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Leicestershire Partnership NHS Trust

Public Trust Board 27th January 2026

Declarations of Interest Report

Purpose of the Report

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

Board Member:	Current Declarations:	Declaration Reference:	Date Interest Arose:	Date of Annual Declaration:
Angela Hillery CEO	Hospitality - APNA	3935	14.09.23	21st July 2025
	Loyalty Interests – LLR – voting member	4031	25.10.23	
	Loyalty Interests – East Midland Alliance	4030	25.10.23	
	Loyalty Interests - Sister employed by William Blake charity – homes for people with a Learning Disability	4029	25.10.23	
	Outside Employment – NHFT – Joint CEO	4068	14.11.23	
	Director of 3Sixty (On behalf of NHFT)	4108	01.04.23	
	Member of NHS Employers Workforce Policy Board	4106	01.04.23	
	Member of National Mental Health Programme Board	4105	01.04.23	

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 Interests - Executive Reviewer for Care Quality Commission	6435	21.07.25	
	Hospitality - Royal Society of Medicine Travel expenses	6436	22.07.25	
	Hospitality – NHS Providers - Pre-conference dinner for NHS Providers RECHARGE Conference 2025, honouring Claire Murdoch	6670	10.11.25	

Board Member:	Current Declarations:	Declaration Reference:	Date Interest Arose:	Date of Annual Declaration:
	Hospitality – NHS Providers - Two-day ticket to NHS Providers RECHARGE Conference 2025	6671	11.11.25	
	Loyalty Interests - Member of Mental Health Supply Side Review Working Group	6713	17.12.25	
	Loyalty Interests - Son – Police Officer Northamptonshire Police	6712	17.12.25	
	Loyalty Interests – Nephew is Senior police officer at Northamptonshire Police	6711	17.12.25	
Jean Knight Deputy CEO/Managing Director	Loyalty Interests – Northamptonshire Street Pastors	3664	01.04.23	2nd April 2025
	Loyalty Interests – Age UK Northamptonshire	3663	01.04.23	
	Loyalty Interests – BLMK ICB	3662	01.04.23	
	Loyalty Interests – Ellis (formerly Berendsen)	3661	01.04.23	
	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
	Loyalty Interests – President of UK Centre for the Advancement of Interprofessional Education (CAIPE)	6755	1.1.26	
Josie Spencer NED	Loyalty Interests – Leicestershire Police	5584	01.04.24	8th April 2025

Board Member:	Current Declarations:	Declaration Reference:	Date Interest Arose:	Date of Annual Declaration:
Chris Skelton NED	In Progress	TBC	TBC	TBC
Tim Harrison NED	In Progress	TBC	TBC	TBC
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	
	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	Loyalty Interests – Independent Member of the Audit and Risk Committee - Rutland County Council	6690	20.11.25	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	

Board Member:	Current Declarations:	Declaration Reference:	Date Interest Arose:	Date of Annual Declaration:
	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 Chief People Officer	Nil Declaration	6252	NA	2nd April 2025
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 Chief Nurse	Outside Employment – Director - National Mental Health, Learning Disabilities Nurse Directors Forum	6704	1.5.25	9th December 2025
	Outside Employment – Trustee - Churches Housing Association of Dudley and District (CHADD)	6703	15.9.25	

Board Member:	Current Declarations:	Declaration Reference:	Date Interest Arose:	Date of Annual Declaration:
	Outside Employment – Executive Reviewer - Care Quality Commission (CQC)	6702	3.12.25	
Bhanu Chadalavada Medical Director	Outside Employment – Four Elements Medical Services LTD	4045	01.11.23	9th September 2025
Paul Sheldon Chief Finance Officer	Outside Employment - Northamptonshire Healthcare FT - Joint role with LPT and NHFT	4116	19.09.23	16th May 2025
	Loyalty Interests – Carly Sheldon (wife) – Senior Finance Manager at Black Country ICB	4275	01.04.23	

Decision Required

Briefing – no decision required

Governance Table

For Board and Board Committees:	Public Trust Board 27th January 2026
Paper sponsored by:	Kate Dyer Director of Governance & Risk
Paper authored by:	Kay Rippin Deputy Trust Secretary
Date submitted:	19th January 2026
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:	March 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

LPT Trust Board

Minutes of the Public Trust Board meeting held 25 November 2025 commencing at 9.30am via Microsoft Teams

Present
Faisal Hussain, Interim Group Chair
Josie Spencer, Non-Executive Director/Interim Deputy Chair
Melanie Hall, Non-Executive Director/Interim Senior Independent Director
Hetal Parmar, Non-Executive Director
Liz Anderson, Non-Executive Director
Jean Knight, Managing Director/Deputy Chief Executive
Sharon Murphy, Executive Director of Finance and Performance
Bhanu Chadalavada, Medical Director
Linda Chibuzor, Group Chief Nurse

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, Group Chief People Officer
David Williams, Group Executive Director of Strategy and Partnerships
Paul Sheldon, Chief Finance Officer
Kate Dyer, Director of Corporate Governance and Risk
Kamy Basra, Associate Director of Communications and Culture
Sonja Whelan, Corporate Governance Coordinator (Minutes)

TB/25-6/082	**Apologies for Absence** Apologies were received from Angela Hillery and Manjit Darby.
TB/25-6/083	**Families, Young People, Children, Learning Disability and Autism Services: Lived Experience** Sam Leak introduced the service presentation which would focus on Lived Experience across the organisation but with particular attention to the FYPCLDA directorate. The team prepared a video presentation to illustrate the work undertaken and would pause midway for questions and answers followed by an opportunity for discussion at the end. The team introduced themselves as Colin Cross (Deputy Director), Emma Stuart-Smith, (Digital Practitioner/Speech and Language Therapist), Tasha Suratwala (People Council and Lived Experience Partner) and Raj Gill-Harrison (People Council and Lived Experience Partner). Colin Cross began the presentation which consisted of a narrated video shown on screen interspersed with pre-recorded contributions from individuals.

	The first section of the video defined lived experience as the first-hand knowledge, insight, and expertise that individuals gain from directly experiencing health and care services as patients, service users, carers or family members. The benefits of using lived experience partners in the FYPCLDA directorate were outlined which highlighted the enabling of partnerships to ensure services reflected needs. It was noted that lived experience was now recognised as expertise equal to professional knowledge and qualifications and there had been a cultural shift within the trust to include lived experience voices in multi-disciplinary teams, governance meetings and improvement workstreams. The Trust's vision was then presented - which was to ensure patients and carers are influential partners in driving and delivering change and working as equal partners in shaping and improving services, as personal experiences of lived experience partners provided insight to inform service design and decision-making. The Trust had developed a lived experience framework to create structured opportunities for meaningful involvement across Leicester, Leicestershire and Rutland and there were growing numbers of lived experience partners in diverse roles across directorates, with continued recruitment planned. The video was paused for a contribution from Colin Cross, who shared an example of lived experience in practice. He described the redesign of health visiting and school nursing services in 2022, which included creating a single point of access. Initially, the proposed name was "Healthy Together One," but feedback from people with lived experience suggested that the name should clearly describe the service. Based on this input, the service was named "Healthy Together Helpline," which better communicated its purpose. Colin then introduced the second part of the video, which showcased real-world examples of lived experience within FYPCLDA. The second section of the video demonstrated how lived experience is used from ward to board level, featuring contributions from staff, leaders and lived experience partners. Tiff Webster, Joint Director for Children and Young People Services, spoke about her involvement in lived experience engagement and co-production initiatives aimed at improving patient experience and access. She highlighted progress made through the People's Council and lived experience partners, while noting the need to reduce duplication and bring initiatives together. Jo Tolley, Co-production Lead for Special Education Needs and Disabilities and Inclusion Rights, emphasised the importance of ensuring the voice of children and young people was central to all work. She described progress made by the Inclusion Alliance and LDA Collaborative in improving inclusivity for disabled and neurodivergent individuals, while stressing the need to broaden engagement to ensure all voices are heard and equal partnerships are built. Emma Stuart-Smith, a speech and language therapist, shared her perspective as an autistic individual and parent of two autistic children. She explained how her team provides digital information through the ChatAutism tech service and collaborates with others who have lived experience of autism. Emma highlighted that lived experience is vital, as feedback shows it helps people feel listened to and understood, which improves health outcomes.

The video also outlined specific projects where lived experience partners have contributed within FYPCLDA. These included involvement in the LDA Collaborative and the development of the Annual Health Check programme, as well as participation in STOMP/STAMP work to reduce over-medication for people with learning disabilities and promote non-drug therapies. Lived experience partners have co-chaired meetings and helped deliver training in these areas. Further examples included contributions to CAMHS improvement work, where partners attended planning meetings for the "Thriving While We Wait" project, provided voice recordings for Crisis Team animations, and offered feedback to improve the language and format of CAMHS access digital contacts. Care navigation teams have also benefited from lived experience input, with partners attending events and sharing insights into the challenges families face when accessing specialist provision and navigating education and healthcare plans. This involvement has enhanced the team's understanding and ability to provide appropriate support.

The presentation continued with a contribution from Raj Gill Harrison, a lived experience partner within the FYPCLDA directorate. Raj explained her involvement in co-production work alongside clinicians, children and young people in home enteral nutrition services, particularly PEG feeding across Leicester, Leicestershire and Rutland. She described working closely with dietitians and quality improvement advisors to ensure that co-production was authentic and central to the work, rather than tokenistic. Raj highlighted the need for improvement in fully embedding the voices of young people and carers through more meaningful engagement. She expressed her aspiration for stronger collaborations with diverse and intersecting communities, including ethnic minorities, varied gender identities, cultures and all age groups, to ensure co-production is fully embedded and partnerships between staff, patients and carers are strengthened. Raj also shared her positive experience of participating in the Director of Nursing Allied Health Professional Fellowship programme, which she found deeply meaningful given her own lived experiences of using children and young people's services.

The next section of the presentation addressed the challenges faced. It was noted that there is underrepresentation of certain groups, including young people, neurodivergent individuals and ethnic minority communities. Additionally, there are only a limited number of paid, secure roles for lived experience partners, with many positions being low paid, bank or voluntary. It was noted that lived experience roles can be undervalued compared to clinical posts, and there is a lack of clear progression pathways into leadership roles. The team would like to see further embedding of lived experience following the scoping of the current lived experience partners work in the directorate with a subsequent roll-out across the whole system. An action plan was being developed to support these objectives, and progress will be reviewed at senior leadership level.

The Chair thanked everyone for their presentation which powerfully illustrated the value and importance of co-production, ensuring the voices of our community and staff are central to how services are shaped and delivered. Questions were then invited.

	Hetal Parmar thanked the team for their presentation and shared that, as a parent of two children with special needs, it was heartening to see the voice of lived experience being embedded within services. The collaboration and the impact achieved through sharing stories and working together was acknowledged. Hetal then asked how this good practice was being shared more widely given the potential for collaborative learning across the wider region. In response, Raj Gill-Harrison confirmed that collaboration was supported through the involvement of Tiff Webster, Group Director across Leicestershire and Northamptonshire Trusts and noted the opportunity to tailor approaches to reflect different demographics and populations in each area. Internally, options being considered included sharing information through staff webpages and making resources public-facing via the trust website to increase understanding and inclusivity. Discussions were ongoing about promoting this work more widely through senior leadership teams and Directorate Management Team meetings (DMTs). Kate Dyer conveyed thanks for the presentation and expressed appreciation for the ongoing engagement with the People's Council on governance matters. She emphasised the importance of ensuring that engagement activities contribute meaningfully to governance, policies and practice, and that the voices of service users are authentically heard and integrated into decision-making and confirmed this remains a priority and looked forward to next steps. The Chair acknowledged Kate's comments and reiterated the Board's commitment to lived experience. The importance of maintaining a strong link between the Board and the People's Council was acknowledged, noting efforts to ensure representation and engagement through Board development sessions and joint meetings. Liz Anderson congratulated the team for their presentation and, noting her role as a University of Leicester representative, emphasised the importance of connecting lived experience work with the education of future healthcare professionals and saw opportunities for closer collaboration between the Trust and the University to embed service user voices in training, address challenges and explore alignment of payment structure to ensure patients and carers are appropriately rewarded. Her question focused on how partnership working could be strengthened so that students could hear these messages. Raj Gill-Harrison responded that she had been working with the University for several years as part of the patient carer teaching team. She explained that lived experience is increasingly integrated into interprofessional training to reflect real-world practice and promote understanding from the outset of students' careers. Initiatives included embedding patient and carer stories into teaching, sharing both positive and negative experiences, and involving diverse voices from physical and mental health backgrounds. The development of the Empathy Centre was highlighted, which supports practitioners in building listening skills and managing sensitive conversations. It was emphasised that lived experience involvement has a strong impact on students' approach to compassionate care and improves their ability to deliver meaningful patient-centred services. The Chair thanked Raj and reinforced the importance of engaging students early in their training to ensure they understand the value of lived experience and its contribution to improving care.

	Jean Knight extended thanks for the overview and acknowledged the positive impact of lived experience on programme outcomes, as observed during service visits and quality improvement meetings. She expressed appreciation for the work being done and confirmed that she and other executives will actively seek to influence the ICB to ensure these principles are embedded in strategic commissioning decisions. Linda Chibuzor thanked the team for their presentation and highlighted the vital role of lived experience experts and practitioners in supporting recovery journeys, noting the positive impact of sharing experiences with service users and families. Assurance was provided that similar roles exist within Northamptonshire Healthcare Foundation NHS Trust (NHFT) where there was strong participation from young people and reiterated the importance of shared learning across the Group. Bhanu Chadalavada thanked the team for a fantastic presentation and highlighted the impact of lived experience within research and service development, noting its role not only in recruitment but also in shaping project design and development. He referenced resources such as the “Decode” project as examples of how lived experience helps explain the rationale and methods behind investigations and emphasised the power of this level of involvement for the Trust. Bhanu expressed gratitude for the People’s Council’s involvement in the clinical plan, particularly in identifying priorities and clarifying their implications for direct patient care and training. He endorsed the importance of bringing the lived experience voice in early, observing that having a lived experience partner present changes the nature of discussions and promotes compassion at the outset; he noted projects are underway to ensure this early-stage inclusion. Within the partnership, he acknowledged contributions from groups such as carers’ forums and parent networks, explaining that knowledge from prior experiences is being used within ongoing Group discussions. David Williams thanked the team for their presentation and added comments to build on earlier points regarding strategic commissioning intentions. He highlighted the alignment with the Trust’s Thrive strategy, which focuses on healthy communities and inclusion, ensuring that all voices are heard. It was noted that this approach enriches service delivery and design. The ChatHealth service, originally developed by LPT over a decade ago and now used by multiple organisations, was referenced as an example of innovation and income generation. The service had expanded beyond school nursing and health visiting to include ChatAutism, and Health Innovation East Midlands is supporting efforts to raise its profile through podcasts and other initiatives. The benefits of technology-based services was acknowledged, such as ChatHealth and ChatAutism, which allow people to access support via text messaging without the need for phone calls or face-to-face appointments, reducing stress for those who find traditional interactions challenging. The Chair thanked David for the additional context and emphasised the importance of reaching voices that are not often heard, recognising this as an area of continued focus. The need for strategies to engage individuals who do not typically participate was noted, as these perspectives were critical to continuous service improvement.

	Tasha Suratwala provided examples of work within the Learning Disabilities and Autism (LDA) Collaborative to support neurodivergent individuals through reasonable adjustments. She highlighted a joint annual health check project with NHS England, which ensures checks for people with severe mental illness, learning disabilities and autism and adjustments included offering home visits for those unable to attend clinics. The importance of a personalised care approach rather than a standardised model was emphasised, and the need to ask patients, carers and families what matters most to them. Initiatives such as the use of digital flags to support individual needs was also referenced. Tanya Hibbert thanked the team for the presentation and highlighted ongoing work to engage diverse communities across LLR. Also referenced was initiatives delivered in partnership with third sector organisations through Culture of Care and Patient and Carer Race Equality Framework (PCREF), aimed at amplifying the voices of groups such as the African Heritage Alliance, Bangladeshi and Southeast Asian communities to ensure inclusivity and broaden representation and reaching those 'less heard' voices. The Chair expressed appreciation to the presenting team and all colleagues involved in preparing the session noting the significant value of co-production and lived experience in shaping services and requested that appreciation be conveyed to colleagues who were not present.
TB/25-6/084	**Questions from the Public (verbal)** There were no public questions.
TB/25-6/085	**Declarations of Interest (Paper A)** The Board received this report and noted the declarations of interest contained within. Josie Spencer advised, for transparency, that her declaration in the published paper still referenced outside employment with Staffordshire and Stoke-on-Trent ICB. She confirmed that this was amended but too late for inclusion in the papers and reported that she resigned from that position on 31 October 2025. There were no declarations of interest in respect of items on the agenda.
TB/25-6/086	**Minutes of the previous Public Meeting held 30 September 2025 (Paper B)** The minutes were approved as an accurate record of proceedings. **Resolved:** The Board approved the minutes.
TB/25-6/087	**Matters Arising (Paper C)** All actions were confirmed as complete and approved for closure. **Resolved:** The Board approved the closure of all completed actions.
TB/25-6/088	**Trust Board Workplan 2025/26 (Paper D)** The Trust Board Workplan was presented for information. No questions or queries were received.

TB/25-6/089	**Chair's Report (Paper E)** The Chair presented this report for information, which summarised Chair and Non-Executive Director (NED) activities and key events relating to the well-led framework for the period October-November 2025. The following key points were highlighted:- • The Chair reported that since taking on the Interim Group Chair role, he had completed a comprehensive induction programme, including meetings with colleagues across the Group, Integrated Care Board (ICB) and partner organisations. • Josie Spencer was formally welcomed to the role of Interim Deputy Chair and Melanie Hall was formally welcomed to the role of Interim Senior Independent Director. • All NED appraisals documents have been completed and submitted to NHS England (NHSE) on 30 September 2025. • The recent Group Board Development Workshop held with NHFT colleagues featured sessions on Freedom to Speak Up and Mental Health Act training. Both were highly informative and well received.
TB/25-6/090	**Chief Executive's Report (Paper F)** In the absence of the Chief Executive, Jean Knight presented this report, which provided an update on current local issues and national policy developments since the last public board meeting. Key points highlighted included:- • NHSE have launched their Advanced Foundation Trust programme, with NHFT participating in the first cohort. This initiative provides an opportunity for LPT to learn from NHFT's experience, particularly as the programme includes an assessment of readiness to become an integrated health organisation. • Work was underway to submit LPT's medium-term plans covering the next three to five years. These plans are being developed to align with ICB priorities and reflecting the needs of the population. • The CQC have launched their 'Better Regulation, Better Care' public consultation aimed at creating a clearer regulatory framework for providers and the public. The consultation remains open until 11 December 2025. • The recent provider capability assessment, which involved self-assessment across six areas, had been submitted to NHSE and feedback is awaited. • Thanks were offered to colleagues for managing the recent industrial action by resident doctors. • The success of the Celebrating Excellence Awards was highlighted and appreciation was extended to the Communications Team for delivering such a well organised event. • A new 'Whilst You Wait' website had been launched to provide support for patients, carers and families during the waiting period for appointments. The site offers specific advice for ADHD and CAMHS and would continue to be developed and enhanced. Josie Spencer welcomed the introduction of the 'Whilst You Wait' website and expressed her support for the initiative noting its importance in addressing concerns about long waiting times. To be able to assess whether the site is meeting patient needs, she asked whether information on website usage was

	available eg number of visitors and types of resources accessed. It was confirmed that the analytical information is available. Liz Anderson described the 'Whilst You Wait' website as excellent, congratulated those involved in its development and asked how patients and carers were being directed to the site. Furthermore, sought clarification on opportunities arising from NHFT's involvement in the Advanced Foundation Trust Programme, noting the tight timescales and significant workload associated with the process. The potential for collaborative work and research opportunities that could feed into future developments was highlighted. Jean Knight confirmed that patients and carers are currently notified about the website through their GPs and referral processes. As the site has only recently been launched, work will continue to strengthen communication and ensure wider awareness. It was noted that links are already shared through platforms such as the Joy App in the Directorate of Mental Health and that further improvements will be explored. With regard to the Advanced Foundation Trust Programme, the challenging timescales were acknowledged but the importance of learning from NHFT's experience and working alongside them was emphasised, particularly in relation to data collation and areas relevant to LPT's own organisational development. David Williams added that NHFT's participation in the programme presents significant learning opportunities for LPT. He explained that NHFT is among the first eight organisations to pursue Advanced Foundation Trust status, which could lead to an integrated healthcare organisation contract—likely limited to only two organisations nationally. David highlighted that this development positions NHFT at the forefront of new healthcare models, enabling innovative approaches to population health and service delivery. He stressed the potential for LPT to apply these learnings locally and strengthen links with academic institutions such as the University of Leicester. It was noted that LPT currently meets the criteria to pursue Advanced Foundation Trust status and integrated healthcare organisation status in the future, making this an important area to monitor. Melanie Hall also commended the 'Whilst You Wait' website, and agreed with previous comments that it would be helpful to monitor traffic and consider expanding the content to include a broader range of waiting well advice. She also praised ChatAutism, noting its value as a rich resource for individuals with neurodiversity who prefer not to engage through chat, online forums, or face-to-face interactions. An addition, Melanie acknowledged the significant number of estates-related change programmes being delivered by the Trust and praised the executive team and wider staff for managing these complex projects seamlessly and delivering improvements effectively. The Chair thanked Jean Knight for presenting the Chief Executive's Report which was received for information. He then referred the most recent Midlands Chairs' Briefing, highlighting concerns around flu vaccinations and the high levels of bed occupancy in acute trusts across the Midlands due to flu-related illnesses. He stressed the importance of continuing to encourage colleagues to promote flu vaccination uptake.
TB/25-6/091	**Environmental Analysis (verbal)** Jean Knight provided a brief update noting there was little additional information to report this month. The Health and Wellbeing Board meetings for the City and

