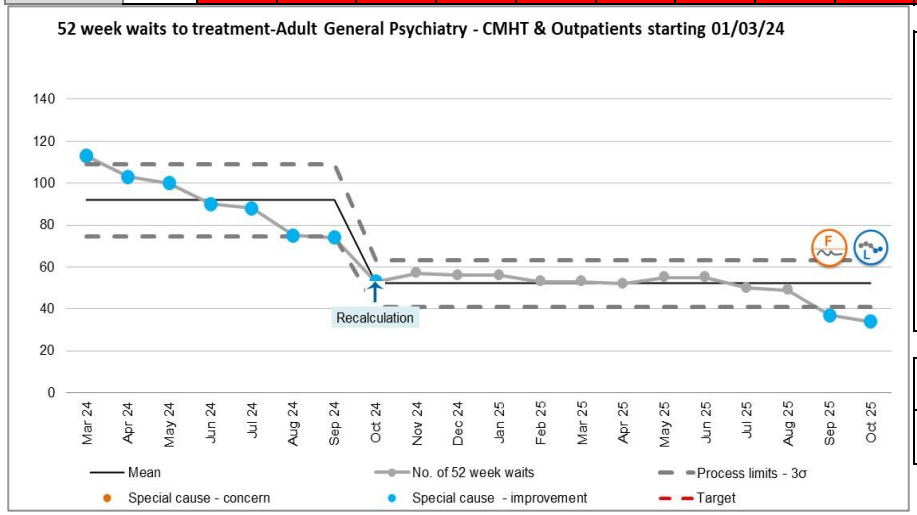
Mean	Lower Process Limit	Upper Process Limit
25.2%	19.0%	32.0%

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

The service 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 provision with Strategy and Partnerships Team supporting. Next step to share System approach with LPT Exec for agreement to progress. Waiting list validation ongoing with a focus on mitigation lists. Non-compliant with planned trajectory, narrative to explain variance provided to ICB / NHSE alongside resubmission of trajectory - no change to milestones. Planned milestones met for refurbished estate at Beaumont Leys and plans progressing for refurbishment at Hynca Lodge - appointments booked into new estate with CYP now being seen in these venues. Meetings ongoing with ICB re updating service specification. Agreement to extend contract of Health Now to January 2026 to continue weekend clinics owing to variance to trajectory. Agreed use of bank / agency staff to deliver joint LPT / UHL Super Sundays, plans to deliver currently being finalised. IQIPS benchmarking assessment outcome received, detailed action plan created pulling together actions from bronze cell, steering group, and benchmarking to support servce improvement. Clinical quality summit has taken place, with actions in place, including consolidating clinical leadership and auditing processes. Follow up clinical summit planned for Nov 2025.

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

	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
DMH	0	53	57	56	53	53	52	55	55	50	49	37	34



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.

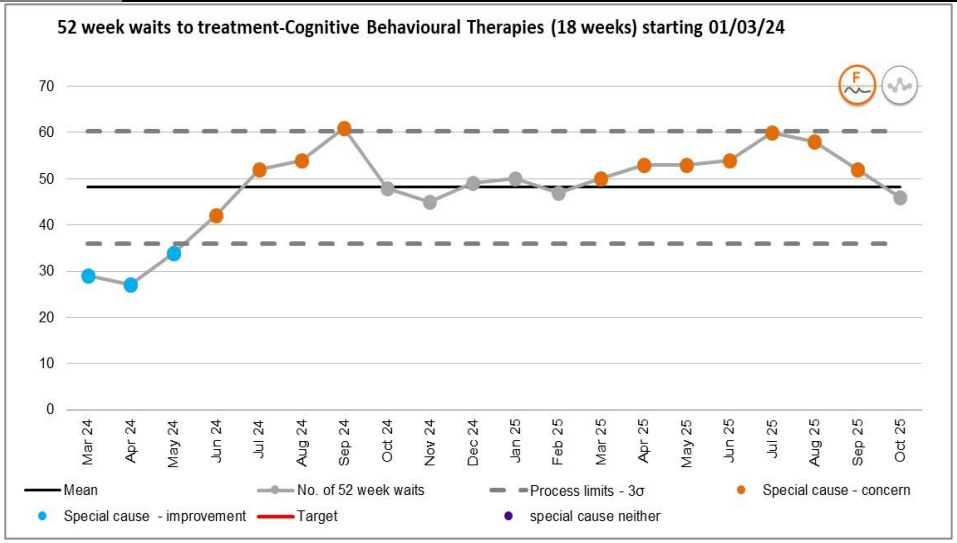
Mean	Lower Process Limit	Upper Process Limit
52.2	41.1	63.2

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

Work is taking place to ensure that waits for treatment are reported according to NHS guidance and the Trust's Access to Treatment Policy. Impact of this work expected to be visible in data from November onwards with a signficant reduction in numbers waiting and length of wait.

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

	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
DMH	0	45	49	50	47	50	53	53	54	60	58	52	46



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
48.2	36.0	60.4

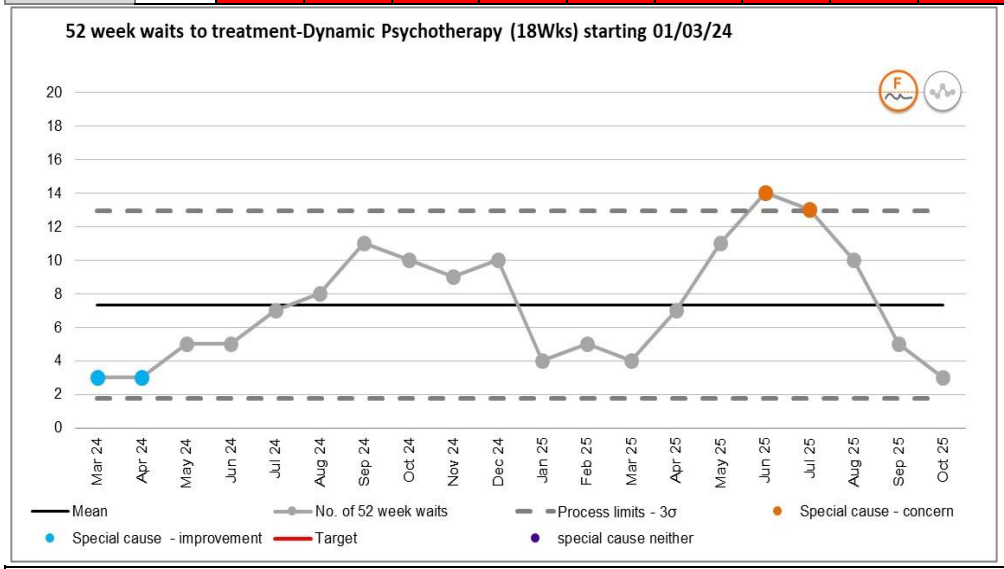
Operational Commentary (e.g. referring to risk, finance, workforce)

CBT represented at Neighbourhood Team's psychological consulter meetings and currently in recruitment to fill 2 gaps to facilitate contribution to clinical discussions on formulation and psychological interventions. This reduces the numbers of referrals for people not ready or able to be helped by a CBT intervention. Work on controlling flow of referrals into the service is beginning to take effect.