	County took place in September, as previously reported, and the Rutland meeting was cancelled and rescheduled for December. Service visits continued and feedback from these was actively reviewed. The Chair offered a further update and informed the Board that both Andrew Moore (UHL Chair) and he were meeting more regularly with the ICB team across Leicestershire and Northamptonshire and colleagues from East Midlands Ambulance Service were now involved, bringing more joined up perspectives and greater collaboration into the system. The Chair also reported on discussions from a recent national briefing with Chairs and Chief Executives regarding local government reorganisation and its potential implications for health and wellbeing and scrutiny arrangements and confirmed that Board will receive further updates on these developments through future Chief Executive and Chair reports.
TB/25-6/092	**Board Assurance Framework (Paper G)** Kate Dyer presented this report outlining strategic risks as part of the continuing risk review process. The report identified thirteen risks in total, five of which have been allocated to the Group. For LPT, eight risks were identified, six of which currently carry a high score. All actions are monitored through governance processes and monthly executive meetings. The highest scoring areas relate to access to services, workforce, environment and capital funding. Josie Spencer asked if the Board should expect any significant changes to some of the more intractable issues of whether the position was likely to remain largely the same by year-end. Kate Dyer responded that while considerable work is being undertaken to mitigate risks, new challenges continued and remained high due to their strategic nature so did not anticipate there would be significant changes to the scores before the year-end, although work to strengthen mitigation tracking was ongoing. Melanie Hall highlighted as an example of effective governance and action, a detailed discussion that had taken place on the Board Assurance Framework (BAF) at the Finance and Performance Committee (FPC) which she Chairs. Kate Dyer welcomed these comments and emphasised that the increased visibility of risks on the Corporate Risk Register (CRR) had enabled more mature discussions at committee level. Discussion followed on risk appetite and the importance of committees tracking key risks and ensuring appropriate mitigation. It was acknowledged that Level 1 committees already provide assurance on the proximity and impact of risks through detailed assurance papers, which highlight emerging issues, mitigation progress, and areas requiring further action. Linda Chibuzor welcomed the earlier comments and confirmed that the Quality and Safety Committee will take forward a focused review of risks, including consideration of any barriers to progress and whether risks are positioned at the appropriate level. The Chair emphasised the importance of ensuring that all lead executives and committee chairs work with their respective committees to replicate this approach across Level 1 committees.

	Resolved: The Board received this report for information and assurance.
TB/25-6/093	**Quality and Safety Committee AAA Highlight Report: 21 October 2025 (Paper H)** Josie Spencer introduced this report and drew attention to the following:- • There continued to be an alert around the number of waits over 52 weeks – a key issue identified was the functionality of the Electronic Patient Record (EPR) system and a need to amend processes. • Whilst it was appreciated the ongoing actions happening in executive forums we wanted to agree what we might want to see at QSC from an assurance point of view and a conversation is ongoing separately about that. • The medical school quality visit which produced very positive findings was welcomed by the QSC. • Melanie Hall will be assuming the NED portfolio for Freedom to Speak Up (FTSU). • Current feedback arrangements via the People and Culture Committee (PCC) were considered ineffective so a revised approach will be proposed in a paper to QSC in December 2025. • Monitoring continued on turnaround times for complaint responses. • A new issue was raised from the Quality Forum regarding the use of AI and Co-pilot tools by clinical staff to assist with record-keeping. Executive Management Board was aware and considering how such technologies might be adopted – developments would be monitored. • Following the local area SEND inspection that took place in September, LPT achieved Level 2 which surpassed the national trend and the committee expressed appreciation for all staff involved in achieving this positive outcome. Liz Anderson commented on the importance of monitoring the safe integration of technology, particularly the use of AI in clinical record-keeping and the need to link with Universities to ensure consistency in systems used by students and staff. Bhanu Chadalavada provided assurance regarding the governance of emerging technologies, confirming that Data Privacy Impact Assessments (DPIAs) are being undertaken for all new digital tools. He reported that DPIAs have been completed for three proposed AI solutions designed to condense clinical conversations into outpatient letters; three clinical teams had volunteered to participate in pilot projects for these tools and initial reviews had assessed potential risks and identified mitigations. It was acknowledged that CoPilot was currently being utilised for non-clinical purposes and that the team remained vigilant in managing risks associated with technology adoption. Melanie Hall referred to the Leicester Medical School's suggestion to broaden the teaching experience to include locum staff and asked for further clarification. Bhanu Chadalavada responded that the quality visit undertaken in March included a detailed review of the teaching offer across inpatient and community settings. At the time of inspection, there were a higher number of locum consultants in the community, some of whom were not on the GMC education register, which is required for clinical supervision training. Since then, recruitment

	has improved, and the Trust has increased the number of medical students supported by substantive consultants and specialty doctors with the appropriate credentials. Bhanu explained that the medical school advised that locums could also be added to the education register to maintain teaching capacity, and the Trust is exploring this option given the experience of some locum staff. Sharon Murphy provided additional assurance regarding the governance of technology use within the organisation and confirmed that all software undergoes a DPIA prior to introduction, ensuring an appropriate level of safety. She further advised that the Data Privacy Group holds regular discussions to review adequacy of current measures and highlighted that momentum around AI adoption was increasing and, as a result, the organisation may need to develop a dedicated AI Policy in the future. **Resolved:** The Board received this report for information and assurance.
TB/25-6/094	**Safe Staffing Report (Paper I)** Linda Chibuzor presented this report which provided a full overview of nursing safe staffing during the month of September 2025, including a summary and update of Allied Health Professional (AHP) and medical vacancies, 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), Nurse Sensitive Indicators (NSIs) and patient experience feedback. The key points were outlined as:- • Vacancy levels and staffing concerns are monitored through the PCC – no current concerns were highlighted; actions are in place to manage and mitigate any risks. • Fill rates – the data is uploaded nationally. Some areas show staffing below required hours and this is reviewed alongside NSSIs to assess any impacts on incidents. No evidence was found linking staff levels to reported incidents during the review period. The mitigation measures were outlined. • Staffing establishments were based on planned levels, however, variations occur due to sickness or reduced activity. • Weekly reviews of incidents are conducted through the Incident Management Group for further scrutiny. • Assurance was provided that mitigations have been effective in maintaining safe staffing levels. Liz Anderson noted a recurring theme of security issues and patient concerns requiring additional staff and asked whether LPT was experiencing a higher level of patient acuity and risk compared to the national average or whether this was a normal pattern with an effective response system. Also queried, was whether the increased staffing needs were seasonal or indicative of a more vulnerable position for the Trust. Linda Chibuzor explained the situation was not unique to LPT and reflected a national trend. Due to successful community-based interventions, patients are admitted when they are acutely unwell, which results in higher risk profiles and increased staffing input. Additional staffing may also be needed during discharge planning and community reintegration phases. Linda clarified that the

	term “acuity” refers to the complexity and severity of patient needs and suggested that future reports could include more narrative to explain this term for non-clinical readers. Sam Leak added to Linda Chibuzor’s explanation by providing an example from Community Health Services. She explained that the teams are exploring ways to cohort patients differently, particularly those who transfer from the acute trust and may initially require higher staffing levels. As these patients step down through processes and systems, their staffing needs reduce. Transformation work was underway to ensure the right skill mix and staffing levels are in place to support this approach and deliver the best outcomes for patients. **Resolved:** The Board received this report for information and assurance.
TB/25-6/095	**Patient Safety and Learning Assurance Report (Paper J)** The Group Chief Nurse presented this report which provided assurance of the efficacy of the incident management and Duty of Candour compliance processes. Incident reporting supporting this paper had been reviewed and refreshed to assure that systems of control continued to be robust, effective, and reliable thus underlining the commitment to continuous improvement of incident and harm minimisation. The report also provided assurance around ‘Being Open’, supporting compassionate and timely engagement with patients and families following a patient safety incident, numbers of investigations and the themes emerging from recently completed investigation action plans, a review of recent Ulysses patient safety incidents and associated lessons learned/opportunities for learning. Key areas were highlighted as:- • The Trust’s positive reporting culture - high levels of reporting are not indicative of over-reporting but rather a reflection of a healthy culture that enables analysis of trends and themes; without sufficient reporting, learning opportunities would be limited. • The top five reported patient safety incidents were outlined within the report and how these are being reviewed and managed. • An improvement project was underway to address the increase in pressure ulcers, particularly those that develop while patients are receiving care from the Trust. • Learning from deaths remained a key focus, and the report included details of LeDeR reviews for patients with learning disabilities as well as updates on patient safety reviews and progress in managing these. • There have been no Duty of Candour breaches during the reporting period. The Chair emphasised the importance of the Trust’s strong reporting culture and its focus on learning, which provides significant assurance to the Board. The reflection also considered how learning from incidents is shared across the organisation to ensure improvements are embedded widely. Reflecting on the earlier discussion about lived experience, Melanie Hall raised a point regarding tissue viability and pressure ulcers and asked how the Trust is involving carers and families in managing the risk of pressure ulcers in the community, both before and after they develop and suggested that training and support for carers could play a key role in prevention, noting that some issues

	arise within the Trust's care while others are inherited. Sam Leak confirmed that prevention remains the primary focus, with extensive work undertaken across Community Health Services and the wider Trust to involve families and carers in reducing pressure ulcer risk. While acknowledging the complexity of the issue and that some cases are unavoidable, she stressed the importance of early identification and family engagement. Families are also involved in feedback and actions following incident investigations, and further discussions will explore additional support. Linda Chibuzor advised that the Trust has a dedicated Pressure Ulcer Group working on improvements in this area, with patient and carer involvement integral to the work. She emphasised the role of Patient Safety Partners as the voice of service users and confirmed that assurance on their involvement will be sought and reported through the Quality and Safety Committee. Liz Anderson commended the Trust for its commitment to learning and improvement, noting the recent Pressure Ulcer Conference held on 20 November as an example of proactive work in this area, and highlighted that such initiatives demonstrated the organisation's focus on raising awareness and maintaining momentum on prevention. **Resolved:** The Board received this report for information and assurance.
TB/25-6/096	**Finance and Performance Committee AAA Highlight Report: 23 October 2025 (Paper K)** Melanie Hall presented this report and provided an overview of the following key points:- • Continued oversight of the CAMHS project affecting the Beacon Unit with good progress in transformation and service improvement. Full assurance was expected within the next one to two committee cycles. • FPC noted the imperative to move into a positive position from Month 7 and was assured about progress while acknowledging future performance risks. • Ongoing focus on waiting lists and patients waiting over 52 weeks was highlighted, with reference to the recent Board Development Workshop, which provided valuable insights on reducing waiting lists, supporting patients while they wait, and suggestions for improving data sets. • Strong overarching assurance was received on the digital plan noting the drive to strengthen links between the CRR and BAF. • Good progress was reported on estates and facilities transformation projects including their impact on budgets and key capital programmes. • The 'Right Care Right Person' group was stood down due to successful transformation and improved relationships with the police. • Completion of the archives transfer project was noted, supporting the Trust's move away from paper records. Hetal Parmar commended the clarity of the AAA report and welcomed the emphasis on celebrating outstanding practice, noting that several areas highlighted in the report demonstrated excellent work. **Resolved:** The Board received this report for information and assurance.

TB/25-6/097	**Finance Report – Month 7 (Paper L)** The Executive Director of Finance and Performance introduced this report which provided an update on the Trust financial position for the period ended 31 October 2025. Key points highlighted included:- • Reporting a £1.8m deficit which was in line with the plan. • Improvement in the run-rate with an in-month surplus being almost £300k higher than expected, driven largely by reduction in out of area placements within the Mental Health Directorate. Cost Improvement Programme: • Year to date delivery continues to improve within clinical directorates • Forecast outturn remains on track for full delivery despite £2.5m of corporate schemes without specific plans, requiring non-recurrent mitigations. • Overall, 34% of the CIP plan is currently delivered non-recurrently, impacting the underlying financial position. Forecast Outturn: • Run-rates are reducing, mostly in the non-pay area of spend – this was a concern progressing into the 2026-27 planning round. • Scenarios have narrowed, with the likely stretch now at a £2.4 million deficit. • Partial funding for winter beds confirmed, reducing pressure compared to earlier forecasts. • Remaining known risk relate to out-of-area beds. • Forecast outturn remains break-even against plan based on current assumptions. Capital Programme: • NHS England confirmed deferral of £1.8m for schemes to be delivered in 2026-27. • Funding continues for critical infrastructure risk schemes, supporting backlog maintenance reduction and enabling some schemes to be brought forward. • Forecast capital outturn for this year is £18.2m, with £6m spent to date. • Confidence expressed in delivering required spend; compliance with Month 8 capital forecast submission is critical to securing future funding. Better Payment Practice Code: • Three of four targets met in-month; cumulative performance improving and edging towards the 95% target. Underlying Position: • Currently showing a £12.4m deficit, mainly due to non-recurrent mitigations and high CIP driven by shortfalls in pay award funding. • Underlying position will inform 2026-27 and medium-term financial plans – first submission due 17 December 2025 and final submission 12 February 2026 with both to come through Board for approval prior to submission. Josie Spencer raised a query regarding the underlying financial position for the next year, confirming her understanding that the pay award shortfall for the

	current year cannot be recovered and highlighting concerns about the temporary vacancy pause. She observed that if these issues persist, the underlying position could deteriorate and emphasised the importance of moving more CIP schemes onto a recurrent footing to mitigate this risk. Josie expressed appreciation for the hard work being undertaken and welcomed the progress achieved to date. Hetal Parmar sought clarification on wording in the commentary on page 120 regarding the central reserves position. He queried the reference to an underspend of £1.6m and its relationship to overspend offsets. Sharon confirmed that the current central reserves position is underspent by £1.6m and acknowledged that the wording in the report could be made clearer. She committed to correcting this in the next report and confirmed that there are no overspends in reserves this year. Hetal Parmar further reflected on the Integrated Care System (ICS) financial position and commended the Trust for aiming to achieve break-even in the current climate, noting that this is a significant achievement given the wider financial pressures. Reassurance was sought that the overall ICS deficit would not create additional risk or impact for LPT, given the tightness of the Trust's financial plan, and asked for confirmation that this is well understood at ICS level to avoid any further demands on the organisation. Sharon Murphy responded that the question is more likely to arise in discussions with NHSE rather than the ICS but confirmed that the risks faced by LPT are well understood. She highlighted the recent confirmation of funding for winter beds as an example of the support provided, demonstrating recognition that the Trust cannot absorb additional risks without assistance. Sharon noted that this reflects confidence in the accuracy of LPT's forecasting and the credibility of its risk assessments. She assured the Board that the ICS position is understood and managed internally. **Resolved:** The Board received this report for information and assurance.
TB/25-6/098	**Performance Report – Month 7 (Paper M)** The Executive Director of Finance and Performance presented this report which provided an overview of the Trust's performance against Key Performance Indicators (KPIs) for October 2025. Key areas highlighted included:- • All indicators improved against target in DMH. • Slight deterioration and continued lower performance in CINSS and speech therapy within CHS - actions are in place to address issues. • FYPC - urgent performance deterioration was noted in CAMHS eating disorders; however this service operates with very low numbers, making performance highly variable. Community paediatrics showed lower performance, while audiology had improved – both were consistent with previous trends. • 52 week waits decreased across DMH except ADHD which remains a challenge. • CMHTs and therapy services for personality disorders showed a consistent downward trend in waits being reported. • Neurodevelopmental waits increased in FYPC alongside small rises in community paediatrics and audiology; other waiting times in FYPC had reduced.

	• Out of area bed days reduced, aligning with financial improvements. • Length of stay in CHS decreased and was now above target. • Delayed transfers of care increased, potentially contributing to longer stays in mental health services • The usual deep dives into these areas would take place at the next Accountability Framework Meeting. **Resolved:** The Board received and approved this report.
TB/25-6/099	**People and Culture Committee AAA Highlight Report: 8 October 2025 (Paper N)** In the absence of Manjit Darby, Chair of the People and Culture Committee, Melanie Hall presented this report. Attention was drawn to the following key areas of highlight: • The Trust's preparedness and processes implemented during and after the Resident Doctors' industrial action had been managed effectively. • The Midlands Temporary Staffing Support Programme was noted as a welcome initiative as an additional measure to reduce agency usage and provide support. • Sickness absence rates remained above target, reflecting national trends and pressures, particularly due to flu and Covid and the Trust continued with significant efforts to encourage flu vaccination update. • There had been a notable improvement in occupational health waiting times. • With reference to the employee relations deep dive that was undertaken, it was reported that data development work was ongoing to enhance assurance around timescales, hotspots and triangulation of issues raised. • The Race Equality and Disability Equality action plans had been reviewed and were ready for publication. • October's Freedom to Speak Up month was highlighted as a success with significant staff contributions and the Trust continued to promote speaking up as a critical component of its culture. Sarah Willis provided further context to the update and explained that, in relation to the Midlands Temporary Staffing Support Programme, the Trust had originally been advised after the July agency usage data that it would be required to attend a meeting in October; this meeting has not yet taken place, and there is no formal confirmation as to whether it will proceed. It was noted that since July, the Trust has seen a consistent month-on-month reduction in agency usage and it is possible that, as a result of this improvement, the Trust has been de-escalated nationally, although this has not yet been confirmed. The situation would continue to be monitored and any updates shared when available. Sarah also addressed sickness absence, providing assurance that the Workforce Development Group, which is the Level 2 Committee reporting into the People and Culture Committee (PCC), had undertaken a detailed deep dive analysis into the management of sickness absence. Actions arising from this review would be reported back to the PCC at the next meeting. With regard to the residential doctors' industrial action, Bhanu Chadalavada assured the Board that all rotas and on-call shifts were covered to maintain

	patient safety, although some outpatient clinics were cancelled due to late notifications. The support of the EPRR team was acknowledged and ongoing work aligned with the NHS Ten Point Plan to improve support for resident doctors and reduce the risk of future industrial action was noted. Lastly, thanks were offered to Dr Saquib Muhammad and the revalidation team for the progress in medical appraisals, reporting 99% completion. **Resolved:** The Board received this report for information and assurance.
TB/25-6/100	**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/25-6/101	**Any Other Urgent Business** There was no other urgent business. It was noted that Manjit Darby, Non-Executive Director, will leave the Trust at the end of November 2025. The Chair, on behalf of the Board, expressed thanks for her valuable contribution, particularly her work on the People and Culture Committee, and wished her well for the future.
TB/25-6/102	**Papers/updates not received in line with the work plan** All papers and updates were received in accordance with the workplan.
	Close - date of next public meeting: Tuesday, 27 January 2026 at 9.30am

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Leicestershire Partnership NHS Trust

Public Trust Board 27 January 2026

Matters arising from the Public Trust Board meeting held 25 November 2025

Action sheet

Minute no.	Action/ issue	Lead	Due date	Status	Evidence
	No outstanding actions				

T H R I V E

D

Leicestershire Partnership NHS Trust

LPT Trust Board Workplan 2025/26

		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	Group Agenda	Group Agenda
Managing Director’s Report	Every meeting	-	-	-	-	-	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
Environmental Analysis *(internal and external factors impacting on the Trust & risk-based items)*	Every meeting	X		X	X	X	X	X
Chief Executive's Verbal Update ***(Confidential Agenda)***	Every meeting CEO	X		X	X	X	X	X
Environmental Analysis ***(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	Annual Chair			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
(Confidential Agenda)								
LPT well led action plan - time ltd item ***(Confidential Agenda)***	Every meeting Dir Gov & Risk	X		X	X PLAN CLOSED	CLOSED	CLOSED	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 *(08.01.26)*	X *(17.02.26)*
Safe Staffing Monthly Report	Every meeting Group Chief Nurse	X		X	X	X	X	X
Patient Safety Report and Learning Assurance Report	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			
Framework for Quality Assurance and Improvement (FQAI)	Annual Medical Director						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
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 *(15.04.25)*		X *(19.06.25)*	X *(21.08.25)*	X *(23.10.25)*	X *(22.12.25)*	X *(19.02.26)*
Finance Report	Every meeting Dir Fin & Perf	X		X	X	X	X	X
Performance Report	Every meeting Dir Fin & Perf	X		X	X	X	X	X
Charitable Funds Committee AAA Report	Quarterly Chair, CFC	~~X~~ ~~18.03.25~~ Deferred to July		X 18.03.25 and 26.06.25	X 11.09.25		X 19.12.25	X 13.03.26
Approval of Annual Financial Plan ***(Confidential Agenda)***	Annual Dir Fin & Perf							X
People and Culture:								
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)*	Transferred to Group Workplan	Transferred to Group Workplan
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							

		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
Externally Commissioned Reports	As required							
System-wide Winter Planning	As required							
Award of legal contracts	As required							
Maintaining High Professional Standards in the NHS (MHPS)	As required							
Appointment of Senior Independent Director, Deputy Chair, Chairs of Committees	As required							
EGM Agenda								
Going Concern Assessment	Annual Dir Fin & Perf		X					
Audited Financial Accounts	Annual Dir Fin & Perf		X					
Letter of Representation	Annual Dir Fin & Perf		X					
KPMG ISA 260 and Auditors Annual Report	Annual Dir Fin & Perf		X					
Head of Internal Audit Opinion	Annual Dir Gov & Risk		X					
Annual Governance Statement	Annual Dir Gov & Risk		X					
LPT Quality Account 2024/25	Annual Group Chief Nurse		X					
LPT Annual Report 2024/25	Annual Group Chief People Officer		X					

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Leicestershire Partnership NHS Trust

Public Trust Board 27th January 2026

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 December 25 – January 26. Activities relating to formal Committees of the Board are reported through custom reports.