Continuing to make good progress on the number of patients waiting for CBT treatment, from 131 in September to 107 in October 2025. The number of patients waiting over 52 weeks has reduced from 56 in September to 46 in October 2025, and is below the trajectory.

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

	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
DMH	0	9	10	4	5	4	7	11	14	13	10	5	3



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
7.4	1.75	12.95

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

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

The longest waiters for individual treatment have waited longer than due to particular requirements (therapist / slot availability), the majority now have start dates for treatment.

The MBTi patients waiting over 52 weeks have been offered start dates, but were unable to join group offered and are waiting for a new group to begin. Team are planning an extra MBTi group to accommodate increase in people waiting with two groups starting in September. The team will offer individual MBTi as an exception to those unable to attend groups.

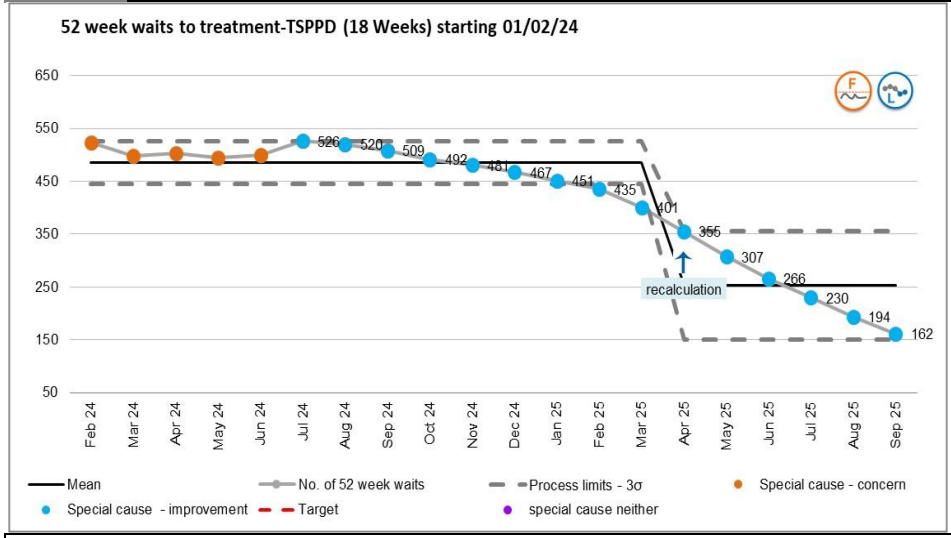
A new analytic group has been established which will increase capacity, this commenced in September 2025.

Recruitment to 1.0 WTE vacancy with expected outcome of increasing capacity to reduce the waiting list, the post holder commenced in September 2025

Working to ensure patients are 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	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
DMH	0	492	481	467	451	435	401	355	307	266	230	194	162



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
252.3	149.7	355.0

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

Development of consultation and training support to community services to enhance the primary care offer (small scale). ICB funding no longer available for 2025/26. Develop foundational training in Trauma Informed Care to delivered early 2026

All TSPPD referrals to come through Neighbourhood Teams and agree the directorate wide secondary care referral criteria. Business as usual will be provided by the Mental Health Neighbourhood Teams during the transition period. TSPPD Specialist consulter continues

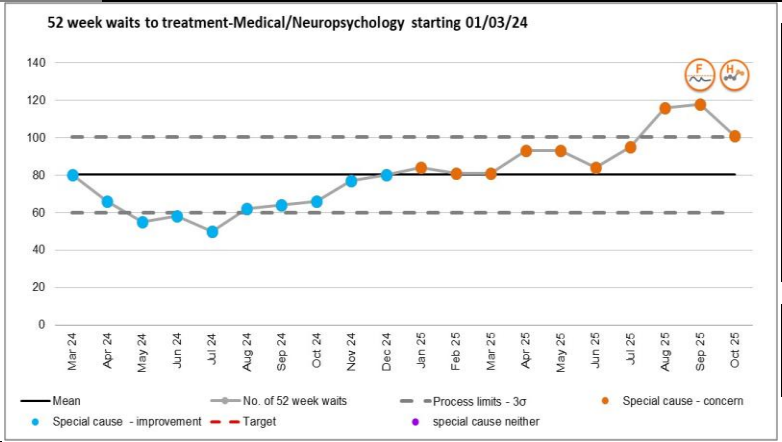
Agree and implement a clinical model for the current TSPPD waiting list and governance processes to work through waiting list before transforming provision. Action due Dec 2026

Design new Neighbourhood Team clinical model to be tailored to meet the needs personality difficulties. Action due 2026

Establish the 'Personality Disorder Hub'. Action due January 2027

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

	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
DMH	0	77	80	84	81	81	93	93	84	95	116	118	101



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
80.2	59.9	100.5

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

Medical Psychology

Despite updated capacity and demand summary no UHL funding is available for additional staffing to meet demand. There continue to be long waits for general medical (approx. 52 weeks) and pain psychology (about 104 weeks). There are no lengthy 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 the pain service all new referrals are now offered group intervention or signposting as an alternative / interim intervention. The aim is to reduce the treatment waiting list and impact will be regularly reviewed. For patients already on the treatment waiting list the clinical pathway has been reviewed to ensure pateints remain appropriate.

For general medical referrals, as well as assessing number of sessions offered service is 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) to ensure remaining on the list is appropriate and consider alternative options. This has been running well and will be assessed for effectiveness once the first three groups have been reviewed.

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

Neuropsychology

Outpatient neuropsychology: No patients waiting longer than 52 weeks. Current longest wait from Mar 2025. Trajectory for waiting list to reduce to approx 6 months by Q4.

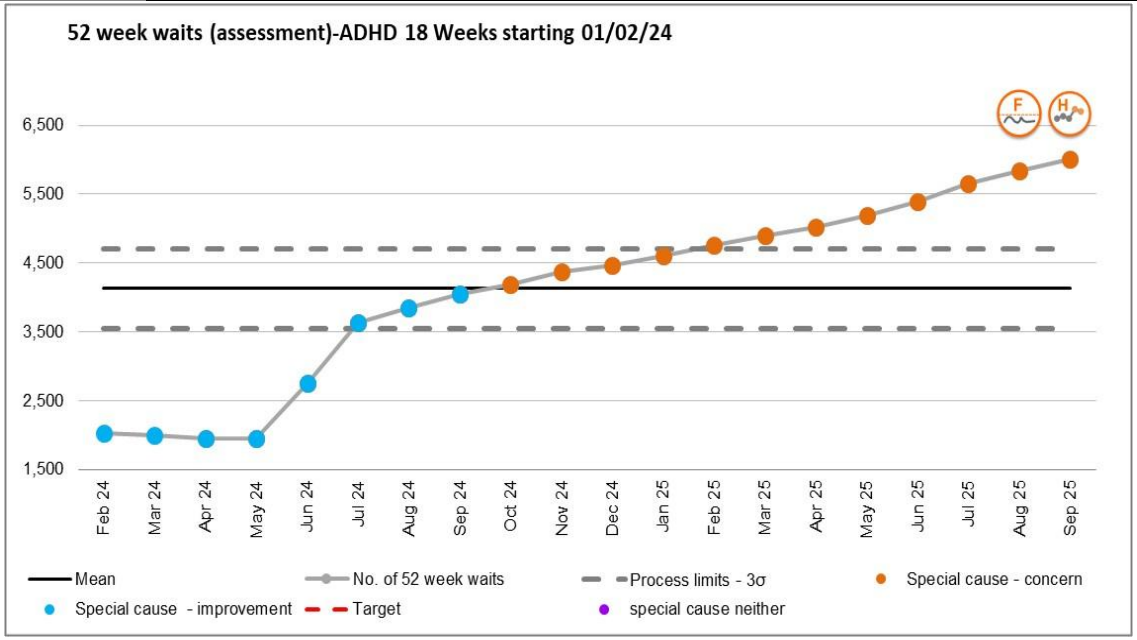
Assistant Psychologist providing telephone triage to support waiting list validation, contact is made with those on the waiting list for over 6 months to ensure treatment remains relevant. This ensures the waiting list is accurate and holds only those who still wish to access the service, reducing DNAs and cancellations.