Analysis of the Issue

NED Update

I would like to welcome two new members to our LPT Board. Chris Skelton has joined us as an Associate Non-Executive Director from 1st January 2026. Tim Harrison joined LPT as a Non-Executive Director from 1st December 2025, Tim is also a NED at NHFT and will continue in that role.

With the introduction of a new Non-Executive Director and Associate Non-Executive Director, we are taking the opportunity to review our membership and leadership of key committees to ensure they remain effective, well-balanced in expertise, and able to provide strong oversight, challenge and assurance in support of the Board's objectives.

Board Development

At our December LPT Board Development session we were joined by representatives from our People's Council, including a recorded video from the Chair of the Council. There was an update of the work done together on improvements in collaboration and coproduction with the Council. There was consideration of impact of the Board Member pledges and how these should continue. We received a progress against the delivery of the Trust's Lived Experience Framework.

We were also delighted to be joined by our Head of Co-Production, Participation and Patient and Carer Experience to discuss the Patient and Carer Race Equality Framework (PCREF), NHS England's first anti-racism framework. This forms part of our wider work around Together Against Racism across both Trusts.

We took some time to hear from our colleagues at Raising Health and understand the alignment between the charities objectives and our own THRIVE strategy. We took some time to discuss the importance of the Charity Governance code and carry out some group work around the eight principles of the code.

Our Deputy Director for Safety & Emergency Planning joined us to provide an update on the NHSE Violence and Aggression standards and we discussed our responsibilities as a Board to support and ensure the safety of our staff and patients.

We also received an update on the responsibilities and accountabilities for Board Members with regards to Controlled Drugs regulations.

Both the People and Culture and Nominations and Remuneration Committees have had their first meetings in common with NHFT.

Working with Partners and Stakeholders

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

- NHS Providers Chairs & CEO Network Event
- NHS Confederation and NHS Providers Quarterly Shared Leadership Forum East Midlands Alliance (EMA) Learning Event
- System Chair Meetings
- System Chair & CEO Meetings
- Meetings between Chairs of NHFT/LPT Quality & Safety Committee Meeting and Chairs of East Midlands Alliance Quality & Safety Committees
- Joint NED Catch Up
- Networking meeting with Provider NED's

Public, Patient and Staff Engagement

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

- Group Hospital Associate University Meeting
- Disability History Month Event
- Service Visit - Short Breaks
- Service Visit Charnwood CMHT
- ISLA Community Service visit
- DAISY Award presentation

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

Briefing – no decision required

Governance Table

For Board and Board Committees:	Trust Board January 2026
Paper sponsored by:	Faisal Hussain, Interim Group Chair
Paper authored by:	Sinead Ellis-Austin, Head of Chair/CEO Office
Date submitted:	19th January 2026
Name and date of other committee / forum at which this report / issue was considered:	N/A
Level of assurance gained if considered elsewhere	☐Assured ☐ Partially assured ☐ Not assured
Date of next report:	March 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)	N/A
Is the decision required consistent with LPT's risk appetite:	N/A
False or 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)
Liz Anderson	12/11/2025	Group Hospital Associate University Meeting	I
Liz Anderson	18/11/2025	Group University Hospital Status Workstream- Education	I
Hetal Parmar	18/11/2025	Fraud Awareness Training	E
Liz Anderson	19/11/2025	Honorary titles evening University of Leicester	I
Hetal Parmar	19/11/2025	360 Internal Audit catch-up	I
Melanie Hall	01/12/2025	FPC Agenda planning meeting	I
Chair	01/12/2025	LPT Trust Bord Agenda Sign Off	I
Chair	02/12/2025	NHS Providers Chairs & CEO's Network Meeting	E
Chair	02/12/2025	NED Interview Feedback Session	E
Chair	02/12/2025	Chief Nurse	I
Chair	03/12/2025	Disability History Month Event - Joint	I
Chair	04/12/2025	Council of Governors Workshop	E
Chair	04/12/2025	Council of Governors Meeting	E
Chair	04/12/2025	NHFT Board Development Session	E
Chair	05/12/2025	NED Mid-Year Review	I
Chair	05/12/2025	Chief Finance Officer	I
Chair	05/12/2025	Group Director of Strategy & Partnership	I
Chair	05/12/2025	Director of Comms (LPT)	I
Chair	05/12/2025	Audit & Risk Committee	I
Melanie Hall	08/12/2025	SID Role discussion with NHSE	E

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Chair/NEDs	08/12/2025	LPT NED Informal Catch Up	I
Melanie Hall	09/12/2025	Monthly meeting with FTSU Guardians	I
Chair/NED	09/12/2025	NED Mid-Year Review	I
Chair	09/12/2025	System Chairs Meeting	E
Chair	09/12/2025	NHS Confederation and NHS Providers Quarterly Shared Leadership Forum	E
Melanie Hall	10/12/2025	Service Visit - Short Breaks	I
Chair	10/12/2025	Mental Health Network Chairs Conference Call	E
Chair	10/12/2025	System Chairs/CEOs Meeting	E
Hetal Parmar	10/12/2025	GGI 2025 Insights	E
Chair	11/12/2025	Induction for Midlands Aspiring Chairs Event	E
Melanie Hall	15/12/2025	Service Visit Charnwood CMHT	I
Chair/NED	15/12/2025	NED Mid-Year Review	I
Chair	15/12/2025	UHL/UHN Chair	E
Chair	15/12/2025	NHFT NED Informal Catch Up	E
Chair/NED	18/12/2025	NED Mid Year Review	I
Chair	19/12/2025	Joint Corporate Governance Catch Up	E
Chair	19/12/2025	Charitable Funds Committee	I
Chair	22/12/2025	CEO	I
Chair	22/12/2025	NHSE Midlands Chairs & CEOs	E
Chair	22/12/2025	NHFT Private Board	E
Chair	30/12/2025	Group Trust Board Agenda Sign Off Session	I
Chair	06/01/2026	CEO	I

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Chair	06/01/2026	NHFT NED Mid Year Review	E
Chair	06/01/2026	NHFT SID	E
Chair	07/01/2026	NHFT NED Mid Year Review	E
Chair	07/01/2026	Mental Health Network Chairs Conference Call	E
Chair	07/01/2026	Joint Corporate Governance Catch Up	E
Josie Spencer	07/01/2026	Meeting with NHFT QSC Chair	I
Chair	08/01/2026	LNR ICB Chair	E
Chair	08/01/2026	NHFT NED Mid Year Review	E
Chair	08/01/2026	LPT Board Agenda Setting Meeting	I
Chair	08/01/2026	NHFT Board Agenda Setting Meeting	E
Chair	09/01/2026	NHS Providers: AFT Programme Consultation Event	E
Chair	12/01/2026	NHS Confed all member chairs group	E
Chair	12/01/2026	Chief People Officer	I
Melanie Hall	13/01/2026	Monthly catch up with FTSU Guardians	I
Chair	13/01/2026	System Chairs Meeting	E
Chair	14/01/2026	NHFT AFT Application Review meeting with NHSE	E
Josie Spencer	14/01/2026	EMA QSC Chairs network	E
Chris Stark	16/01/2026	DAISY staff award presentation	I
Chair/NEDs	*19/01/2026	Joint NED catch up meeting	I
Chair	*19/01/2026	NHSE Midlands Chairs & CEOs	E
NEDs	*20/01/2026	LPT Monthly Team Brief	I

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Chair	*20/01/2026	Aspiring Chair Talent Programme	E
Melanie Hall	*21/01/2026	SID meeting with Chair	I
Melanie Hall	*21/01/2026	ISLA Community Service visit	I
Chair	*21/01/2026	Monthly SID Meeting	E
Chair	*21/01/2026	Mental Health Network Chairs Conference Call	E
Chair	*21/01/2026	Joint Corporate Governance Catch Up	E
Chair	*21/01/2026	Deputy Chairs	E
Josie Spencer	*21/01/2026	Service visit Physical Health Team - TBC	I
Chair	*26/01/2026	Consultant Interviews	I
Melanie Hall	*27/01/2026	FPC Agenda review meeting	I
Melanie Hall	*27/01/2026	FTSU Strategic meeting	I
Melanie Hall	*28/01/2026	Transformation and QI Meeting	I
Josie Spencer	*28/01/2026	Networking meeting with Provider NED's	E
NEDs/Chair	January 2026	Induction Meetings for new NED/ANED	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 27 January 2026

Managing Director's Report – Public

Purpose of the Report

This paper provides an update on current local developments since the last Board meeting. The details below are drawn from a variety of sources, including local meetings, board visits and through system and Trust governance processes.

Local developments and innovation

National Oversight Framework

Our Trust retained its place in Segment 2 of the new National Oversight Framework for all NHS Trusts. We were ranked 21st out of 61 community and mental health trusts for the second quarter of 2025-26.

New frenotomy service starts

We launched a new pilot frenotomy service to support babies and families experiencing feeding difficulties due to tongue-tie, a condition affecting around one in ten newborn children. This will involve LPT's Healthy Together infant feeding team running weekly clinics for babies aged eight days to 18 weeks until March 2027. Initial feedback received has been positive, both from the families and health partners.

Neighbourhood Developments

LPT will be managing a £900,000 project to improve mental health support at Loughborough's Fearon Hall. This will include a 24/7 open day to anyone with mental health problems, removing the need to see a medical professional such as the GP or a neighbourhood mental health team, and the need to have an appointment.

Fearon Hall is an existing informal setting, with trained support workers who will offer advice and support when people walk through the door. They have access to partners such as GPs, adult social care, Department of Work and Pensions and housing providers. Funding has been provided by Leicester, Leicestershire and Rutland ICB.

The City neighbourhood leads successfully secured additional grant funding from Leicester City Council to increase one to one support in neighbourhood mental health cafes; meaning more people will be able to receive one to one support and support Voluntary Community Sector organisations to offer more follow up support and sessions to individuals.

Flu vaccines for children

Our School Aged Immunisation Service has offered more than 160,000 children and young people a free flu vaccine to help to protect them against the virus this winter. They have visited every

primary, secondary and special school in Leicester, Leicestershire and Rutland (LLR), and held "catch up" clinics over the Christmas holidays to reach any who had missed out.

Christmas at LPT
Our Raising Health team coordinated an appeal which enabled us to deliver 600 presents worth £20,000 to inpatients who were with us on Christmas Day. The value included cash and gifts-in-kind from sponsors Dunelm and Giving World, with volunteers from our capital works contractor Tilbury Douglas helping to pack the gifts. In addition, Leicester City Football Club delivered five sacks of gifts chosen from patient wish to one of LPTs Child and Adolescent Mental Health units, bringing festive joy to teenagers receiving mental health care.

Advice to patients with long-term lung conditions
Our long-term conditions team offered advice to patients with chronic lung conditions which was designed to help them manage their conditions and prevent admission to hospital. The pilot project focussed on patients with Chronic Obstructive Pulmonary Disease (COPD) in North-West Leicestershire.

Conference shares pressure ulcer learning
Around 50 nurses, health care support workers and therapists attended our first ever pressure ulcer prevention conference, designed to spread knowledge about how to prevent and treat pressure ulcers.

Resident doctor strikes
Some resident doctors who are members of the BMA took strike action in November and again in December. Our contingency plans helped to minimise disruption, meaning LPTs services remained robust and effective throughout the strikes.

HSJ awards
Our change leaders attended the HSJ healthcare industry awards event, as the Our Future Our Way programme was shortlisted in the Staff Wellbeing category for these awards. Unfortunately, they were not the ultimate winners, however it was great recognition of the work undertaken to change the culture within LPT for the better.

Team Time Out 2025 concludes
More than 200 LPT teams took part in Team Time Out, getting to know each other and building team spirit in a variety of off-site activities. These included meditation, sports days, boat rides, meals out, crafts and more. More than 98% of teams who shared feedback said the initiative improved their team's health and wellbeing.

Website advice
We added Winter Wellness hubs to our Health for Kids and Health for Under 5s websites, giving parents and carers advice on how to prevent or treat seasonal bugs.

Health and Wellbeing Boards
Both the City and County Health and Wellbeing Board (HWBB) meetings took place in December 2025 as well as the bi-monthly LPT/Healthwatch meeting. A Board member also attended the County Health Overview and Scrutiny Committee, the Leicester, Leicestershire and Rutland (LLR) Joint Health Safety Committee in November and the Rutland HWBB in December.

Key discussion points at the Rutland HWBB included our neighbourhood strategy and the Rutland joint health and wellbeing strategy. At the LLR Joint Health Safety Committee digital focus was given to the digital tools available and being developed for patients and those supporting them. In the City HWBB topics related to the SEND Alliance Change Partnership programme, the healthy weight programme and the board received an update from the young voices' consultation. In Leicestershire HWBB presentations were received from the Office of the Police and Crime Commissioner as well as updates on the Neighbourhood Models of Care and the Dementia strategy.

Partnership Training
For three mornings in November (25th, 26th and 27th), LPT provided resilience and circles of influence training to circa 120 East Midlands Housing employees who deal directly with residents regularly, to increase their awareness of mental health support in LLR.

Adverse weather
In December the Met Office and UK Health Security Agency issued amber cold health alerts for the East Midlands, escalating to freezing and snow alerts in early January as Storm Goretti made its way across Europe and the British Isles. Business continuity plans were enacted and although the snow fall did not reach anticipated levels, wet and freezing conditions proved to make travelling conditions hazardous. Despite this our staff and services went above and beyond to ensure patients continued to be well looked after during this period.

Urgent and Emergency Care (UEC)
In December and January, the UEC system has sustained significant pressure within the UEC pathways which led to the opening of Grace Dieu ward within LPT in December. In January the sustained demand has led to the opening of all available capacity within the Healthcare footprint, including the use of escalation areas in UHL and one over capacity in both LPT and UHL. On a number of occasions, a pause to the release to respond mandate has been enacted. Colleagues continue to work in partnership to manage the risk and ensure patient safety is maintained.

In November 2025 the National Getting It Right First Time (GIRFT) team undertook a review of the management of mental health patients within the UHL footprint. The outcome of the review was overall very positive and there are a number of recommendations which are currently being actioned as a system.

Digital Developments
The Looked After Children's health team has created a Care Leavers code and icon which is to be added to the Young People's SystmOne Health record at the point they leave care at 18 with their explicit consent.

Digital Health Transformation Service Team celebrated of 10 years of innovation in the NHS driving forward technology in line with THRIVE strategy and 10-year plan.

Care Quality Commission (CQC)
The CQC carried out an inspection of our community mental health services for adults of working age in May 2025. The inspection was part of a series of inspections of mental health services across England following publication of the Section 48 review into Nottinghamshire Healthcare NHS Trust after a fatal incident in Nottinghamshire. The report was published on the CQC website on Wednesday 14 January 2026 with the outcome being that the service was rated as 'requires improvement'.

In November 2025 there was an unannounced inspection of the Children and Adolescent Mental Health Community Services and we await the outcome of the inspection which we expect in due course.

Staff and Patient Voice

Service visits
21 Service visits were undertaken by the Board in November and December across a range of operational and enabling services and sites, including the community integrated neurology and stroke services, acute mental health inpatient units and learning disability psychology and community nursing services. One visit undertaken very early morning, during handover from night to day staff, to ensure colleagues working out of normal hours have the opportunity to be heard and thanked. Board members listened to staff enthusing over their NHS journey's including a members of staffs own apprenticeship journey leading to them being appointed a Podiatrist within the Community Health Services Division. Board members undertaking visits also listened to the passionate journey of a member of the Community Mental Health Team's (CMHT) Adults and Older Adults team talk about the hugely positive impact the Women's Group they set up 15 years previously continued to have on the women in their community.

Patient Voice
DAISY Awards are an international recognition programme that honours and celebrates the exceptional care many nurses and midwives provide every day. In November, an Advanced Nurse Practitioner within Community Health Services received a nomination and became an honouree following the family of a patient calling her 'exceptional', compassionate, professional and dedicated whilst treating their mother.

Children's Young People and Families engagement called "What You Saying?" led by LLR, in which LPT participated, report findings issued in December 2025. Over 3,000 voices heard, including young people, parents/carers, and healthcare professionals to shape local health and care services via LLR ICB's 3-Year Children's, Young People & Families Engagement Plan (2025-2028).

Positive feedback from patients on Watermead and Beaumont Wards at the Bradgate Unit was received during a service visit, praising staff for taking such great care of them.

Enormous thanks to all staff and partners who are taking such an active role in achieving our vision of creating high-quality compassionate care for all.

Relevant external meetings attended since last Trust Board meeting

December 2025	January 2025
LPT & Healthwatch	LLR & Northamptonshire Freedom to Speak Up and Executive Leads
Trust legal team	Joint CQC Workshop
Group Strategic Executive Board	NHSE/LPT/NHFT Provider Review Meeting
Joint Governance & Risk Leadership Group	Group Strategic Executive Board
Leicester City Health & Wellbeing Board	Public Health and Health Integration Scrutiny pre-meet
Leicestershire County Health & Wellbeing Board	LLR SRO ASC Super Surge action
LLR Urgent & Emergency Care Collaborative	Midlands COO/MD/DoN/NHSE monthly
Joint People and Culture Committee in common	Leicestershire, Northamptonshire and Rutland Health Partners' Executive
	*Principles of Incident Response seminar
	*Public Health and Health Integration Scrutiny
	*Joint Governance & Risk Leadership Group
	*Group Trust Board
	*LLR Academy Reverse Mentoring for Inclusion Celebration Event - speaker
	*LLR Mental Health Collaborative
	*LLR Developing Diverse Senior Leaders Celebration event

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

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:	Jean Knight, Managing Director
Paper authored by:	Jean Knight, Managing Director Sam Beaty, Business Manager
Date submitted:	19.01.26
Name and date of other committee / forum at which this report / issue was considered:	
Level of assurance gained if considered elsewhere	☐Assured ☐ Partially assured ☐ Not assured
Date of next report:	March 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 27 January 2026

Board Assurance Framework

Purpose of the Report

A summary of strategic risks on the Board Assurance Framework (BAF) and changes made in the last two months since the last Trust Board meeting on the 25 November 2025.

Analysis of the Issue

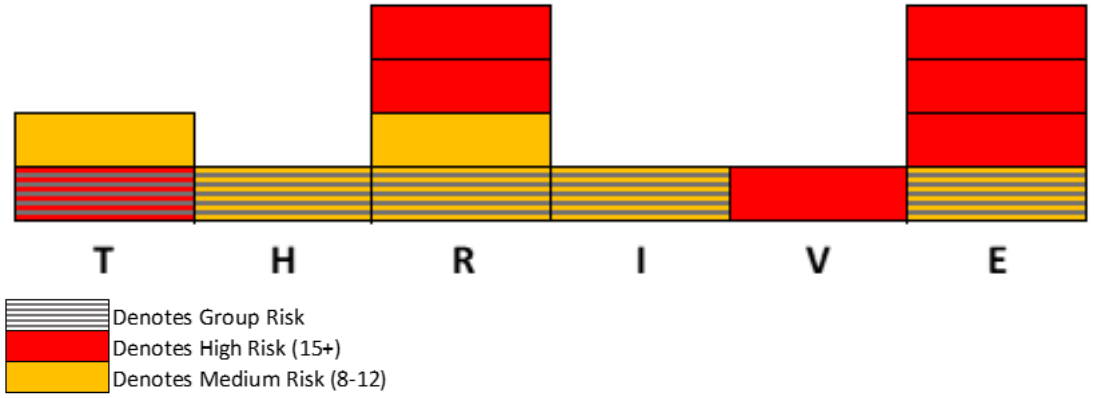
An effective BAF supports the understanding and discussions around delivery of the Trust's strategic objectives as detailed in our strategy THRIVE, by identifying the principal risks that may threaten the achievement of those objectives. The full BAF (provided separately) contains risks which are overseen either by the Leicestershire Partnership NHS Trust (LPT) Board, and those which are prioritised for oversight across our Group model arrangement with Northamptonshire Healthcare NHS Foundation Trust, the detail of which is provided to the Group Trust Board.

T H R I V E

BAF Summary

No	BAF No.	Risk Title	Score
Section 1 - T Technology [Finance and Performance Committee Oversight]			
1	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
2	BAF1.1	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]			
3	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]			
4	GROUP BAF 3	If we are unable to build a sustainable approach to the continual development our **research, innovation and professional learning 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
5	BAF3.1	Without **timely access** to services, we cannot provide high quality safe care for our patients which will impact on clinical outcomes.	20
6	BAF3.2	If we do not continue to review and improve our systems and processes for **patient safety**, we may not be able to provide the best experience and clinical outcomes for our patients and their families.	15
7	BAF3.3	If we do not have appropriate **emergency preparedness**, resilience and response controls in place, we may be impacted by accidents, disruption and system failures affecting our ability to maintain continuity of services.	8
Section 4 – I Including Everyone [People and Culture Committee Oversight]			
8	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
Section 5 – V Valuing people [People and Culture Committee Oversight]			
9	BAF 5	If we do not adequately utilise **workforce** resourcing strategies, we will have poor recruitment, retention and representation, resulting in high agency usage.	20
Section 6 – E Efficient and Effective [Finance and Performance Committee Oversight]			
10	GROUP BAF 6	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
11	BAF 6.1	If we cannot maintain and improve our estate, or respond to maintenance requests in a timely way, there is a risk that our estate will not be fit for purpose, leading to a poor-quality **environment** for staff and patients.	20
12	BAF 6.2	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
13	BAF 6.3	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

The risk profile for all 13 BAF risks is provided below, by our strategy ‘THRIVE’



LPT BAF Changes during December 2025 and January 2026

Since the last LPT Trust Board held on the 25 November 2025 the following changes have been made, these have been reviewed and approved by the LPT Strategic Executive Board (SEB) ahead of presentation to Board for final approval;

- The sections for I and V (which were combined on the BAF) have been separated for clarity. This has changed the numbering for some risks on the LPT BAF.
- We will be proposing to combine the LPT BAF4.2 [now numbered BAF5] & NHFT BAF6 both relating to the use of workforce strategies to become a Group BAF risk. Subject to approval by the Group Trust Board, the risk will be overseen by the Group People and Culture Committee.
- 16 actions from the LPT BAF action log (which tracks and manages progress with the mitigations detailed within the BAF risks) were presented to SEB (13 in December 2025 and three in January 2026) and were supported ahead of approval by the Trust Board this month; they are detailed below.

Closures

December 2025

BAF no.	Action	Exec Lead
3.4 EPRR	EPRR policy compliance Group	Managing Director
3.4 EPRR	Developing LPT winter plan to feed into LLR winter plan to be agreed by NHSE	Managing Director
4.2 Workforce	Workforce Development Group to monitor time to hire	Group Chief People Officer
4.2 Workforce	Directorate level time to hire reports	Group Chief People Officer
4.2 Workforce	Review rostering policy in line Internal Audit Report	Group Chief People Officer
4.2 Workforce	Deep dive into agency & bank use to EMB Oct 25	Group Chief People Officer
5.2 Environment	Medical Directorate rep at relevant Estates meetings to be identified	Medical Director

5.2 Environment	Oversight of financial constraints via SEB and Trust Board meetings	Director of Finance
5.2 Environment	Governance route escalations EMEG	Chief Finance Officer
5.2 Environment	Annual Estates Plan approved	Chief Finance Officer
5.2 Environment	Escalation of Health & Safety issues	Chief Finance Officer
5.2 Environment	Oversight of estates risks on Ulysses	Chief Finance Officer
5.4 Finance	DMH to manage private provider costs as business as usual	Director of Mental Health

January 2026

BAF no.	Action	Exec Lead
6.4 Finance	Enhanced cash reporting	Director of Finance
6.4 Finance	Closure of plan gap with additional recovery actions	Director of Finance
6.4 Finance	Deep dive reporting at EMB/ SEB/FPC/TB where required	Director of Finance

Proposal

- To approve the proposed changes, including the closure of actions which mitigate risk on the BAF
- To present the impact of these changes in terms of additional controls and assurance, and potential rescoring of risk where relevant in the next iteration of the BAF.

Decision Required: Approval of proposed changes

Governance Table

For Board and Board Committees:	Trust Board 27 January 2026
Paper sponsored by:	Kate Dyer Director of Governance and Risk
Paper authored by:	Kate Dyer Director of Governance and Risk
Date submitted:	19 January 2026
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 10 February 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:	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

LPT Board Assurance Framework

January 2026

BAF **1.1**	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 11.12.2025
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 **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 **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	Assurance of security posture/compliance from core IT service suppliers. Impact of training and phishing campaigns	• Implement InTune as the new Trust MDM. **Chief Information Officer (CIO) March 26** • Collaboration with cyber security teams across LLR. **CIO March 26** • Adoption and deployment of strategic cyber security solutions **CIO March 26** • Governance Plan to Jan EMB to clarify clinical digital leadership - **Feb 26**	• 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.
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 **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		Cyber training action plan to address this control gap to Jan EMB – **Feb 26** DTAC process review **Director of Finance March 26**	Escalation of capital limitations impacting on delivery of digital agenda to EMB Raised at next IMTC to gain clarity on what is currently in place. – NHFT/DTS sharing their approach and process which Audit and NHSE have recommended.

BAF **3.1**	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	18 December 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 • collaborative meetings • Waiting well web page live 31 Oct 2025	• National strategy for neurodiversity demand • Local commissioning plans for addressing significant increases in neurodiversity demand • Global shortage of ADHD medication	**1st Line:** Directorate attendance at Access Group and AFM WL trajectories and initiatives by service Operational risk profile AFM/EMB	Linkage of health inequalities to access group actions Clarity over policy compliance	• Health Inequalities work to support Access Group actions. **Director of Strategy – Paper to SEB Jan 26** • Policy compliance with access policy – Director of Governance – **February 2026 Access Delivery Group** • 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) **Interim Director of FYPCLDA Jan 26**	ADHD Solutions closure means reduction in support across LLR as detailed on CRR. Control gaps outside of LPT remit to address.
		2nd Line: • Access Group with AAA to AFM/EMB • Board Development session held 30 Oct 25 • Monitoring NHS111/2 activity in directorate and shadow MH • Clinical task and finish group workplan with priorities agreed			
		3rd Line: • Internal Audit – Patient Observations 24/25 significant assurance • Internal Audit – Remote Consultations March 2023 significant assurance • CQC feedback and ratings			
Effect: **Clinical Outcomes**					
• Reducing Harm Whilst Waiting Policy & compliance oversight • Help while waiting website • Clinical Outcome performance measures • Incident reporting & learning from incidents • Quality & Safety Metrics dashboard Report	- Data insight & reporting on harm whilst waiting	**1st Line** Directorate attendance at Access Group and AFM for escalation	Clarity over policy compliance measures and rates	• Accountability framework with key safety & quality metrics as defined by the CNO (in line with insightful board guidance and national operating framework presented to EMB on 2 December 2025. Further work to develop agreed set of metrics ongoing. **Managing Director Jan 26**	Quality dashboard delivery framework developed (3-year programme)
		2nd Line Monthly performance report with clinical outcomes measures to Quality and Safety Committee and AFM Clinical Harm – no overarching policy so local processes in place for consistency	Comprehensive quality dashboard focusing on outcome measures, including those attributed to waiting		
		3rd Line - Annual feedback from Community & Mental Health Survey	External review of waiting times on patient safety		

BAF **3.2**	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 13 January 2026
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**	**15**
Target Risk	5	2	10

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: Patient safety systems, processes and governance improvement & learning, CQC outcomes					
• Service safety checks/huddles & escalation • CQC mock inspections & quality visits • Safety Forum • Psychological Safety Workstream • Complex Case Huddle • System and process learning shared through governance meetings • PSIRF priorities agreed at EMB Oct 25	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 Safety Huddle confirmation of improvements in patient safety	• Suicide prevention work & training **Medical Director, update – QSC Feb 26** • Completion of the agreed PSIRF thematic reviews- 1 complete, 2 further dues for completion **Chief Nurse update Feb 26** • Weekly complex case huddle ongoing – evaluation planned for March 26 • Safety Huddle evaluation audit taking place – reporting March 26 to Safety Forum – March 26	• 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 • Quality & Safety Metrics dashboard Report	Effective use of technology to support data analysis	**1st Line:** Directorate oversight of local quality & safety systems and processes.	Comprehensive oversight of quality measures	Further definition of safety and quality metric set to be confirmed **Managing Director Jan 26**	Quality dashboard delivery framework developed (3-year programme). Accountability framework with key safety & quality metrics presented to EMB on 2 December 2025, to QSC Jan 26
		2nd Line: Horizon scanning & national leaning			
		3rd Line: Coronial feedback/NHSE oversight; HOSCs			

BAF **3.3**	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 • 1st draft LLR winter plan 25/26 – agreed by NHSE • 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 **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			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
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 **2nd Line:** Training oversight and management Submitted EPRR core standards assessment for 2025/26 **3rd Line** • Internal Audit – Business Continuity August 2022 Significant Assurance • EPRR core standards assessment 2025/26 – full assurance received.	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**	Taken part in industrial action audit for national review.

BAF **5**	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 15th January 2026
Strategic Link	THRIVE: **VALUING EVERYONE**	
Governance	Group People and Culture Committee, Group Strategic Executive Board, Group 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**					
• WRES & WDES action plans Directorate plans 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	• Actions resulting from recent staff survey findings when available	• Delivery of the workforce and agency reduction plan 2025/26 **Group Chief People Officer March 26** • Workforce Operational Plan refresh **Group Chief People Officer March 2026** • Analysis of staff survey results once embargo is lifted- **March 26**	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
		2nd Line: Workforce Development Group (including oversight of time to hire); Directorate Workforce groups & HCA Retention Working Group Strike Action Group (as required) including organisational debriefs; People & Culture Committee	• Delivery of the workforce and agency reduction plan • Refresh the workforce operational plan		
		3rd Line: System people and culture board System CPO meetings Internal Audit E-Rostering Oct 2025 Moderate Assurance Internal Audit Time to Recruit Nov 2025 Significant Assurance			
Effect: **High Agency Usage**					
• Agency Reduction Plan • Jobtrain implemented • Safe staffing Policy • Dynamic Risk Assessment process (DRA)	Nurse vacancies	**1st Line** EQIAs DRA and break glass criteria to stop deployment of Thornbury HCA		Delivery of the workforce and agency reduction plan **Group Chief People Officer March 26 as above**	• No off-framework usage outside of break glass • THP numbers reducing • Benefits realisation of Jobtrain
		2nd Line Agency reduction group AAA to People & Culture Committee EMB deep dive review of bank and agency Oct 25	Delivery of the workforce and agency reduction plan		
		3rd Line • LLR People Programme Delivery Group • Internal Audit Agency Staffing April 2023 Advisory (no high-risk actions)			

BAF **6.1**	If we cannot maintain and improve our estate, or respond to maintenance requests in a timely way, there is a risk that our estate will not be fit for purpose, leading to a poor-quality **environment** for staff and patients
Date	Included 1 April 2025. Last updated 15.1.2026
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, August 26** • Through the Strategic Property Group an updated assessment of clinical, supervision and training space will take place – **March 26**	
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 Oversight of financial constraints via SEB and Trust Board meetings **3rd Line:** CQC feedback			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	• 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 process for identifying and logging environmental concerns	• Review building compliance standards with Chief Nurse & **Chief Finance Officer – Feb 26** • Comms to support adherence to process for identifying and logging environmental concerns – **Feb 26**	Ongoing CRR/ directorate risk reviews taking place

BAF 6.2	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 09.01.26
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 top slice of capital funds in 2026/27	• Requested deferral of £1.8m to 26/27 **Director of Finance and Performance. Nov 25** • External audit of 25/26 accounts **Director of Finance and Performance** June 2026	NHSE approved; action closed
		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	None		
		2nd Line: Monthly corporate report EMB/SEB/FPC and oversight at the System Finance Meeting & system capital committee including any relevant escalations			
		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~~ LLR infrastructure plan **Director of Finance and Performance Feb 26**	In progress
		2nd Line			
		3rd Line KPMG 2024/25 annual accounts and VFM conclusion	25/26 annual accounts audit	**External audit of 25/26 accounts Director of Finance and Performance June 2026**	
Effect: **Non achievement of capital strategy (LPT and System)**					
• National planning guidance – LPT & ICS delivery plan	• LLR ICB medium term capital strategy • Management of Trust's capital plan	• **1st Line:** ICS Capital committee reviews organisational delivery & ICS Finance committee		• Submit LPT 26/27 & medium-term plan. **Director of Finance Feb 26** • Manage Trust's capital plan **DoF March 26**	In progress
		2nd line:			
		3rd line:			

BAF 6.3	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 09.01.26
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 ward closure could lead to increased private provider costs	• Deliver forecast outturn position for each directorate **All Exec directors Mar 26** • External audit of 25/26 accounts **Director of Finance and Performance June 2026**	
		2nd Line: Accounting policies / SFIs and SORD [Audit and Risk Committee]	Policy compliance		
		3rd Line: External Audit 24/25 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	• CIP – identify & deliver CIP programme **Mar 26** • Ensure transparent & compliant contract awards **Mar 26** • Policy compliance audit and oversight **DoF Mar 26** • External audit of 25/26 accounts **DoF June 2026** • DoF/service financial escalation meetings**-Mar 26**	
		2nd Line:	Beacon Unit viability; non recurrent CIP; In year overspends & funding gaps.		
		3rd Line: Annual Internal Audit – Budget setting, reporting and monitoring – significant assurance November 2025			
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 Feb 26**	
		2nd Line			
		3rd Line KPMG 2024/25 annual accounts and VFM conclusion	25/26 annual accounts audit		
Effect: **Non achievement of financial strategy (LPT and System)**					
• LPT financial strategy & plan	• LLR ICB revenue strategy • 24/25 non delivery of ICB plan & 25/26 variances	• **1st Line:** Organisational reports to ICS Finance Committee	In year LLR plan delivery materially off plan	• Develop 26/27 & medium-term financial plan **DoF Feb 26** • 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

Alert, Advise and Assure Highlight Report

Audit and Risk Committee - 5 December 2025

Meeting Chair and Report Author Hetal Parmar / Val Glenton

Quorate Yes

ALERT: Alert to matters that need the Board's attention or action, eg areas of non-compliance, safety or threat to the Trust's strategy

Agenda Item:	Reference:	Lead:	Description:	BAF Ref

ADVISE: Advise the Board of areas subject to on-going monitoring or development or where there is negative assurance

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Counter Fraud, Bribery and Corruption Progress Report	ARC/25/073	Anti-Crime Team Manager, 360 Assurance	Discussion focused on component 11 of the Counter Fraud Functional Standard (CFFS) 'access to and completion of training' which was unlikely to achieve compliance by year end, it was currently RAG rated amber. This was the same position as the 2024/25 final submission.	N/A

T H R I V E

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
			This is an advise not an alert as the Trust does have specific and targeted training and awareness programmes in place and the Trust's Counter Fraud Specialist has delivered fraud awareness training to HR, Finance, Procurement, FTSU and Estates & Facilities staff (ie'high risk' staff). Materials are available and promoted to all staff in the Trust. Counter Fraud Awareness is not currently part of mandatory training for the Trust which has been discussed and agreed within the organisation. While this would provide additional evidence that could lead to a green RAG rating, the Trust's view is that due to the other programmes that are in place, there is no evidence that there is a weakness in our arrangements. ARC noted all other components of the CFFS were on track to be delivered.	
Governance and Risk Report	ARC/25/078	Director of Governance and Risk	Phase three of the policy improvement process was taking longer than expected to implement as the introduction of compliance measures to policies had been more complex than expected.	N/A

ASSURE: Inform the Board where positive assurance has been received

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Counter Fraud, Bribery and Corruption Progress Report	ARC/25/073	Anti-Crime Team Manager, 360 Assurance	ARC received a good level of assurance on the work of the Counter Fraud, Bribery and Corruption Team specifically on the proactive and reactive areas of work.	N/A
Counter Fraud, Bribery and Corruption Policy	ARC/25/077	Director of Governance and Risk	**Policy approval** ARC approved the policy which had been updated to reflect the 'Failure to Prevent Fraud' standard as set out in the Economic Crime and Corporate Transparency Act 2023 that came into force on 1 September 2025.	N/A

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Governance and Risk Report	ARC/25/078	Director of Governance and Risk	ARC received a good level of assurance that robust systems and processes were in place to secure an effective governance and risk framework and in particular on the policy improvement system. Key areas of work included; • A review of the risk module on Ulysses to ensure that automated risk reports were easily accessible. • The work being undertaken with NHFT to review the Risk Management Policy with a view to developing a group policy that would take account of arrangements for a group BAF. • Phase three of the policy improvement programme was being implemented. LPT had 222 policies in total, all were in date and being put into an accessible format. The plan was to introduce policy compliance measures as part of this phase and to highlight input from people with lived experience.	N/A
Chief Executive Waivers and Awarded Tenders Q2 2025/26	ARC/25/079	Director of Finance	ARC received assurance that a robust system was in place for waivers, 52 had been approved this year to date which compared favourably to 61 over the same period the previous year. A £1.1m reduction in value had also been seen which demonstrated the ongoing improvement work by the Procurement Team was having a positive effect.	N/A
Freedom to Speak Up Annual Report	ARC/25/081	Freedom to Speak up Guardian	ARC received an update on the work of the FTSU Guardians and was assured by the range of activities they carried out. ARC noted the increase in cases reported which was evidence of greater staff confidence in raising concerns.	N/A

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding

Agenda Item:	Reference:	Lead:	Description:	BAF Ref

I

Leicestershire Partnership NHS Trust

Public Trust Board 29th January 2026

NHSE Core Standards for EPRR – Final Position

Purpose of the Report

This report provides assurance that Leicestershire Partnership NHS Trust (LPT) is fully compliant in discharging its EPRR responsibilities, aligned to the LPT EPRR Policy and the Civil Contingencies Act (2004).

Analysis of the Issue

Compliance with the NHS Core Standards for EPRR

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

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

In 2025, LPT were required to report against **58 standards** that are grouped across the **10 domains** Listed below. There was no deep dive in this year's self-assessment.

T H R I V E

Ser	Domain	Number of Standards applicable to a Community and Mental Health Trust
01	Governance	06
02	Duty to Risk Assess	02
03	Duty To Maintain Plans	11
04	Command and Control	02
05	Training and Exercise	04
06	Response	05
07	Warn and inform	04
08	Cooperation	04
09	Business Continuity	10
10	CBRNE	10
Total		**58**

EPRR Core Standards Score – 2024 (previous year)

In 2025 NHSE deemed LPT to be **Fully Compliant** with an agreed overall compliancy rate of **100%**, broken down into 54 Standards fully compliant and 04 Standards partially compliant.