Repeat assessments offered by Assistant Psychologists where clinically suitable to reduce the need for qualified appointments from 2 to 1.
All other neuropsychology services within 18 weeks waits (paediatric neuropsychology, stroke, inpatient neuropsychology, HD psychology, metabolic)

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 most appropriate services and reduce duplication. Completed QI project with Vita Minds.

EXCEPTION REPORT - ADHD 18 weeks (assessment) - No of waiters over 52 weeks *(Month in arrears)*

	Target	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
DMH	0	4193	4372	4467	4607	4757	4898	5014	5190	5398	5661	5833	6006



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
4129.7	3550.9	4708.4

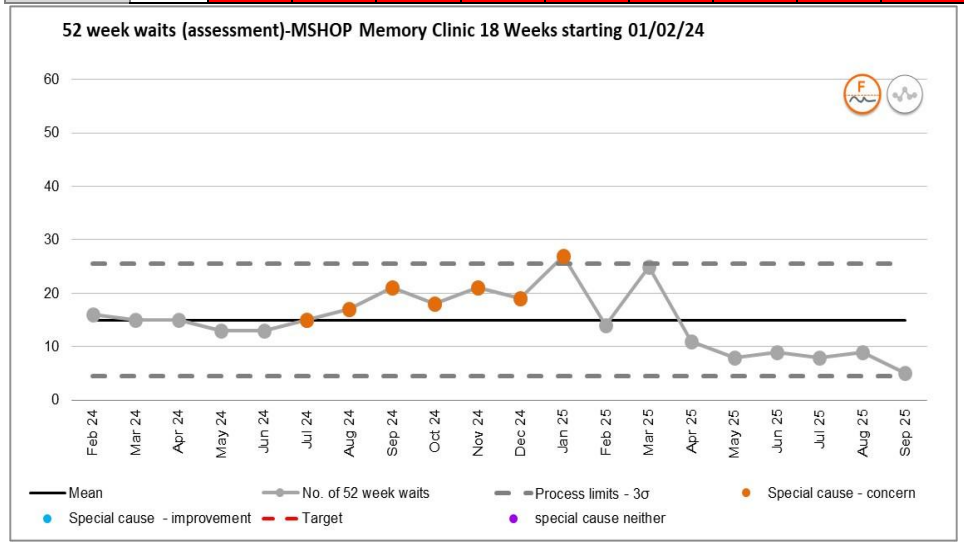
Operational Commentary (e.g. referring to risk, finance, workforce)

Following ICB and EMB agreement, work has commenced to develop a more efficient pathway with shorter waits for assessment and treatment and ensure patients are signposted to the service most appropriate to their needs. A group co-chaired by DMH Exec Director and ICB Associate Director oversees workstreams to progress Adult ADHD pathway transformation. This includes increasing productivity, reviewing best practice elsewhere, potential for 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 and implementation of replacement of ADHD Solutions for psychological/psychoeducational support for patients waiting. The service working closely with the Communications Team to develop waiting well support pages on the LPT website, these are now live with further work progressing to continue to enhance.

EXCEPTION REPORT - MHSOP Memory Clinics 18 week local RTT (assessment) - No of waiters over 52 weeks

(Month in arrears)

	Target	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
DMH	0	18	21	19	27	14	25	11	8	9	8	9	5



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
15.0	4.5	25.5

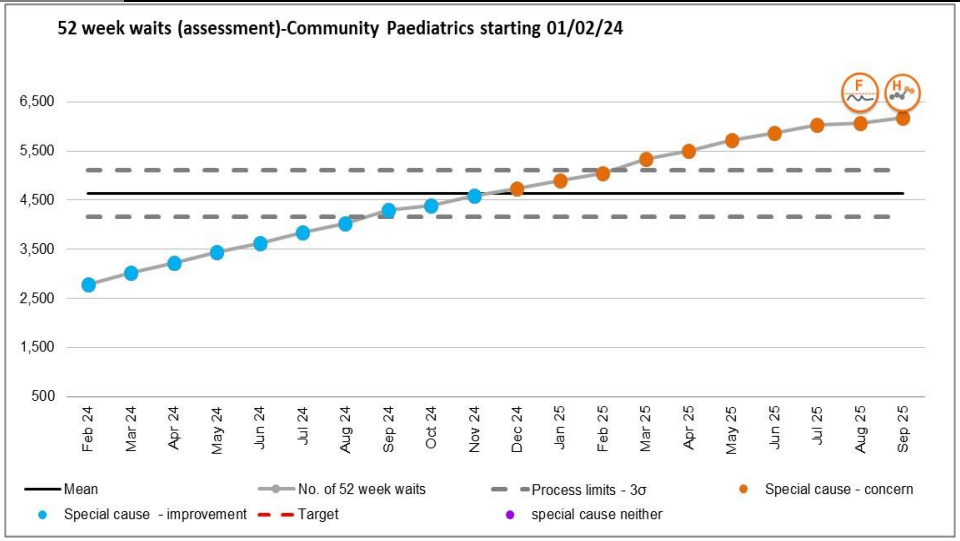
Operational Commentary (e.g. referring to risk, finance, workforce)

Implementation of One Stop Clinic pilot (rapid access clinics) commenced March 2025 with noted improvement in numbers waiting and length of wait where patients are seen and diagnosed in clinic. Has enabled assessment and diagnosis on-the-day. Advanced pathway clinics running as a pilot from June 2025, for patients over 85 and where there is a high suspicion of dementia. 200 patients identified from a review of the waiting list with 54 patients assessed and 43 diagnosed on the same day between June and September 20205. A review of both models to take place in Q4 to assess effectiveness in improving the patient experience and waiting times.

All patients waiting receive wellbeing calls following 8 week waits and then every 8 weeks thereafter, support workers provide these calls following a clear script to check risks, support network available and signpost to support available. Any escalating or unmanaged risks are referred to a clinician for review and call back if needed.

EXCEPTION REPORT - Community Paediatrics (assessment) - No of waiters over 52 weeks *(Month in arrears)*

	Target	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
FYPCLDA	0	4392	4586	4740	4895	5044	5335	5509	5723	5858	6022	6067	6182



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.

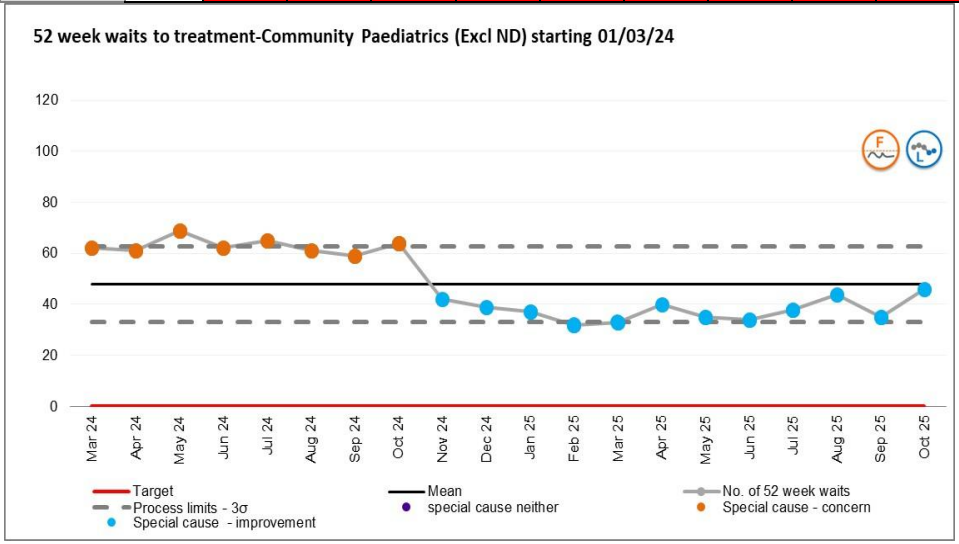
Mean	Lower Process Limit	Upper Process Limit
4629.2	4153.4	5104.4

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. 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 in excess of 3 years. With this skill mix in place, we continue to review and revise the assessment pathways for ASD/ADHD. Referral demand continues at a level which exceeds service capacity. The service continues to prioritise referrals at triage as urgent or routine with those classified as urgent offered appointments within 18 weeks. A targeted transformation workstream is reporting through Transformation and Quality Improvement Group and remains ongoing.

EXCEPTION REPORT - Community Paediatrics (Excl ND) (treatment) - No of waiters over 52 weeks

	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
FYPCLDA	0	42	39	37	32	33	40	35	34	38	44	35	46



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.

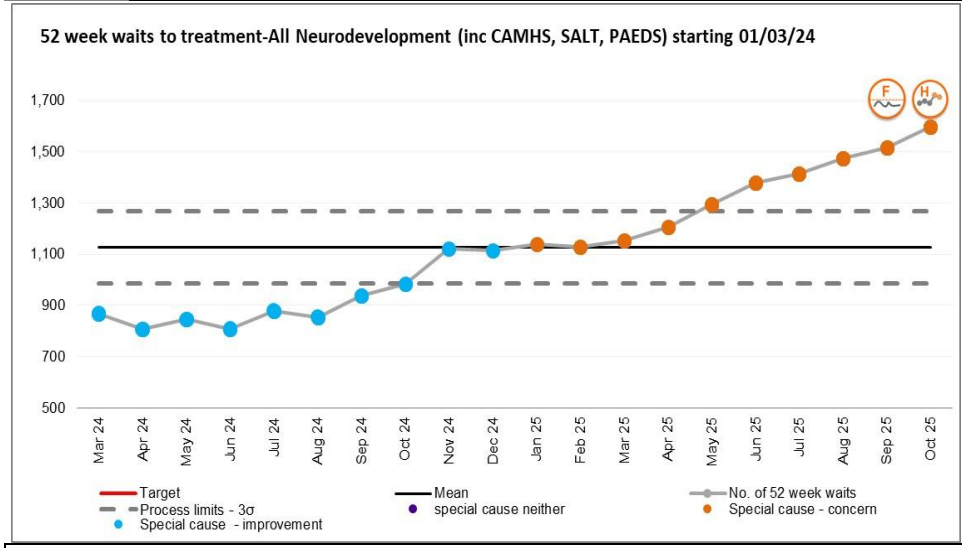
Mean	Lower Process Limit	Upper Process Limit
47.9	33.1	62.7

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

Patients may present with co-occuring ND concerns (SALT, EP, school observations, etc) and work continues to be ensure differentiation is robust. Actions in place to ensure effective use of job plans (at individual clinician level) to maximise capacity with skills and slot utilisation routinely reviewed to ensure minimal loss of capacity. These actions will support reduced number of waiters going forward. ADHD Nurses to lead on digitisation of medication reviews for those aged 10+, work remains underway with the anticipated outcome of freeing up space on nurse caseloads to allow CYP to transition from Paediatrician caseload to increase capacity.

EXCEPTION REPORT - All Neurodevelopment (inc CAMHS, SALT, PAEDS) (treatment) - No of waiters over 52 weeks

	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
FYPCLDA	0	1121	1113	1140	1128	1155	1205	1294	1378	1415	1473	1518	1597



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.

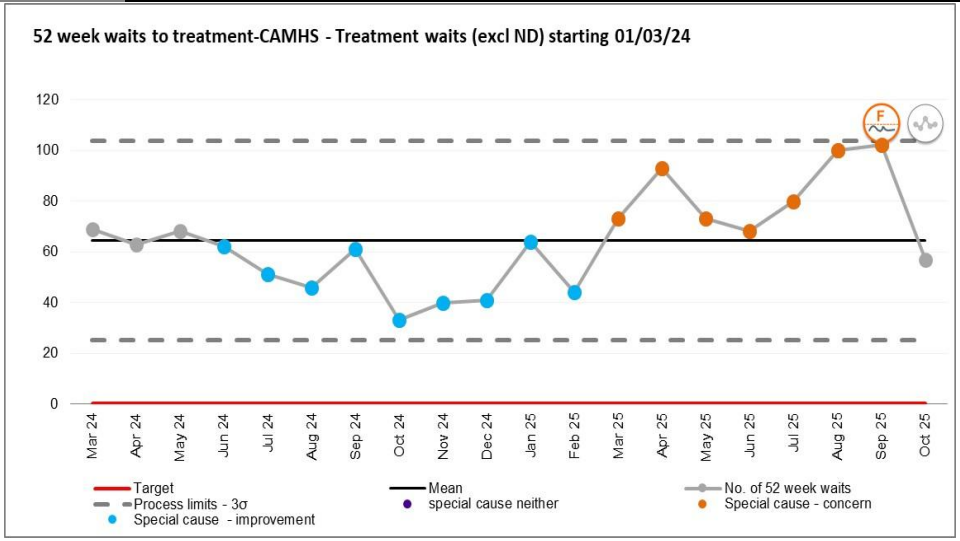
Mean	Lower Process Limit	Upper Process Limit
1126.1	984.2	1267.9

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

This page pulls together all CYP waiting for further intervention for ND post assessment in either community paediatrics or CAMHS. CYP with complex needs / where there are comorbidities remain on the appropriate specialist lists. Numbers waiting continue to increase as demand outstrips capacity. CYP / parents / carers given advice on where to seek support whilst waiting, this includes evolving VCS options, and information on how to escalate should there be a change in presentation. PTLs are in place to ensure effective oversight of the waiting list with changes in priority or status actioned promptly. Due to numbers waiting PTL focuses on those waiting longest. Work continues with the ICB to develop a broader, system based approach to ND, recognising that addressing demand and creating capacity impacts across health, education and social care. ND waits are considered as part of the Trust-wide work on access, with focus on longest waiters, and gives assurance that measures are applied robustly. Scoping work underway to assess current and future opportunities to link with wider system work related to ND inclusion.