EPRR Core Standards Score – 2025 (current)

LPT has completed and finalised the self-assessment against the applicable NHS Core Standards for EPRR in England. Following the confirm and challenge process with LLR ICB and NHSE, LPT have again been deemed **Fully Compliant** with this year's EPRR Core Standards.

EPRR Work Programme / Core Standard Observations

A number of observations were noted by ICB/NHSE. These items have been incorporated into LPT's EPRR's annual work programme for 2025/2026. The work programme is reportable to the bi-monthly EPRR Business Continuity and Emergency Planning Steering Group to monitor progress.

Proposal

To accept the paper as assurance of LPT's position

Decision Required

Briefing – no decision required.

Governance Table

For Board and Board Committees:	LPT Trust Board
Paper sponsored by:	Jean Knight – Accountable Emergency Officer
Paper authored by:	Dan Adamson – Shared Head of EPRR
Date submitted:	15/1/2026
Name and date of other committee / forum at which this report / issue was considered:	Health and Safety Committee – 6th November 2025 Local Health Resilience Partnership – 20th November 2025 Quality and Safety Committee – 8th January 2026
Level of assurance gained if considered elsewhere	☒Assured ☐ Partially assured ☐ Not assured
Date of next report:	N/A
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)	BAF 3.1
Is the decision required consistent with LPT's risk appetite:	n/a
False or Misleading Information (FOMI) considerations:	n/a
Positive confirmation that the content does not risk the safety of patients or the public:	Y
Equality considerations:	Y

J

Leicestershire Partnership NHS Trust

Alert, Advise and Assure Highlight Report

Quality and Safety Committee 08 January 2026

Meeting Chair and Report Author - Josie Spencer Non- Executive Director & Interim Deputy Chair

Quorate Y

Policies and expiry date: Nil

ALERT: Alert to matters that need the Board's attention or action, eg areas of non-compliance, safety or threat to the Trust's strategy

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Risk based Deep dives	QSC/25/178 QSC/25/179 QSC/25/179		Due to time constraints the following papers were deferred to the February 2026 Committee: • Community Nursing • Audiology • Complaints Performance assurance report	3.3
Accountability Framework Meetings Triple A	QSC/25/164	Kate Dyer	The Committee received the Triple A report from the Accountability Framework Meetings held in October and November 2025. There was one alert around waits over 52 weeks for neurodevelopmental pathways. The issue is not new; however reductions have been seen across other services and the lack of progress for neurodevelopmental assessment is the reason for the alert this time.	3.2 3.3

T H R I V E

			Further assurance was requested around the Central Access Point Quality Summit. It was confirmed that a number of actions agreed are underway and a follow up Quality Summit is planned and there are no known escalations for Quality and Safety Committee. It was agreed to reference this in the Triple A report to Trust Board and that further assurance will be sought at the next QSC in February.	

ADVISE: Advise the Board of areas subject to on-going monitoring or development or where there is negative assurance

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Action Log – Paper B	QSC/25/161	Kate Dyer Linda Chibuzor	**Action 766- Formalised approach to escalation of issues relating to Freedom to Speak Up (FTSU).** The FTSU NED has changed and is now Melanie Hall. A paper detailing options being explored for future reporting for FTSU is going to the January 2026 Executive Management Board (EMB) and will update the Committee in February 2026. **Action 774-Equality and Quality Impact Assessments (EQIA) of CIPs.** The requirements of the Committee in terms of assurance around high-risk areas have yet to be discussed. It was agreed to keep the action open until February 2026.	Group BAF 4 5.4
Board Assurance Framework	QSC/25/163	Kate Dyer	The work around the timely access to services issue was referenced across several papers received by the Committee (including the Quality and Safety Forums and Accountability Framework meeting Triple A reports). Given that there was a Board development session several months ago, the Committee	3.2

			requested that an update paper is received in February 2026, with a focus on the assurance required in regard to "staying safe whilst waiting"	
Quality and Safety Dashboard	QSC/25/165	Linda Chibuzor	The Committee noted a special cause concern in episodes of seclusion over two hours and asked for further assurance about actions underway to manage and decrease this spike. Initial assurance was given, highlighting that the factors around reasons for seclusion are explored and involvement of Heads of Nursing outside of the immediate team, to identify any possible remedial actions and explore different care provision for individuals. It was confirmed that there is no target applied so it is difficult to confirm a trend, the restrictive practice lead will be asked to give additional context in the narrative for future reporting, to provide a balance in terms of information and assurance.	3.3
Penny Dash Report	QSC/25/168	Linda Chibuzor	The Committee received an update report on the Penny Dash Patient Safety Review from July 2025, which looked at six national bodies with responsibilities for patient safety and identified some key recommendations, including simplifying oversight, strengthening leadership culture, develop data and learning, improve workforce capability and reinforcing the principles of the National Quality Board. Work is underway across the Group model to look at governance arrangements. The ongoing work is being reported to EMB and has oversight of the Quality and Safety Forums and this Committee will receive a further update in February 2026, which will include timelines. Given the report the Committee anticipates a need for an increased focus on the patient voice lived experience perspective on the agenda and workplan going forward into the new financial year.	3.3
Level 2 Safety Forum AAA Reports	QSC/25/171	Dr Bhanu Chadalavada	The Committee received the Triple A reports from the October and November 2025 Safety Forums. From October 2025, the Committee received an alert in regard to a Regulation 28 Prevention of Future Deaths notice to which the Directorate has submitted a detailed response. The Committee requested an update on the status of the progress of the areas identified as Alert or advise in the following Safety forum AAA reports, requesting clarity on the actions and outcomes relating to the PfD and the Welford ward seclusion item, which will be provided in February's meeting.	3.3

			The Committee was advised of proposed ICB changes to Oral Nutritional Supplement prescribing and a move towards promoting homemade nutritional drinks, which will be challenging to implement, particularly with Eating disorder patients and this is being followed through the system	
Learning from Deaths reports	QSC/25/177	Dr Bhanu Chadalavada	The Committee received two reports: the Learning from Deaths triple A report and the Safety and Quality in Learning from Deaths Assurance Paper (Quarter 2 2025-26) **Learning from Deaths triple A report** The Committee was advised that CHS have strengthened their mortality review process by implementing a review of a minimum five random inpatient deaths which once completed will be discussed at the Learning from Deaths group. In DMH, the screening is currently completed through a manual review of the notes for the agreed criteria, which is likely to become automated once SNOMED is implemented. This issue is being worked through the IM&T and Data team, a time frame for achieving this has not yet been agreed. In FYPC/LDA a detailed review of the 33 child deaths has been undertaken by a Corporate Patient Safety Team investigator. The absence of a dedicated learning from death's lead continues to put limitations on the dissemination of learning and independent oversight and is being worked through including exploring capacity for thematic reviews with colleagues in role from NHFT. The Learning from Deaths Policy has now been signed off following changes in national guidance. **Quality in Learning from Deaths Assurance Paper Q2 2025-26** The corporate patient safety team continues to work with information and data privacy colleagues to establish a process for recording cause of deaths and whilst this has been achieved quickly for CHS, there have been delays for DMH and FYPC/LDA which are being worked through to resolution. The Committee noted an issue reconciling the data presented for annual backlog of in-scope deaths with the narrative in the report, noting that for DMH the numbers have gone from 7 to 283 which indicated a significant backlog, however the narrative was not clear in the report and further assurance is being sought	3.3

			relating to the data and the narrative which will be reviewed in February's meeting It was agreed that the report, although needing to align to the national template, needs further refinement. The Committee needs to be assured that the data is robust and to understand the organisational learning and improvements in regard to Learning from Deaths. In addition, there is a need to provide the Committee with oversight of the thematic reviews and organisational learning. A number of actions were agreed to develop the Learning from Deaths report. The Committee noted that work is underway with IM & T to address issues relating to manual data collection. Post meeting note – At the time of writing Dr Bhanu Chadalavada had already followed up a number of the actions requested by the Committee and will provide a verbal update to the Board at the meeting on the 27th January 2026.	

ASSURE: Inform the Board where positive assurance has been received

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Policies approved/ extensions granted:			Nil	
Director of Nursing update	QSC/25/162	Linda Chibuzor	The LPT staff flu vaccination campaign continues with increased uptake levels, the Trust is on track to achieve the target.	3.3
Service Visits report	QSC/25/169	Kate Dyer	The Committee received the six-monthly report on the scheduled Board service visits for assurance. There were sixty visits in the six-monthly period. The visits provide an opportunity for people to engage and for services to demonstrate and share their commitment and pride in what they do. Whilst it is difficult to identify specific themes, key areas of feedback are around environment and Estates and workforce, also waiting lists and staffing pressures. There is an action tracker with	3.3

			a link with services and Directorates to ensure a follow up on issues which can be addressed. It was noted that the visits are an opportunity for contact with service users and carers, should this occur as an appropriate part of the service visit.	
Community Assessment Day (CAD)	QSC/25/170	Samantha Leak	The Committee received the presentation for assurance. LPT adopted the learning from other Trusts who had used CADs to address Musculo-skeletal (MSK) illness and provide a holistic, patient centred approach to care. Patients beyond MSK were invited to attend, including podiatry, falls and respiratory services. CADs were held in Leicestershire on two dates in 2025 and a further date is planned for 2026. LPT worked closely with ICB, UHL Physiotherapy and Active Together (local authority) colleagues to deliver these, following some funding being made available. Outcomes from evaluation of the CADs has been multi-faceted with multiple interactions taking place, referrals for pain management and specialist health and wellbeing programmes being made, there were 17 cases of undiagnosed high blood pressure and 1 case where urgent care was required. Patient feedback was positive, and learning has been identified for future events. There is a close alignment with the NHS Ten Year Plan and the Neighbourhood model and prevention agenda.	Group BAF 2
EPRR Core Standards	QSC/25/187	Jean Knight	The Committee noted the excellent position and assurance to be provided to Trust board. The report provided assurance that LPT is fully compliant in discharging its EPRR responsibilities, aligned to the LPT EPRR Policy and the Civil Contingencies Act (2004).	3.4

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding

Agenda Item:	Reference:	Lead:	Description:	BAF Ref

Medical Director update	QSC/25/162	Dr Bhanu Chadalavada	The psychological profession strategic plan was launched in November 2025. The keynote speaker at the conference was Dr Adrian Whitington, National Clinical Lead for Psychological Professions at NHSE. Resident doctor Dr Jessica Katanga won the Daksha Emson Prize for her work on health inequalities in Perinatal Mental Health. Professor Nandini Chakraborthy, consultant psychiatrist, was awarded the Royal College of Psychiatrist's President's Medal for her work on training and workforce impact.	4.2
Safety Assurance Report	QSC/25/172	Linda Chibuzor	The Safety Assurance report accompanies the Triple A reports to further illustrate the work of the Patient Safety Improvement Group. The Committee's attention was drawn to the Falls and Moving & Handling analysis for shorter patients when using commodes within community services inpatient areas, to improve patient safety, reduce incidents of falls and staff being injured. The Committee commended the continuous quality improvement work demonstrated by the commode work.	3.3

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Leicestershire Partnership NHS Trust

Public Trust Board 27 January 2026

Safe Staffing November 2025

Purpose of the Report

This report provides a full overview of nursing safe staffing during the month of November 2025, including a summary/update of Allied Health Professional (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 in-patient nursing workforce metrics; fill rates, Care Hours Per Patient Day (CHPPD), Nurse Sensitive Indicators (NSI's) and patient experience feedback. (Scorecard, Appendix 1).

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.

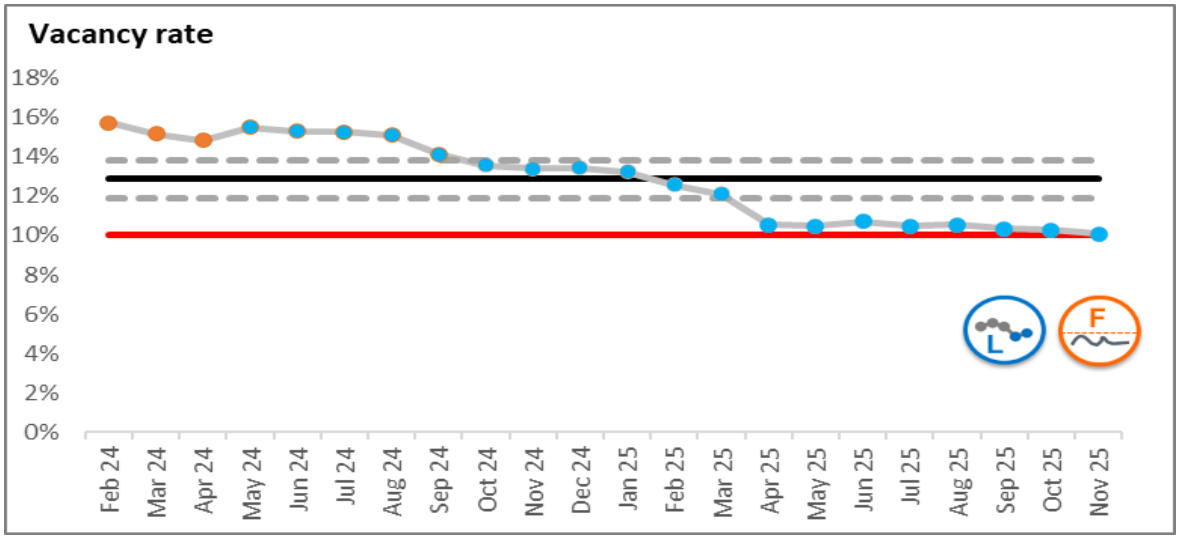
The Trust is required to demonstrate its position regarding mandatory submission of fill rates required by the Department of Health via UNIFY and paying attention to any variance below 80% and above 110%. The upload of these figures to UNIFY occurs on the 15th of each month following review and sign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

Analysis of the issue

Right Staff

Trust overall vacancy rate

In November 2025, the Trust vacancy rate was 10.1%. 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 243.5 Whole Time Equivalent (WTE) with a 12.1% vacancy rate, a decrease of 0.9% since October 2025.
  - Turnover for nurses is at 5.2% which is below the trusts target of 10%.
  - Sickness reported at 6.2 % a decrease of 0.1% since October 2025.
  - A total of 15.0 WTE nursing staff (bands 5 to 8a) were appointed in November 2025.

- HCSW
  - Vacancy position is at 163.9 WTE with an 15.4% vacancy rate, an increase of 0.7% since October 2025.
  - Turnover rate is at 7.6%. which is below our internal target of no more than 10% turnover.
  - Sickness reported at 8.8% which is a decrease of 0.9% since October 2025.
  - A total of 6.8 WTE HCSW were appointed in November 2025.

Allied Health Professionals (AHPs)

- Vacancy position is at 68.6 WTE with an 7.5% vacancy rate.
- Turnover rate is at 8.6%. Which is below our internal target of no more that 10 % turnover.
- Sickness reported at 8.8%
- A total of 5.5 WTE AHP were appointed in November 2025.

Medical

- Vacancy position is at 13.7 with an 8.6% vacancy rate.
- Turnover rate is at 10.0%
- Sickness reported at 2.7%
- No medical staff were appointed in November 2025.

Temporary workforce

- Temporary worker utilisation rate increased this month by 2.36% reported at 26.68% overall, of this Trust wide agency usage increased this month by 0.50% to 2.20% overall.

Right Skills

- Core and Clinical mandatory training compliance is currently compliant (green) on average across the Trust.
- 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 11.6 CHPPD (national average 10.8) for November 2025 consistent with October 2025.

November 2025 scorecard is presented in accessible format in **Appendix 1.** 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 mitigation.

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
CHS In-patients	**Staffing** Key areas to note - Rutland at 24.0% and Ward 1 St Lukes at 23.5% 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 or vacancies.	**Amber**
	Fill rate: Fill rate below 80% of HCA day shifts and night shifts on Dalgleish. Fill rate above 110% of HCA day shifts on Clarendon, ward 3 St Lukes and East ward. HCA night shifts on Clarendon, Rutland, East and Snibston wards.	**Fill rate** Dalgleish ward re-opened mid-November and HCSW reduced fill rate due to reduced bed occupancy and staffing adjusted accordingly. For wards using over 110% fill rate of HCSW this was due to increased patient acuity and dependency, increased enhanced care, one to one supervision and additional beds that been opened due to LLR wide system request. This is an improved position, with a continued focus, the number of wards remains at 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 37 in October to 36 in November 2025. Ward areas to note with the highest number of falls are Dalgleish and ward1 St Lukes. The number of medication incidents has decreased from 23 in October to 14 in November 2025. Ward areas to	**Nurse Sensitive Indicators** It is noted that staffing levels were not a contributing factor when reviewing the nurse sensitive indicators. **<u>Falls</u>** Of the 36 falls reported, 22 falls resulted in no harm, 13 falls resulted in low harm. One patient fall resulted in moderate harm an ISMR was completed and reviewed. The weekly falls meeting continues across all areas discussing themes and improvements in care. All falls discussed at monthly Quality Leads meeting.	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
	note with the highest number of medication incidents is Swithland and ward 4 Coalville. The number of category 2 pressure ulcers developed or deteriorated in our care has decreased from 5 in October to 2 in November 2025. No category 4 pressure ulcer developed or deteriorated in LPT inpatient care in November 2025.	**Medication incidents**. 11 of the incidents reported as no harm and 3 incidents reported as low ham. The main theme was medication unavailable and is being discussed at the CHS Medication group. 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. CHS medication group continues to focus on controlled medication. **Pressure Ulcers** Pressure Ulcers category 2 developed in our care across 2 wards. 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 remained the same at 6 in November 2025 across 3 wards relating to, a reduction in staffing due to last minute sickness and internal staff movement and shifts unfilled. One incident on ward 3 St Lukes resulted in 1 RN on the night shift. Support provided from ward 1 St Lukes with no harm reported. Overall, 5 incidents reported as no harm and one as low harm. Safe planned staffing levels were 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 41.8%, Watermead at 37.1%. Ashby and Beaumont both at 35.0% 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 Acute, Forensic, PICU, 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 acuity for patients with high-risk behaviours, increased therapeutic observations due to high rates of violence and aggression, hospital escorts and staff sickness. **AHP** SALT referrals reduced into Rehabilitation and HD service. Sickness being proactively managed. TI recruited into MHSOP with temporary workforce in place for physiotherapy. Currently sourcing temporary workforce for OT in Rehabilitation.	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
	Fill rate: Fill rate RN on day shifts below 80% on Gwendolen. Fill rate HCA day shifts and night shifts above 110% on Ashby, Aston, Belvoir, Coleman, Kirby and Langley. Fill rate HCA night shifts only above 110% Griffin and Mill Lodge.	**Fill rate:** On Gwendolen Ward there was a lower-than-normal bed occupancy (8 empty beds) during November 2025. There were 23-day shifts that had 2 RNs on duty, the planned staffing is 3 RNs, on those days the reduced number of RNs was as a result of the reduced number of patients (occupancy) and further mitigated by adjusting the skill mix to include a Medicines Administration Technician's (MAT) or backfilling with an additional HCSW (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 and backfilling.	
	Nurse Sensitive Indicators: A review of the NSI's has identified a decrease in the number of falls incidents from 105 in October to 101 in November 2025.	**Nurse Sensitive Indicators:** **<u>Falls</u>** **AFPICU** – 12 reported falls incidents occurred in Acute, Forensic and PICU services (AFPICU) in November 2025. 1 fall reported as moderate harm, patient fell in bedroom, fractured hip and transferred to acute services. ISMR requested. **Rehabilitation** – 5 falls incidents reported and none of moderate harm. **MHSOP** – 84 falls incidents were reported in November 2025. Highest falls on Kirby (40), Coleman (15) and Gwendolen (12). It is noted an increased number of unwitnessed falls, patients placing themselves on the floor (witnessed and unwitnessed) and patient falls whilst mobilising/standing. Staffing levels not identified as a contributing factor.	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
	The number of medication incidents increased from 11 in October to 14 in November 2025. The number of category 2 pressure ulcers developed or deteriorated in our care was 4 in November 2025.	2 falls were reported as moderate harm, all other falls reported in this period as no or low 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. **Medication errors** 13 no harm medication incidents and 1 reported as low harm for AFPICU, Rehab and MHSOP. Themes include staff not following medication procedure, omission, and wrong medication. Staffing levels not identified as a contributing factor. **Pressure Ulcers** There were four category 2 pressure ulcers developed in our care across 2 wards, attributed to high-risk physical and mental health patient factors.	
FYPC.LDA in-patient	**Staffing:** High Percentage of temporary workforce, key areas to note – Agnes at 49.5%, Welford ED at 45.8 and Beacon at 45.1%.	**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. Mitigation remains in place; potential risks being closely monitored. High temporary workforce usage on the Agnes Unit and is currently within their equivalent commissioned beds, operating on 3 pods. Safe staffing is reviewed daily, due to increased patient acuity and complexity staffing levels reviewed and adjusted accordingly.	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
		Welford ED high temporary workforce usage due to increase in patient acuity, increased patients requiring support with naso-gastric feeding, patient complexity requiring therapeutic observations and mealtime supervision. Staffing levels reviewed and adjusted accordingly.	
	Fill Rate: Fill rate below 80% for RNs on day shifts – Beacon and the Grange and fill rate below 80% RN on night shifts at the Grange. Fill rate below 80% for HCA on day shifts and night shifts at the Grange and on day shifts only at the Gillivers. Fill rate above 110% for RN on days and nights on Agnes unit. Fill rate above 110% for HCA on days and nights on Welford ED and Agnes unit and on days only at the Beacon unit.	**Fill rate:** Beacon unit planned staffing is 3 RNs (as per budgeted establishment) for a day shift, staffing levels were reviewed and adjusted according to patient acuity and bed occupancy. 2 RNs worked consistently on day shifts in November 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 staffing levels were reviewed and adjusted according to patient acuity leading to an increased fill rate for both RN and HCSW across day and night shifts. 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 for the month in both services, that also provide cross cover. Beacon unit staffing levels were reviewed and HCSW staffing 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 leading to increased HCSW fill rate on the day and night shifts.	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
	Nurse Sensitive Indicators: The number of falls incidents increased from 4 in October to 6 in November 2025. The number of medication related incidents remained at 6 in October and November 2025.	**Nurse Sensitive Indicators:** **Falls** There were 6 falls incidents, 1 reported as no harm and 5 as low harm. **Medication errors** 6 medication incidents were reported, 4 as no harm and 2 as low harm.	
CHS Community	No change to Key areas to note - City West, City East, and East South, due to high patient acuity. All hubs continue welcoming new staff and have new starters in the pipeline, resulting in backfill whilst staff are inducted and supernumerary. Overall community nursing Service OPEL has been level 2, working to level 2/3 actions.	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 and on-going review of agency usage and reduction. 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) implementation across the service.	
DMH Community	The next phase of the CMHT transformation continues. Key area to note –City West has significant pressure due to high referral rates requiring longer management time in daily huddles and no change to MHSOP community teams. South Leicestershire and City East continue with significant wating times for Community Psychiatric Nurse (CPN) input. No change to key areas to note - 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. Targeted plan in place together with medical staff, to address high referral rates in City West. Mitigation includes daily huddles, staff working additional hours to progress backlog and medical job planning to prevent further build up. Teams actively monitoring waiting lists with large numbers of patients. **Urgent Care** CRHT staffing model fluctuates in response to case load and clinical risk. OPEL level 3 enacted and team leads stepping into planned staffing to support safe staffing. Successful recruitment to 3 posts made in MHLS and recruitment continues for additional 3 MHPs.	