EXCEPTION REPORT - CAMHS (excl ND)(treatment) - No of waiters over 52 weeks

	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
FYPCLDA	0	40	41	64	44	73	93	73	68	80	100	102	57



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.

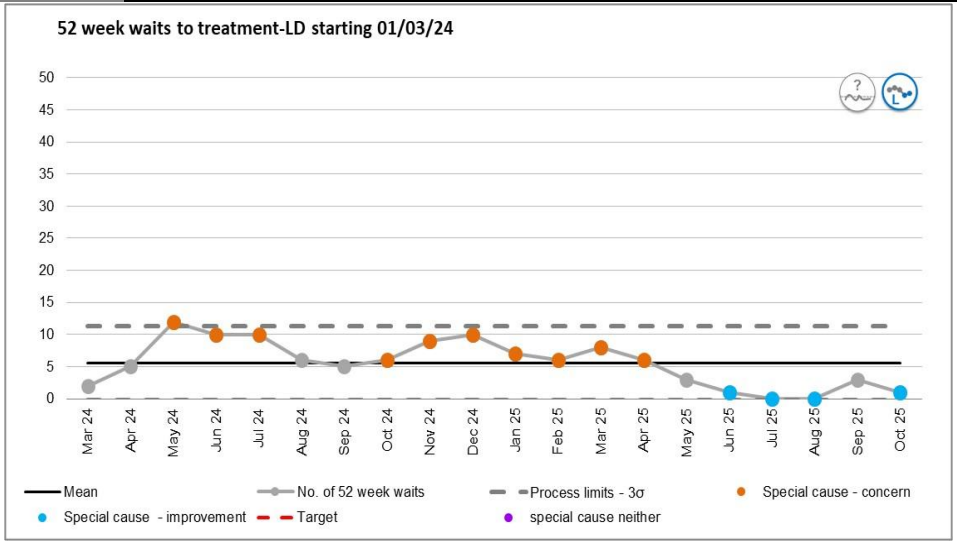
Mean	Lower Process Limit	Upper Process Limit
64.4	25.2	103.6

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

There are currently 57 CYP waiting over 52 weeks for treatment in CAMHS, this is a reduction of 43 from last month.
37 CYP in outpatient - 18 awaiting treatment and 19 awaiting psychiatric opinion (reduction of 7). An overall reduction in treatment waits by 4 from last month.
There are 20 waiters for groupwork - a decrease of 38 since last month. All CYP waiting over 12 months have been reviewed, with documented plan and appointments offered to start group work.

EXCEPTION REPORT - LD&A (treatment) - No of waiters over 52 weeks

	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
FYPCLDA	0	10	7	6	8	6	3	1	0	0	0	3	1



Analytical Commentary

The metric is showing a special cause variation of an improving nature due to lower values. There is no assurance that the metric will consistently achieve the target and is showing a common cause variation.

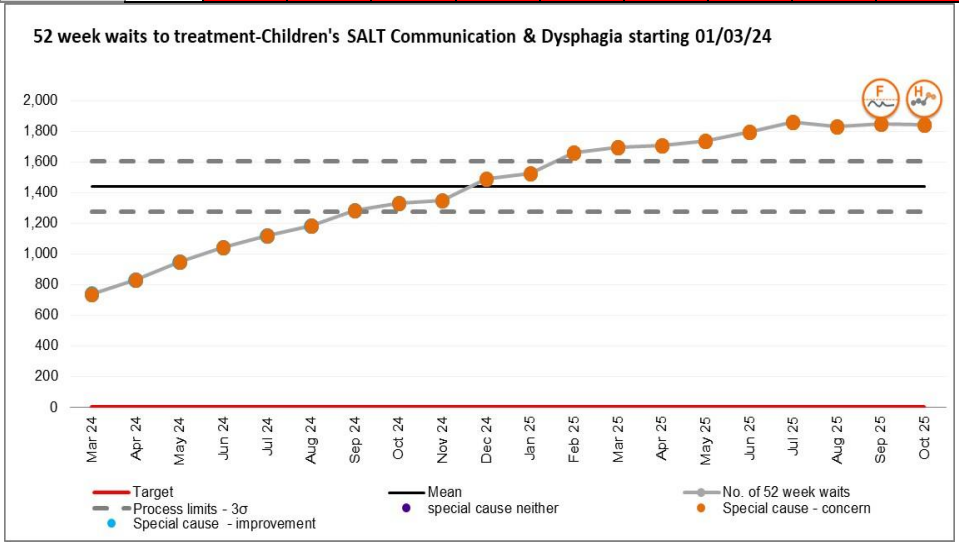
Mean	Lower Process Limit	Upper Process Limit
5.5	-0.2	11.2

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

LD Team have reviewed one remaining patient and have identified a data quality issue resulting in an error in the reported wait time. The service has no patients waiting over 52 weeks.

EXCEPTION REPORT - Children's SALT Communication & Dysphagia (treatment) - No of waiters over 52 weeks

	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
FYPCLDA	0	1346	1489	1524	1661	1692	1704	1734	1794	1858	1831	1845	1839



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.

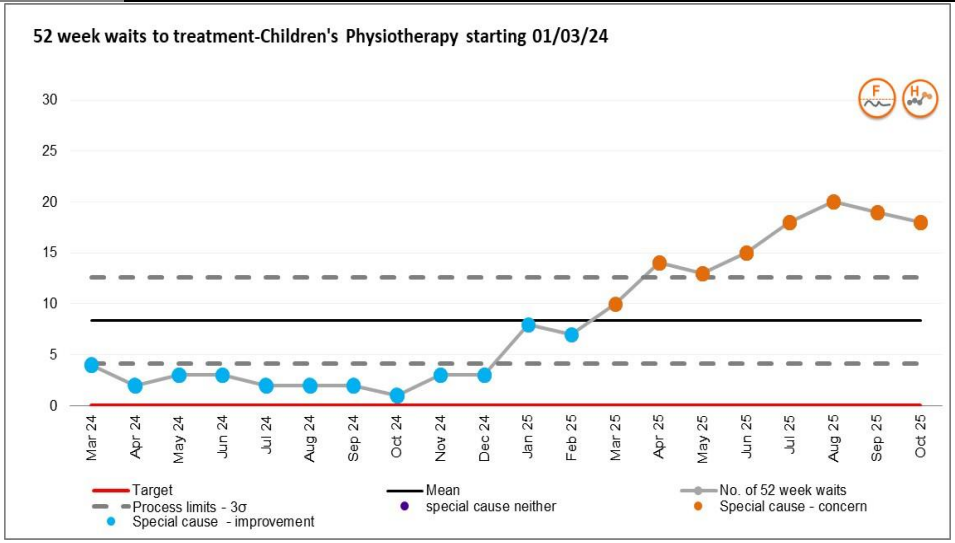
Mean	Lower Process Limit	Upper Process Limit
1439.2	1275.77	1602.53

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

The waiting times for follow-up appointments have increased significantly since June 2023 as a result of increased referrals post pandemic which has in turn led to a bottleneck for intervention. LLR experiences higher demand than expected for the population however referrals are now plateauing.
Capacity is impacted by significant workforce movement within the team, primarily for career progression within LPT, with a less experienced workforce requiring greater levels of supervision, and support which in turn impacts on capacity.
Completing intervention in blocks (in line with the evidence base) has improved outcomes but impacts on capacity, consequently alternative approaches to balance these aspects being considered. This approach has been well received with positive feedback from parents.
Weekly performance meeting with strengthened recovery actions now established alongside weekly PTL meetings. Escalations via FYPCLDA DMT and local area SEND Partnership Boards.
New trajectory set and service ahead of target.

EXCEPTION REPORT - Children's Physiotherapy (treatment)- No of waiters over 52 weeks

	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Sep-25
FYPCLDA	0	3	3	8	7	10	14	13	15	18	20	19	18



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
8.4	4.2	12.6

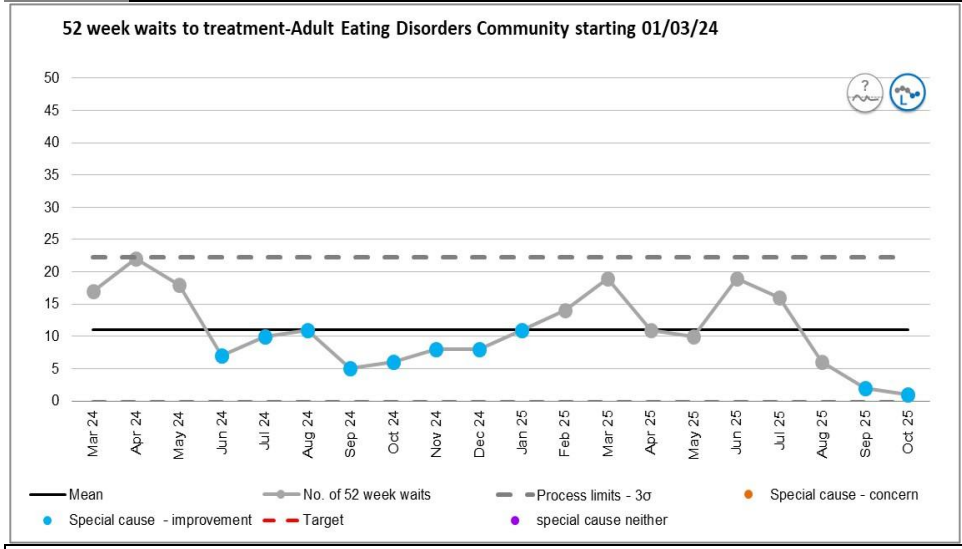
Operational Commentary (e.g. referring to risk, finance, workforce):

Numbers waiting are reducing, work underway to ensure appropriate application of Access Policy to ensure waits correctly recorded.

Of those waiting c15 are awaiting community paediatric appointment as part of tone management pathway and not physiotherapy. Work underway to enable CYP to be correctly reported.

EXCEPTION REPORT - Adult Eating Disorders Community (treatment) - No of waiters over 52 weeks

	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
FYPCLDA	0	8	8	11	14	19	11	10	19	16	6	2	1



Analytical Commentary

The metric is showing a special cause variation of an improving nature due to lower values. There is no assurance that the metric will consistently achieve the target and is showing a common cause variation.

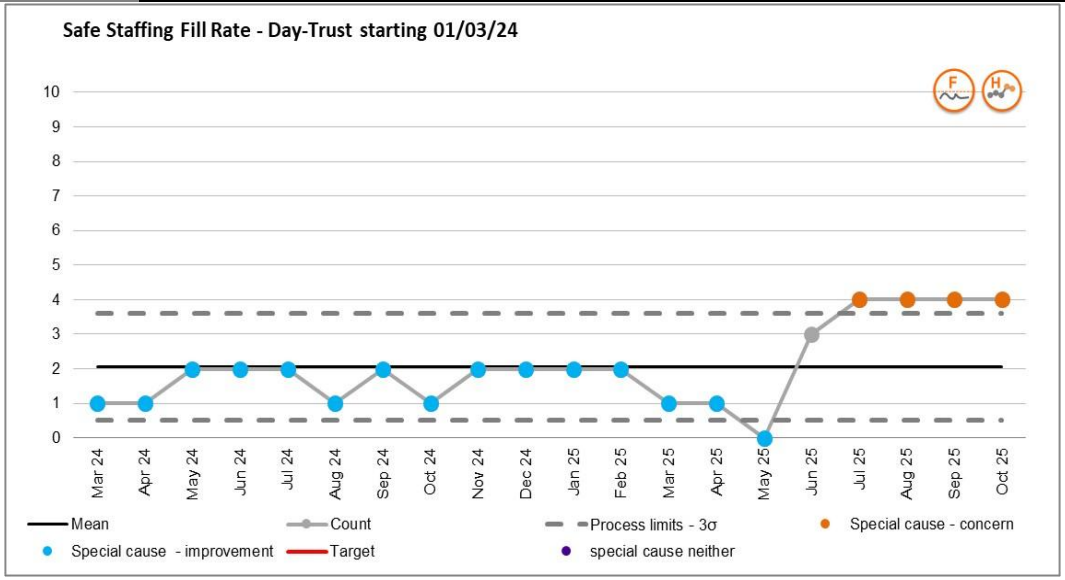
Mean	Lower Process Limit	Upper Process Limit
11.1	-0.2	22.3

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

Numbers waiting has signficantly reduced over since March 2025. Service now robustly applying Access and DNA Policies to ensure waits managed effectively and correctly reported.

EXCEPTION REPORT - Safe staffing - No. of wards not meeting >80% fill rate for RNs - Day

	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
TRUST	0	2	2	2	2	1	1	0	3	4	4	4	4
DMH		1	1	2	1	0	1	0	1	1	1	2	2
LD		0	0	0	1	1	0	0	1	2	2	1	1
CHS		1	1	0	0	0	0	0	1	1	0	0	0
FYPC		0	0	0	0	0	0	0	0	0	1	1	1



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
2.1	0.5	3.6

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

4 wards reported of an RN fill rate of less than 80% on the day shift

FYPC

Beacon - Planned staffing is 3 RNs on the day shift, staffing levels were reviewed and adjusted according to patient acuity and bed occupancy. 2 RNs worked consistently on day shifts reducing the overall average RN fill rate for the month and within a safe staffing model.

LD

1 Grange

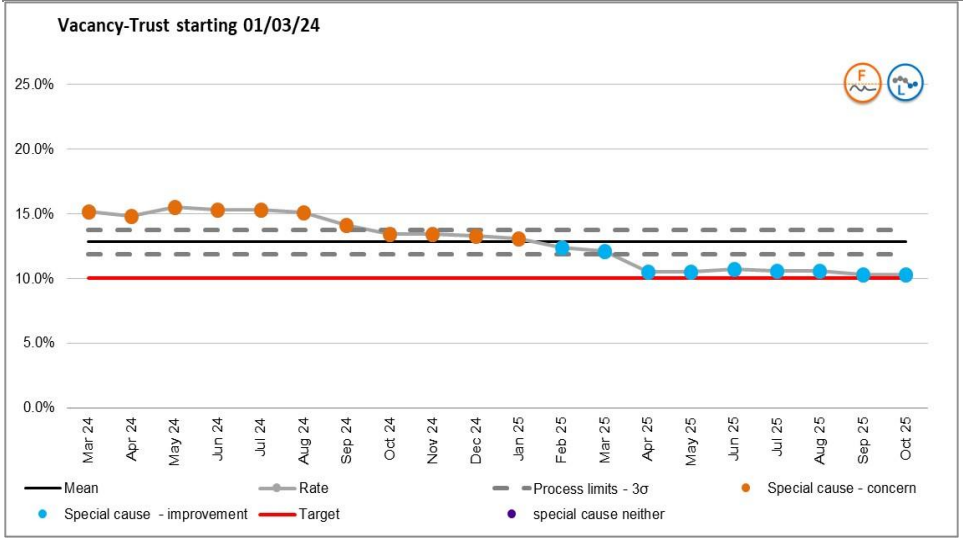
DMH

Gwendolen - Planned staffing is for 3 RN on the day shift and during Oct x 7 shifts had 3 RN, staffing reduced to 2 RN and supported by Medicines Administration Technician and additional Health care support worker (as needed)