Area	Situation /Potential Risks	Actions/Mitigations	Risk rating
		Older adults MHLS now supported by fellows and the Central Duty Rota doctor. Challenges in Mental Health Urgent Care Hub with MHP vacancies being backfilled with additional hours/temporary workforce. **<u>MHSOP Community</u>** No change since the last reporting 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 being filled and recruitment checks progressing.	
FYPC.LDA Community	LDA Dynamic Support pathway and Discharge hub staffing reduced due to sickness and absence and no change to Mental Health School Team (MHST) a number of City and County Healthy Together and School Nursing teams and LD physiotherapy. In Mental Health school team (MHST) challenge continues 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 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. Prioritisation model in place for dynamic pathway and discharge hub 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 continues. Healthy Together utilise a safe staffing model reviewed monthly by service leads and Clinical Team Leaders. The safe staffing model is based on percentages of staff in work. Actions are then taken to mitigate any clinical impact and temporary workforce being utilised.	

Challenges/Risks

- Considering the triangulated review of workforce metrics, nurse sensitive indicators, patient feedback, and outcomes in November 2025, staffing challenges continue with key areas noted and clear actions in place to mitigate risks.
- CNSST II revised implementation commenced in 2 further Community Nursing Hubs in November 2025.
- Annual Establishment Inpatient Reviews to be reported to Executive Management Board February 2025.

Appendix 1- November 2025 Scorecard

Scorecard - November 2025.xlsx

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.

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

Governance table

For Board and Board Committees:	Trust Board
Paper sponsored by:	Linda Chibuzor Group Chief Nurse/Executive Director of Nursing, AHPs and Quality
Paper authored by:	Elaine Curtin Workforce and Safe Staffing Matron, Jane Martin Assistant Director of Nursing and Quality, Emma Wallis Deputy Director of Nursing and Quality
Date submitted:	27 January 2026
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:	
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)	1. Deliver Harm Free care. 2. Services unable to meet Safe staffing requirements
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:	Yes
Equality considerations:	None

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Leicestershire Partnership NHS Trust

Trust Board – 27th January 2026

Patient Safety & Learning Assurance Report for November/December 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 November/December 2025, there were 3360 patient safety incidents reported that were classified as “incidents attributable to LPT” and “Incidents affecting patients”. The top five reported incidents account for 62.62% of all patient incidents reported during this period and are explored in order and in more detail below. This equates to an average of 1680 incidents per month during November and December 2025.

Top 5 reported patient safety incidents November and December 2025

Category	Number of incidents	Directorate with highest % of the total reported
1. Tissue Viability	845	CHS (98.22%)
2. Self-Harm	467	DMH (62.96%)
3. Falls	287	DMH (66.20%)
4. Care/Treatment Under Restraint	262	DMH (53.05%)
5. Violence/Assault	243	DMH (74.49%)

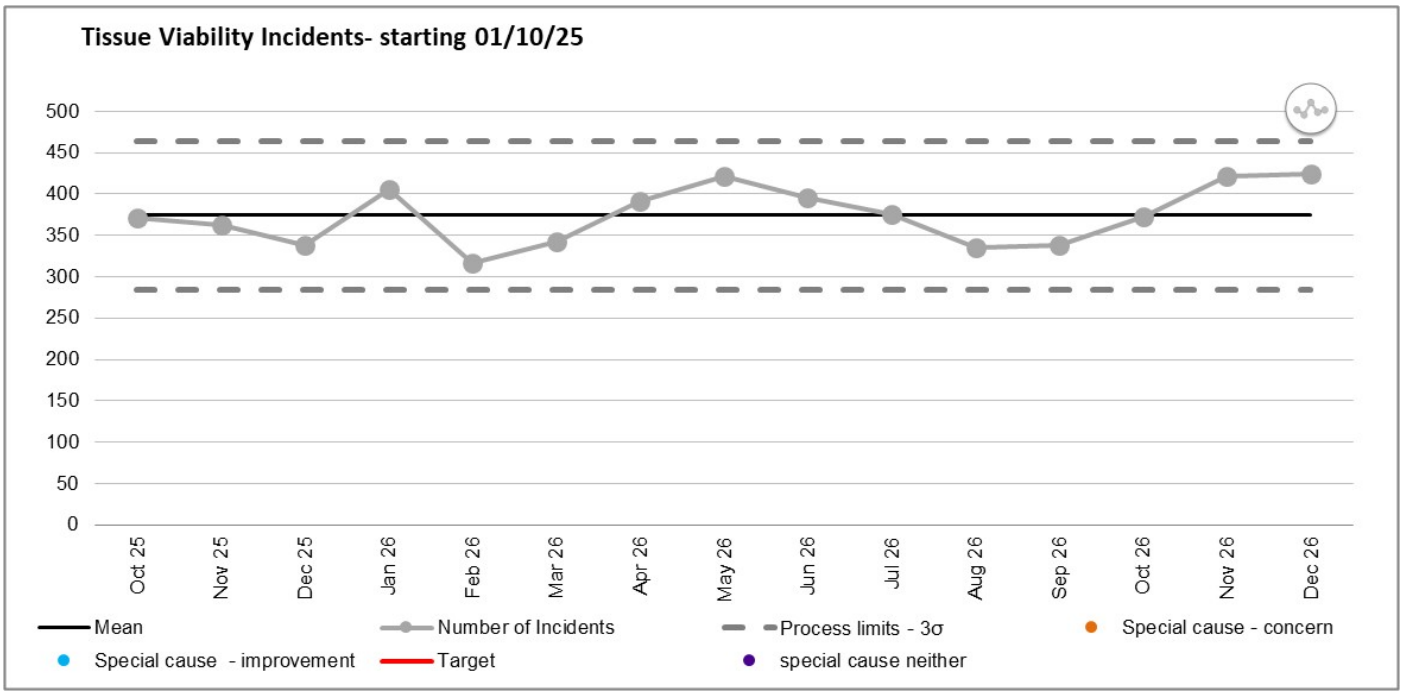
Degree of harm recorded for all patient safety incidents for November and December 2025

Reported degree of harm	Number	% of total incidents reported
No Harm	1827	54.38%
Minor/Low Harm	1469	43.72%
Moderate Harm	48	1.43%
Severe Harm	2	0.06%
Death	14	0.42%

NB: these incidents were reported in November and December 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. There is work ongoing to configure Ulysses to mirror the modern descriptions to make it easy for staff to accurately report.

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



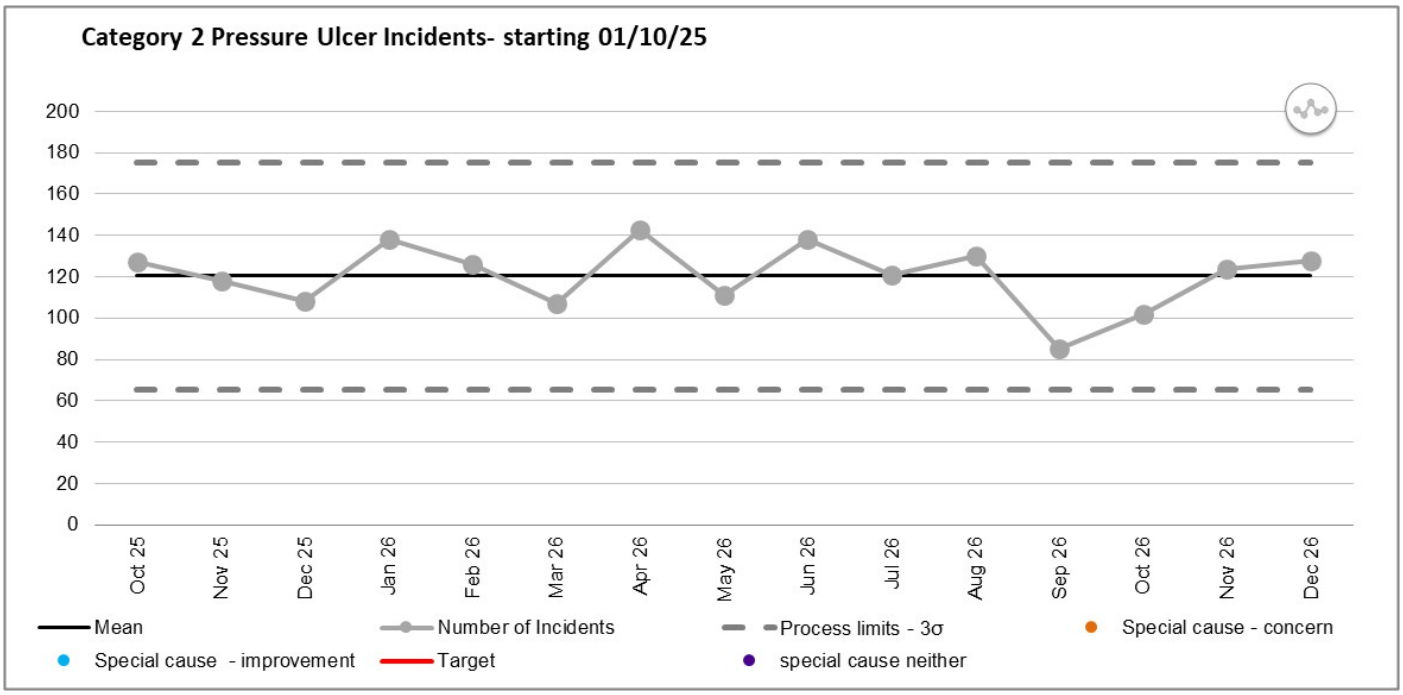
25.14% of all patient safety incidents reported relate to 'Tissue Viability' during November and December 2025; this equates to 845 incidents. This category includes pressure ulcers on admission, developed or deteriorated in our care, skin tears, scalds, wounds, and moisture associated skin damage. As Pressure ulcers (category 2,3,4 and unstageable) represent 62.01% of these, we will focus on this aspect of patient harm.

In November and December 2025, there were 524 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 a 15.93% increase in pressure ulcers reported in comparison to the previous 2 months reporting. This increase is largely attributed to an increase in patients admitted with pressure ulcers on admission to our services.

During this period, 501 (95.61%) were reported in CHS Community Nursing Services and 12 (2.29%) were reported in Community Hospitals (Inpatients).

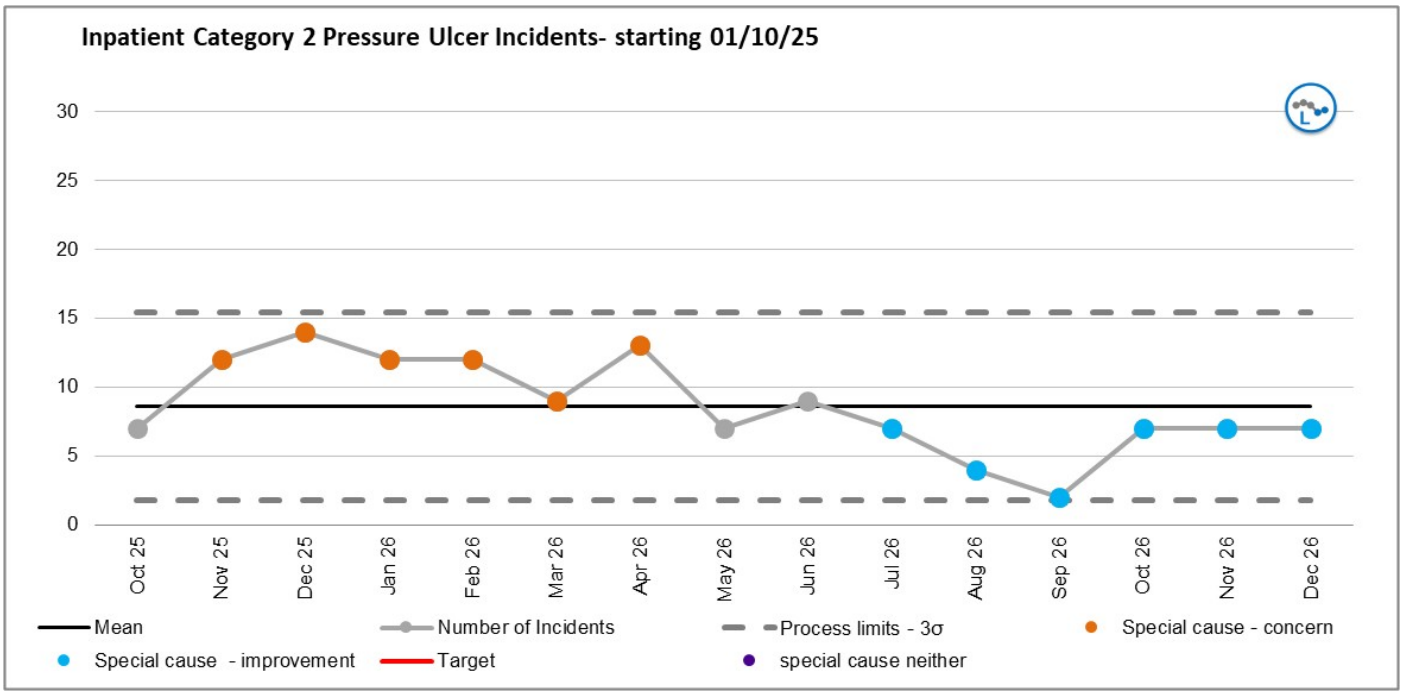
Of the remaining 11 incidents (2.10%), 6 were reported in DMH, 5 were Category 2 Pressure Ulcers – 3 reported by Gwendolen Ward and 2 reported by Langley Ward – and 1 Unstageable Pressure Ulcer reported by DMH City West CMHT. FYPCLD had 3 Unstageable Pressure Ulcers reported by Diana Service and 1 Category 2 Pressure Ulcer reported by LD Physiotherapy Team; finally, 1 Category 2 Pressure Ulcer was reported against the Electronic Patient Record team in Enabling Services (since the data for this report was run, this incident has been returned to reporter and amended to District Nursing Braunstone under CHS).

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



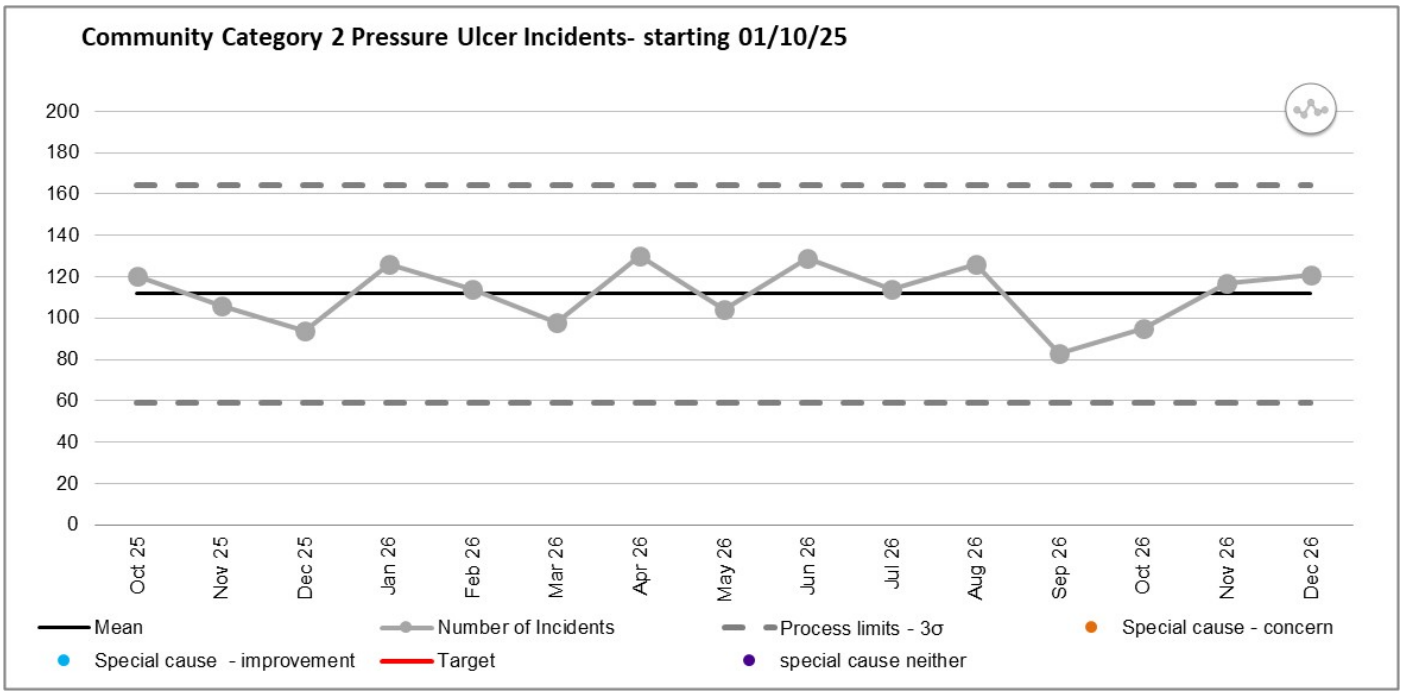
The SPC chart shows normal variation for Category 2 pressure ulcers developed or deteriorated in LPT care, Trust wide.