Aston - Planned staffing is for 3 RN on the Day shift. During Oct x 14 shifts had 3 RN, staffing reduced to 2 RN supported by supernumerary Registered Nurse Associate

EXCEPTION REPORT - Vacancy Rate

	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
TRUST	<=10%	13.4%	13.3%	13.1%	12.4%	12.1%	10.5%	10.5%	10.7%	10.6%	10.6%	10.3%	10.3%
DMH		15.9%	15.7%	16.4%	15.5%	14.9%	13.2%	13.4%	13.8%	12.3%	12.4%	13.1%	13.2%
CHS		13.4%	13.1%	12.9%	12.4%	12.8%	11.0%	10.2%	9.7%	10.0%	10.1%	9.9%	9.3%
FYPCLDA		13.9%	14.2%	12.7%	11.9%	11.3%	9.0%	9.0%	9.9%	10.6%	10.0%	9.3%	9.1%



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
12.8%	12.0%	14.0%

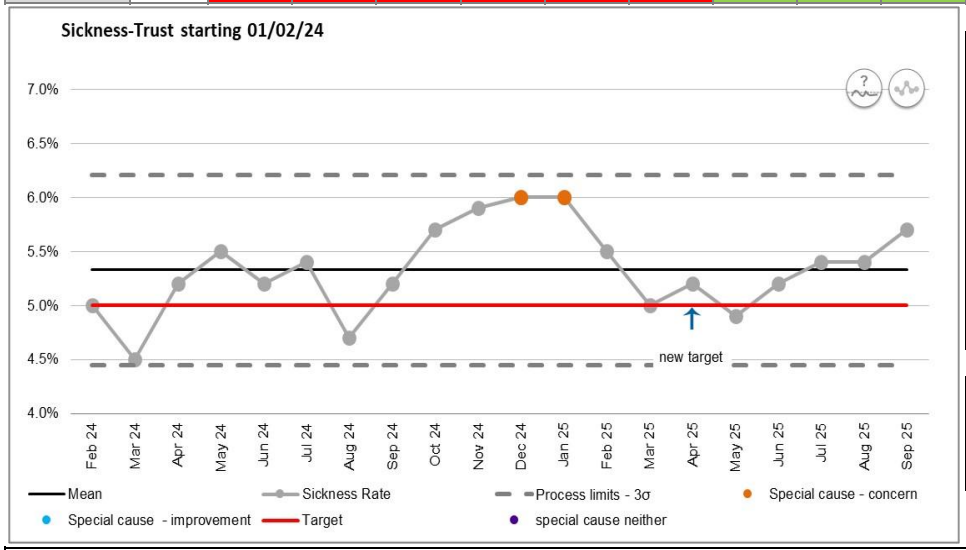
Operational Commentary (e.g. referring to risk, finance, workforce)

For Oct-25, the Trust vacancy rate is 10.3%. 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	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
TRUST	<=5.0%	5.7%	5.9%	6.0%	6.0%	5.5%	5.0%	5.2%	4.9%	5.2%	5.4%	5.4%	5.7%
DMH		6.8%	6.4%	6.3%	7.1%	6.4%	5.7%	6.2%	5.2%	5.9%	6.2%	6.0%	6.6%
CHS		6.2%	6.7%	6.9%	6.7%	5.8%	5.2%	5.3%	5.5%	5.9%	6.1%	6.3%	6.7%
FYPCLDA		5.0%	5.6%	5.5%	5.2%	5.1%	4.6%	4.6%	4.4%	4.8%	4.8%	5.1%	5.0%



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%

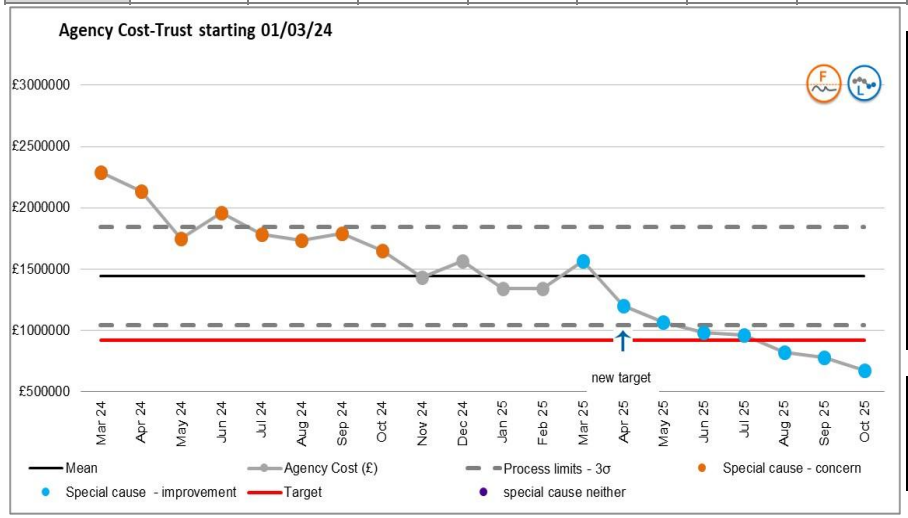
Operational Commentary (e.g. referring to risk, finance, workforce)

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	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
TRUST	<=£922,333	£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	£776,941	£675,681
DMH		£662,096	£613,750	£570,697	£512,094	£876,766	£615,701	£585,755	£548,266	£561,694	£494,207	£362,080	£402,270
CHS		£726,933	£645,533	£779,216	£653,190	£538,428	£446,756	£353,928	£301,236	£289,274	£244,662	£258,596	£231,705
FYPCLDA		£273,926	£175,987	£197,407	£159,573	£143,524	£134,518	£123,986	£129,128	£98,711	£47,309	£123,270	£30,431



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
1441139.5	1040541.8	1841737.1