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



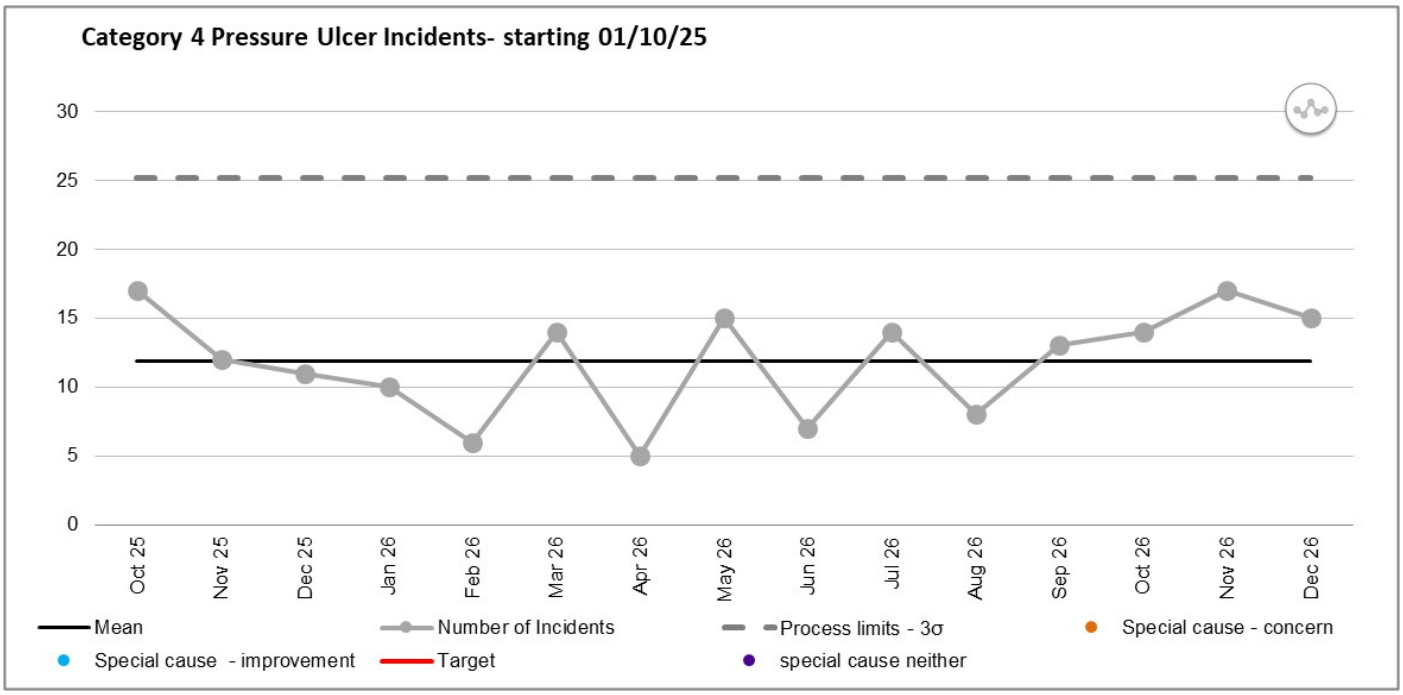
The SPC chart above shows special cause improvement in Catagory 2 pressure ulcers developed in in-patient LPT care. CHS Community hospital pressure ulcer improvement work continues, including the quality account project to reduce Moisture Associated Skin Damage. There is a pressure ulcer validation and learning meeting held weekly led by the senior nursing team.

Community Category 2 pressure ulcers developed in our care.



The chart above details the number of patients who have developed a Category 2 pressure ulcer 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 to support actions and themes from incident reviews are in place, to support the teams and facilitate improvements in prevention and treatment.

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

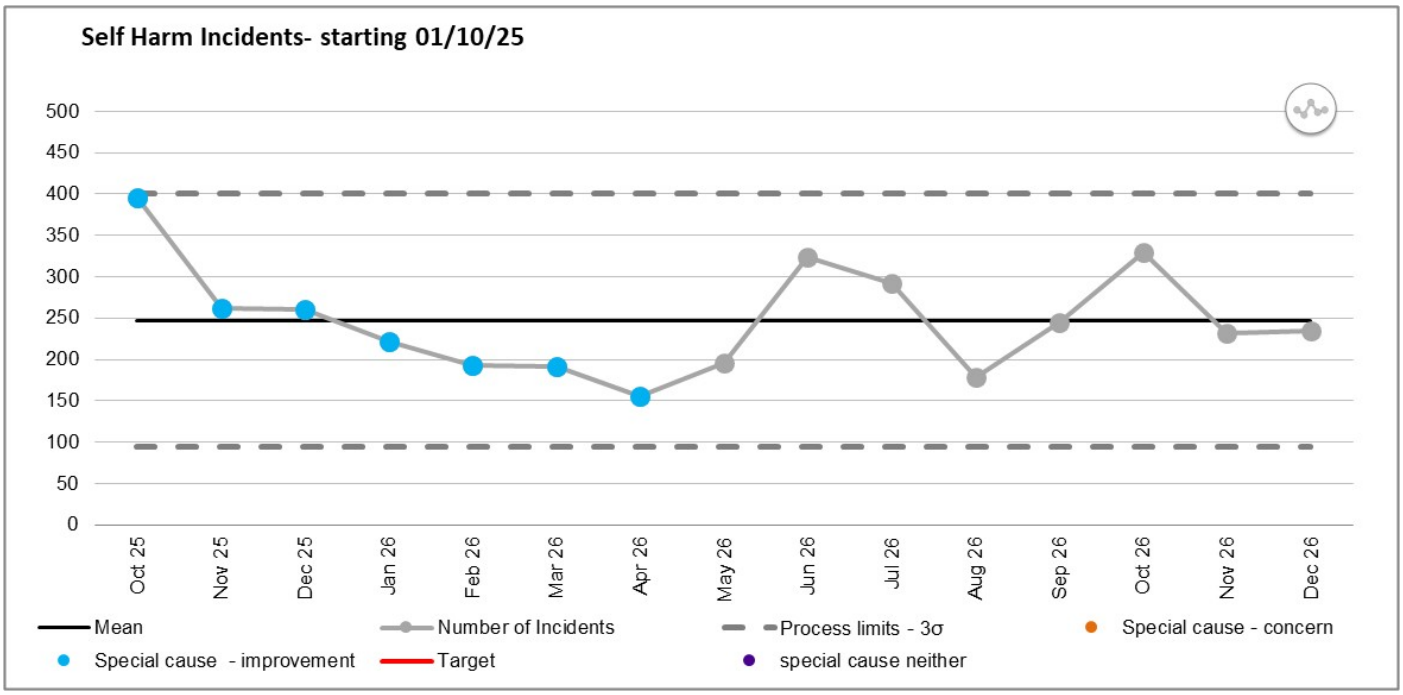


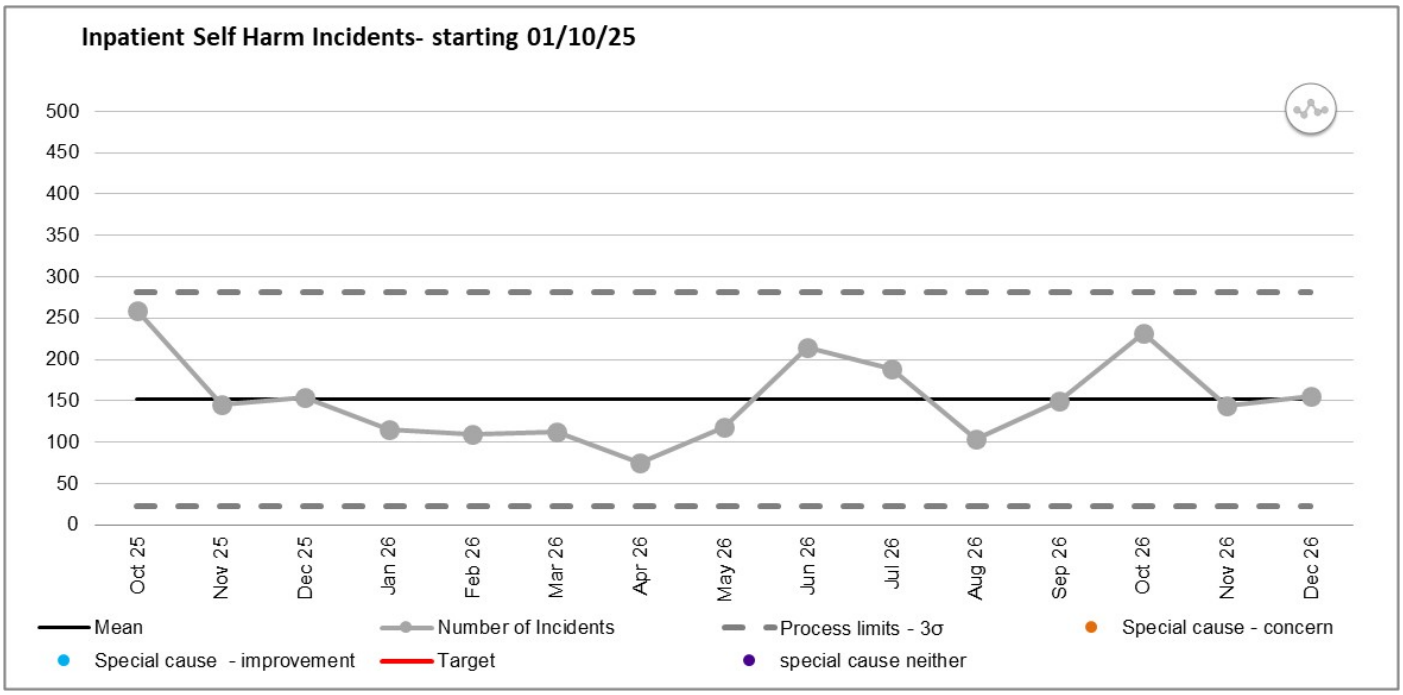
The SPC chart shows normal variation for Category 4 pressure ulcers developed or deteriorated in our care.

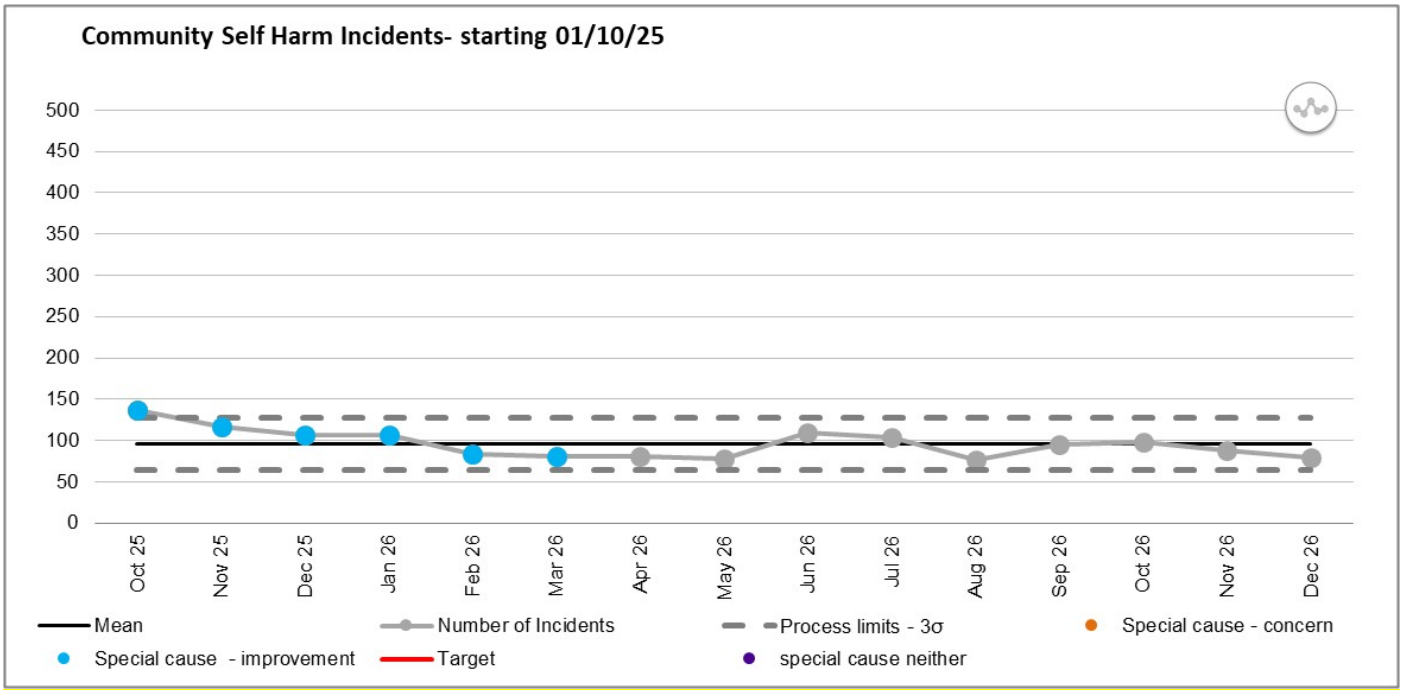
The CHS pressure ulcer delivery group continue to implement improvement work around moisture associated skin damage, repositioning, exploring the use of handheld devices for recording repositioning in care home settings, pressure ulcer prevention at end of life, general equipment processes and patient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

A Trust wide pressure ulcer conference – Stop the Pressure Ulcer Day was held on the 20th November 2025 led by the Tissue Viability Nursing (TVN) team in CHS as part of National Stop the Pressure Week as well as some virtual sessions from our podiatry and safeguarding teams; the feedback from sessions was positive.

2. Self-Harm – inpatient and community







There were 467 patient self-harm incidents reported during November and December 2025, this equates to 13.90% of all reported patient safety incidents during this period. Of the 467 incidents reported as patient self-harm, 300 were inpatient incidents and 167 were community incidents.

During the previous reporting period, there were 567 self-harm incidents reported across both inpatient and community settings, this shows a decrease of 17.64% during the current reporting period. This decrease is mainly inpatient incidents.

The number of incidents has been analysed and over the reporting period there are 3 areas with the largest number of self-harm incidents reported relative to the total number (567) of such incidents reported:

- CAMHS Beacon – 116 incidents (24.84%) This figure involves 5 patients; this is a similar figure to the 118 total incidents reported in the previous reporting period.
- Beaumont Ward – 76 incidents (16.27%) This figure involves 11 patients; this is an increase from 62 total incidents reported in the previous reporting period.
- Heather Ward – 39 incidents (8.35%) This figure involves 10 patients; this is a decrease from 106 total incidents reported in the previous reporting period.

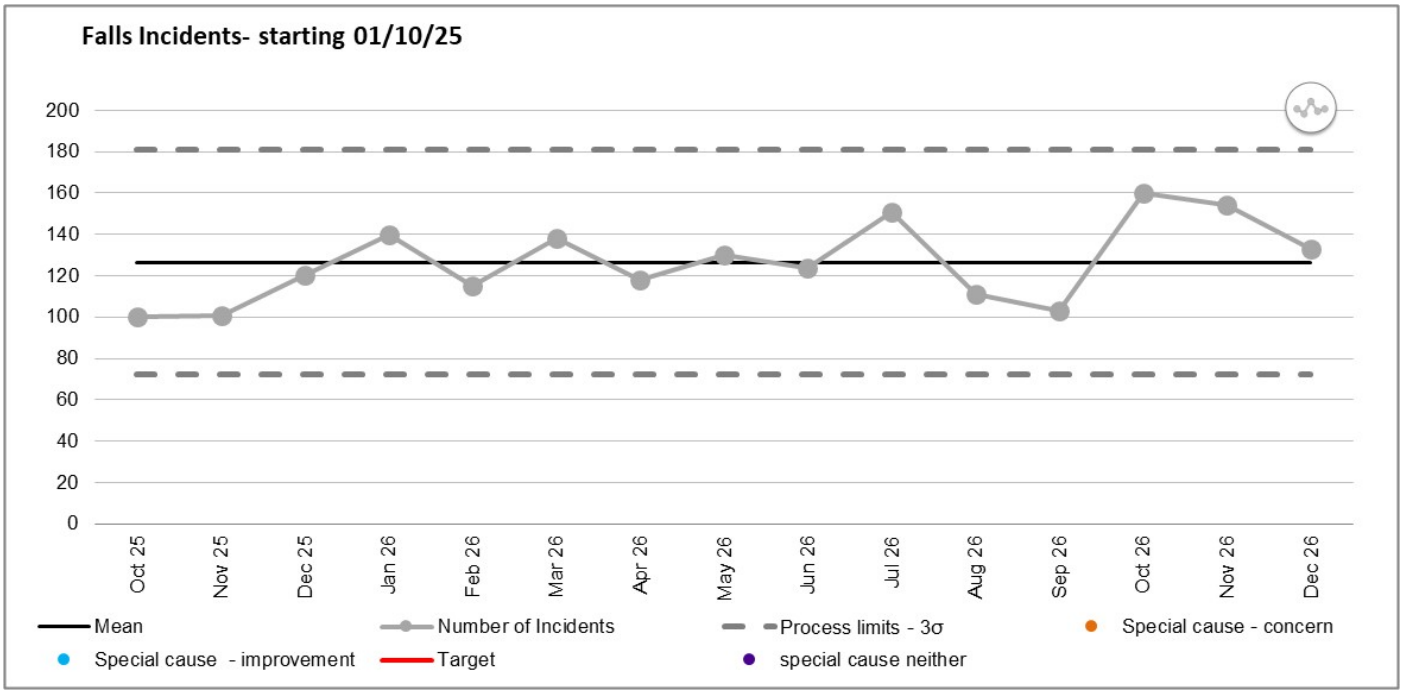
Harm Levels

Within the 3 areas of CAMHS Beacon, Beaumont Ward, and Heather Ward there were 3 incidents reported as moderate harm. Of the 116 incidents reported by CAMHS Beacon, 1 (0.86%) was recorded as moderate harm, (related to non-fixed ligature incident that was well managed) 66 (56.90%) were recorded as minor/low harm, with the remaining 49 (42.24%) being reported as no harm. Of the 76 incidents reported by Beaumont Ward, 1 (1.32%) was recorded as moderate harm,

(since regraded to minor harm) 36 (47.37%) were recorded as minor/low harm, with the remaining 39 (51.32%) being recorded as no harm. Of the 39 incidents reported by Heather Ward, 1 (2.56%) were recorded as moderate harm, (related to a non-fixed ligature which was reviewed in directorate by senior staff who agreed there was no opportunity to have predicted this and care was well managed) and with 19 (48.72%) incidents being recorded as minor/low harm and the remaining 19 (48.72%) being recorded as no harm.

Overall, of the 467 total reported self-harm incidents, 7 (1.50%) have been recorded as moderate harm which are all being reviewed individually, 241 (51.61%) have been recorded as minor/low harm, with the remaining 219 (46.90%) incident being recorded as no harm.

3. Patient Falls, Slips and Trips



There were 287 falls during November and December 2025 representing 8.54% of all reported patient safety incidents. During the previous reporting period there were 260 Falls incidents reported, this shows an increase of 10.38% during the current reporting period.

The number of falls have been analysed and over the reporting period, out of the 287 reported falls incidents, Kirby Ward at the Bennion Centre reported 71 (24.74%) incidents, and Coleman Ward at the Evington Centre reported 33 (11.50%) incidents.

Of the 287 reported Falls incidents, 7 (2.44%) were recorded as moderate harm, 99 (34.49%) were recorded as minor/low harm, 181 (63.07%) were recorded as no harm.

DMH

The increased number of falls in October across all MHSOP wards improved in November apart from on Kirby ward where numbers significantly increased. This was related in part to one patient having 17 falls in November and 11 falls in December. No harm was incurred and the team report that the patient has a history of placing themselves on the floor, however if this is not witnessed it is treated as a fall to ensure thorough assessment. The team undertook a MDT approach to dealing with the Falls risk for this patient. Psychology addressing behavioural elements, Speech and Language Therapists looking at communication strategies, a helmet was provided to reduce risk of head injury, alongside traditional falls prevention measures such as medication review and physical health assessment.

After an increase in first falls and repeat falls on Coleman Ward in September and October with 24 and 26 falls respectively, numbers have reduced to 15 in November and 18 in December (noting: June -10, July-15, Aug- 14).