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		Aug-25	85.0%	91.0%	
MHSDS 72hr Follow-Ups - LPT	>=80%	Aug-25	88.0%	92.0%	
MHSDS CMHealth 2+ Contacts - LLR	0	Aug-25	15285	15285	
MHSDS CMHealth 2+ Contacts - LPT		Aug-25	15230	15225	
MHSDS CMH referrals-spells waiting for a full clock stop - LLR		Aug-25	9385	9375	
MHSDS CMH referrals-spells waiting for a full clock stop - LPT		Aug-25	9365	9350	
MHSDS CMH referrals-spells waiting more than 104 weeks for a 2nd contact - LLR		Aug-25	185	190	
MHSDS CMH referrals-spells waiting more than 104 weeks for a 2nd contact - LPT		Aug-25	190	195	
MHSDS open CMH referrals-spells waiting for a 2nd contact - LLR		Aug-25	3100	3110	
MHSDS open CMH referrals-spells waiting for a 2nd contact - LPT		Aug-25	3120	3130	
MHSDS CYP 1+ Contacts - LLR	17745	Aug-25	18840	18815	
MHSDS CYP 1+ Contacts - LPT		Aug-25	10535	10530	
MHSDS CYP referrals-spells waiting for a full clock stop - LLR		Aug-25	5910	6260	
MHSDS CYP referrals-spells waiting for a full clock stop - LPT		Aug-25	5475	5685	
MHSDS CYP referrals-spells waiting more than 104 weeks for a 1st contact - LLR		Aug-25	560	565	
MHSDS CYP referrals-spells waiting more than 104 weeks for a 1st contact - LPT		Aug-25	530	540	
MHSDS open CYP CMH referrals-spells waiting for a 1st contact - LLR		Aug-25	2160	2405	
MHSDS open CYP CMH referrals-spells waiting for a 1st contact - LPT		Aug-25	1985	2120	
MHSDS CYP ED Routine (Interim) - LLR		Aug-25	83.0%	65.0%	
MHSDS CYP ED Routine (Interim) - LPT	>=95%	Aug-25	83.0%	65.0%	
MHSDS CYP ED Urgent (Interim) - LLR		Aug-25	100.0%	100.0%	
MHSDS CYP ED Urgent (Interim) - LPT	>=95%	Aug-25	100.0%	100.0%	
MHSDS EIP 2 Week Waits - LLR		Aug-25	60.0%	66.0%	
MHSDS EIP 2 Week Waits - LPT	>=60%	Aug-25	61.0%	67.0%	
MHSDS Individual Placement & Support (IPS, Rolling 12 month) - LLR	778	Aug-25	785	810	
MHSDS Individual Placement & Support (IPS, Rolling 12 month) - LPT		Aug-25	785	810	
OAPs Bed Days (inappropriate only) - LLR		Aug-25	355	440	
OAPs Bed Days (inappropriate only) - LPT		Aug-25	340	430	
OAPs active at the end of the period (inappropriate only) - rolling quarter - LLR		Aug-25	0	0	
OAPs active at the end of the period (inappropriate only) - rolling quarter - LPT		Aug-25	0	0	
MHSDS Perinatal Access - (Rolling 12 month) - LLR	1220	Aug-25	1160	1160	
MHSDS Perinatal Access - (Rolling 12 month) - LPT		Aug-25	1170	1175	
MHSDS Restrictive Interventions per 1000 bed days - LLR		Aug-25	-	-	
MHSDS Restrictive Interventions per 1000 bed days - LPT		Aug-25	29	46	
MHSDS - Data Quality DQMI - LLR		Jun-25	55.8%	45.4%	
MHSDS - Data Quality DQMI - LPT	>=95%	Jun-25	94.0%	94.0%	
MHSDS - Data Quality SNoMED CT - LLR		Aug-25	97.0%	96.0%	
MHSDS - Data Quality SNoMED CT - LPT	>=100%	Aug-25	100.0%	100.0%	

3As Highlight Report
Meeting Name: People and Culture Committee (PCC)
Meeting Chair & Report Author: Manjit Darby, Non-Executive Director
Meeting Date: 8 October 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						
Resident Doctors 10 Point Plan Resident Doctors Industrial Action	PCC/25/93		Resident Doctors Industrial Action – The BMA ballot outcome signals further disruption to clinical services. The Trust is preparing contingency plans to maintain patient safety and service continuity while awaiting confirmed strike dates.	5.1		
Midlands Temporary Staffing Support Programme	PCC/25/93		Midlands Temporary Staffing Support Programme – LPT has been placed on NHSE's programme to achieve a 53% reduction in agency usage this year. This reflects regional concerns about cost pressures and workforce sustainability, requiring robust recruitment and retention strategies.	4.1		
Our People Data (Month 5)	PCC/25/95		Sickness Absence – Current rates exceed the 5% target and are projected to rise during winter months. This trend mirrors national patterns and necessitates proactive wellbeing interventions and monitoring to mitigate operational impact. Deep dive reviews are taking place through workforce development group and in directorates.			
ASSURE: Inform the Board where positive assurance has been received						
Our People Data (Month 5)	PCC/25/95		Our People Data (Month 5) – Workforce planning remains on track, with substantive recruitment reducing reliance on temporary staffing. This provides assurance on cost control and service stability.	4.1 5.1	14 16 33	
Workforce Development Group Triple A	PCC/25/96		Occupational Health Wait Times – Significant improvement achieved with first appointments now at 17 days. Continued focus is needed to sustain progress and support staff health, particularly during seasonal pressures. Mandatory Training compliance reviewed, and good assurance provided.	4.1 5.1		
Employee Relations Update	PCC/25/97		Data as of end July shows 62 live cases, though this includes multiple concerns from some individuals. New cases per 1,000 headcount metrics introduced for better real-time monitoring. Increase in live cases for substantive staff, but still within normal variation. New cases decreased in		33	

			July, and average case closure time improved to 58 days (significant progress). Agency staff generate proportionally more concerns than bank or substantive staff. 1 ET claim successfully defended since last report. Drill down by directorate, grade, and ethnicity to identify hotspots. Enhanced triangulation across dashboards (e.g., sickness, turnover, disciplinary actions) for better insight and benchmarking.			
AFM Triple A Summary & Escalations Report	PCC/25/99		Committee assured on the progress and outcomes reported.	4.1		
Group OD update	PCC/25/100		NHFT OD lead supporting LPT to align approaches and create consistency across both organisations. Progress on THRIVE strategy, joint engagement surveys, and upcoming inclusion conferences in November. Career development pilot delivered; leadership and anti-racism programmes working as a single group model. Unified staff survey analysis planned identify common themes. Communications issued following recent national hate incidents to ensure inclusive support for all colleagues.	5.1	17	
Policy Progress	PCC/25/101		Policy Progress – All policies are either current or under review, confirming governance robustness and alignment with best practice.	5.1		
Freedom to Speak Up Update	PCC/25/102		Freedom to Speak Up – 38 contacts in Q2, 13 in October aligns with Speak Up Month campaigns. While positive for transparency, this requires careful follow-up to address underlying concerns and maintain trust.	5.1		
Revalidation Report Annual Sign Off	PCC/25/103		Annual appraisal and revalidation process for registered doctors completed.	5.1		
Implications of The Leng Review	PCC/25/104		Implications of Leng Review – Physician Associates report feeling supported, and benchmarking is underway to ensure role clarity and integration.	5.1		
WRES, WDES Action Plans	PCC/25/105		WRES & WDES Action Plans – Co-designed plans are ready for publication, supporting equality objectives and meeting national requirements.	5.1	17 49	
CELEBRATING OUTSTANDING: Share any practice, innovation, or action that the Committee considers to be outstanding						
Celebratory Acknowledgements	PCC/25/107		As this is MD's last meeting as Chair the committee thanked Manjit for driving our agenda and assisting us with where we are now. Recognition of staff contributions during Speak Up Month and successful delivery of OD initiatives. These achievements highlight the organisation's commitment to openness and cultural development.			