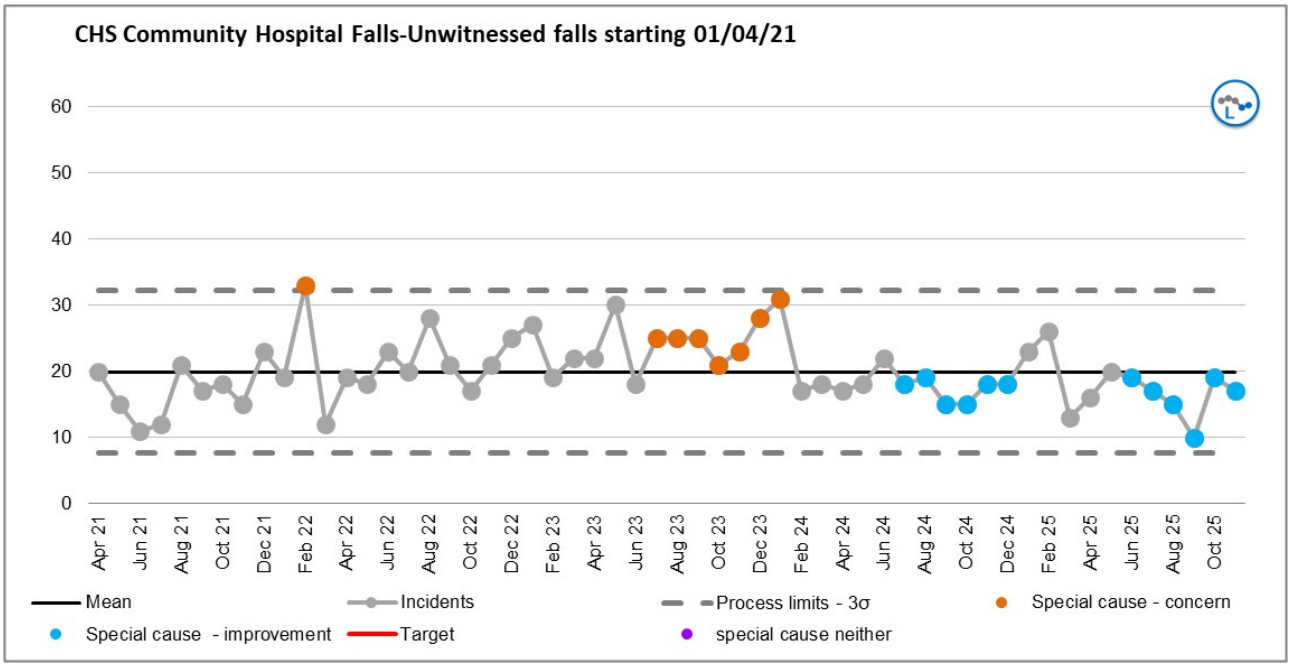
A DMH Deep Dive on Falls was presented at the November meeting and future actions included:

- A review of end-to-end falls process and explore IT/ technology solutions.
- Implementing key recommendations from the National Audit for Inpatient Falls (NAIF) e.g. vision checks, deconditioning support etc.
- Improve local competence in “Look Feel Move” assessment post falls.

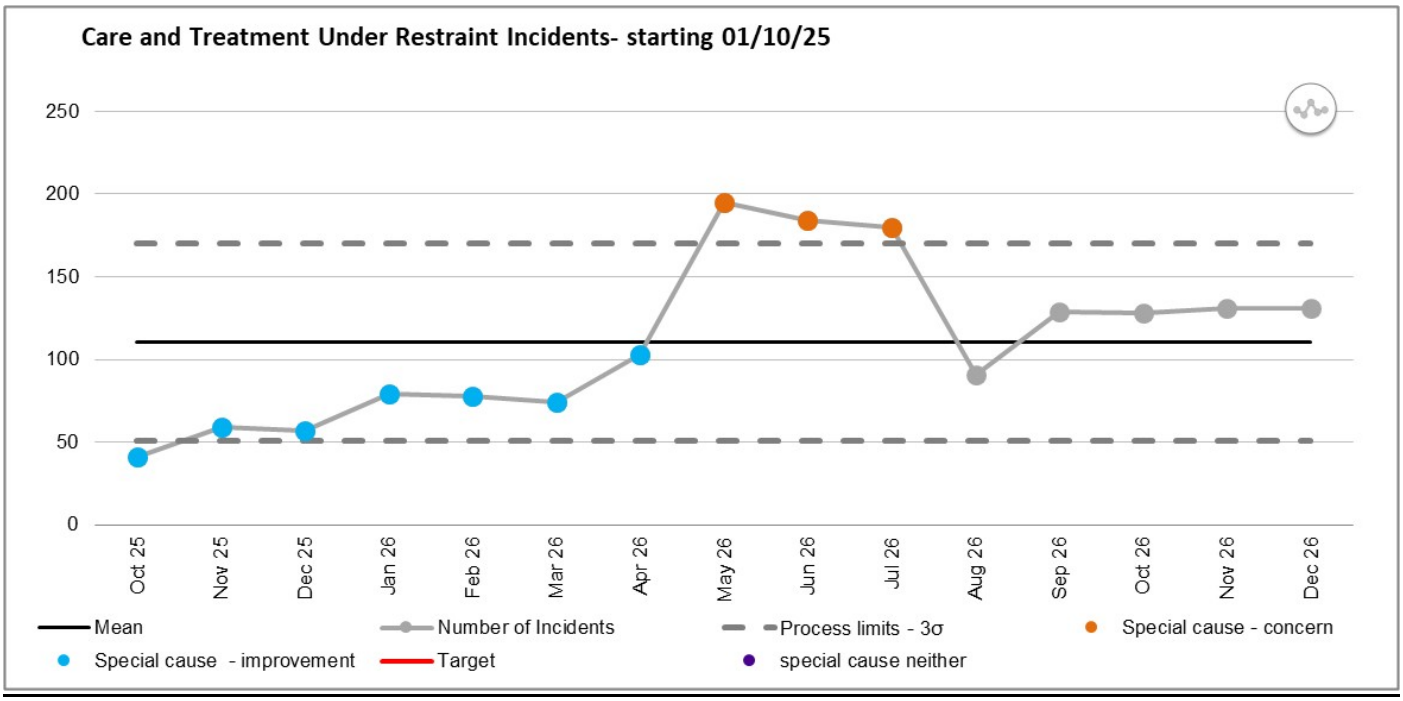
CHS

No current trends to report. A slight rise in number of falls on St Lukes Ward 1 with 7 falls in November related to 6 patients first falls and one repeat fall, 4 of which were unwitnessed.

CHS presented a case study of an 84yr old patient who had fallen 5 times whilst on Beechwood ward. Falls were unwitnessed and mainly occurred at the weekend, early mornings or evenings. The falls did not incur any harm to the patient. It was recognised that the patient’s medical condition presented an increased falls risk, and the falls process had been followed post falls, but the review identified that other factors such as vision and footwear required exploration. The review also identified staff on the ward required clearer guidance regarding the differences between cohort supervision, bay supervision and one to one supervision. Improvement actions have been implemented on the ward following the review and included in the Community Hospitals (CoHo) workplan that is going to be rolled out across all CoHo wards.



4. Care & Treatment Under Restraint



There were 262 incidents where restraint holds were used to support care delivery during November and December 2025, representing 7.80% of all reported patient safety incidents during this period. During the previous reporting period, there were 257 incidents reported where restraint was utilised, therefore this shows an increase of 1.95% 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 the training will be trailed available at the end of quarter 4 (2025).

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

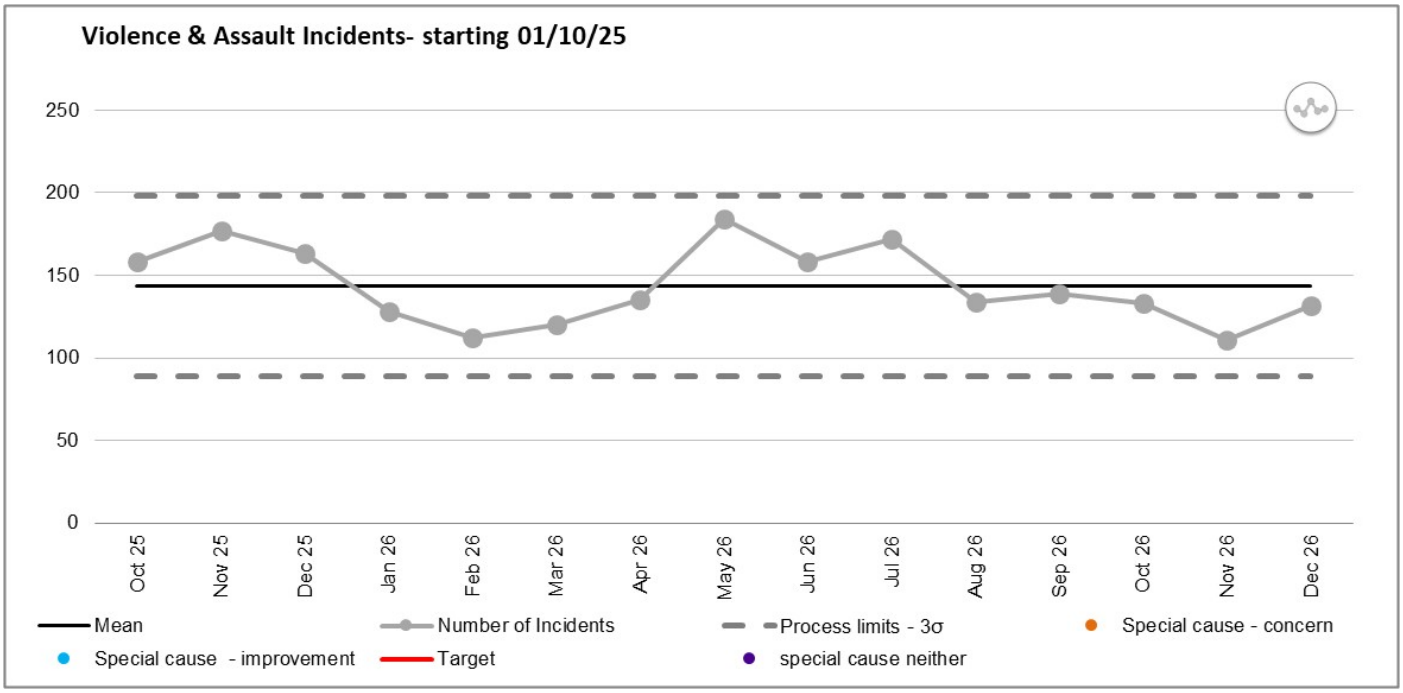
The restraint in Mill lodge is relating to the safe care and management using safeholds during personal care interventions to maintain the safety of the patients and staff delivering care – this is care planned and reviewed regularly with senior staff and the wider multidisciplinary team.

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.

5. Violence/Assault



There were 243 incidents of violence and assault reported during November and December 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 7.23% of all reported patient safety incidents. During the previous reporting period, there were 266 violence and assault incidents reported, this shows a decrease of 8.65% during the current reporting period.

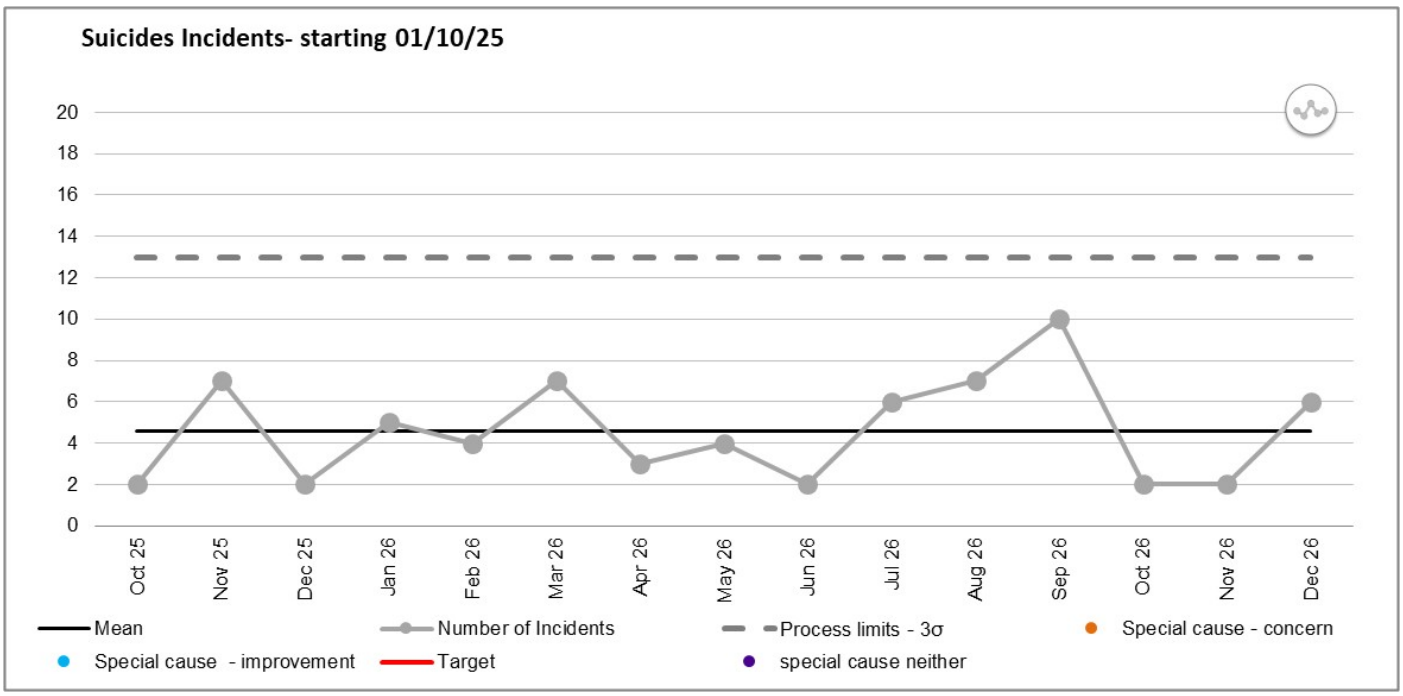
The number of violence and assault incidents has been analysed and over the reporting period, there are three areas with the highest number of incidents reported relative to the total number (243) of violence and assault incidents, Pod 1 at the Agnes Unit and Bosworth Ward and Aston Ward with 24 incidents each. Of these 243 incidents, 125 (51.44%) were reported as physical disruptive behaviour.

Of the 243 incidents reported as Violence and Assault, 2 (0.82%) were recorded as moderate harm, 75 (30.86%) were recorded as minor/low harm, and 166 (68.31%) were recorded as no harm.

There were no incidents of violence and assault requiring review at IRLM during this reporting period and the incidents are reviewed as part of Health and Safety committee and the Least Restrictive Practice Group.

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.

As part of PSIRF we are undertaking a thematic review of suicides where patients have a co-occurring substance use to consider this against national guidance. This has identified some opportunities for learning which are now being explored with staff with expertise and involvement to develop a set of recommendations for improvement.

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 to identify deaths that need further review.

The team are already reviewing patients' protective characteristics to identify any themes that may indicate health inequalities and are working to develop the data set to ensure we have cause of death for all patient deaths so that effective review of themes can be explored to triangulate and identify any inequalities.

LeDeR

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

- There were 3 notifications made by LPT staff to LeDeR related to patients with a known learning disability or autism and who have died for Nov (1) 2025 and Dec (2) 2025.
- For City and Countywide reviews, there were 4 patient death notifications in Nov 2025 and 6 patient death notifications in Dec 2025.
- Of the total 10 notifications,2 are focused and 8 are initial reviews.

For those reviews that also have a patient safety review the two teams are working closely together to better identify opportunities for learning.

LPT Outstanding patient safety reviews:

As of December 16th, 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	1
SMART Action Planning	0	0	0	0
Directorate Sign off Stages	1	0	1	1
Right to Reply Family	2	1	0	1
Right to Reply Staff	0	0	0	1

Submission to CPST	0	0	0	0
Exec Review	0	1	0	2
With ICB	0	0	0	0
Directorate Post Exec Review	0	0	0	0
Total Learning Responses Overdue	**3**	**3**	**1**	**6**

Current Position

- As of 16th December 2025, there were 65 open investigations. 16 DMH, 23 Corporate, 18 CHS and 8 FYPC/LDA.
- Of these 13 are overdue and of these 4 are in right to reply with patient or family.
- 3 DMH (18.75%) are overdue 1 is yet to have a draft the rest all are within the various phases of sign off
- 6 Corporate (26.09%) are overdue all are within the various phases of sign off
- 3 CHS (16.67%) are overdue all are within the various phases of sign off
- 1 FYPC/LDA (12.50 %) are overdue all are within the various phases of sign off

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.

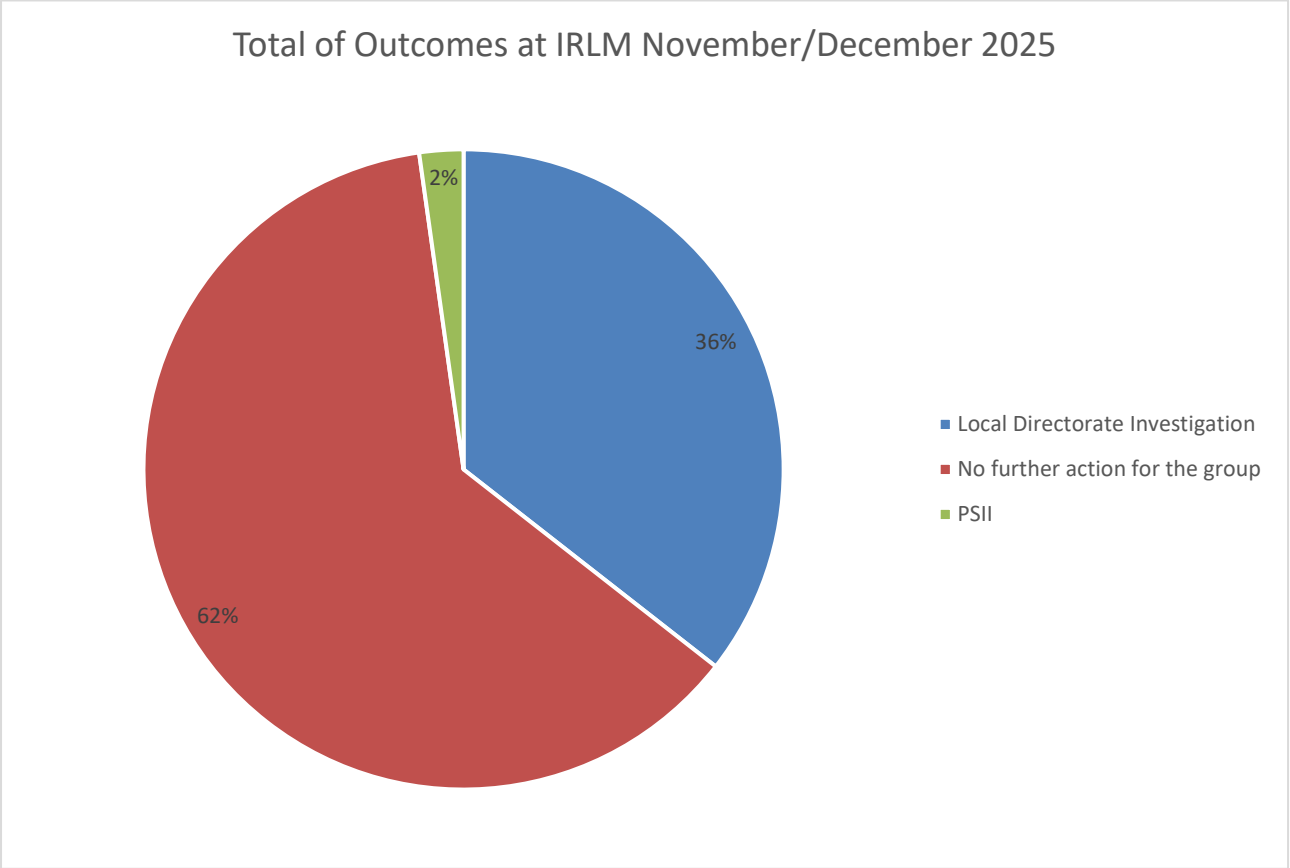
Never Events

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)

45 cases were reviewed at IRLM during November and December 2025. 1 (2%) Patient Safety Incident Investigations (PSII) was declared during this reporting period. 28 (62%) were identified as having already identified any learning and actions put in place. There were 16 (36%) Local Directorate reviews requested to explore appropriate actions, 0 (0 %) initial service managers

reviews (ISMR's) were shared with Learning from Deaths (LfD) for the themes to be aligned with their own.



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

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

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

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

Patient Safety Strategy

Training: SEIPS approach to investigation training.

During November and December 2025, 14 staff had been trained bringing the total so far to 185 members of staff. There are further dates available throughout 2026.

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	88	71
CHS	41	27
FYPC/LDA	53	22
Enabling	3	0
TOTAL	**185**	**120**

Commissioners have also accessed our training, and we have provided places for smaller organisations in LLR who do not have the in-house skills to provide their own. This is an opportunity to share experiences and build relationships.
The team have undertaken some successful reviews where partner organisations have attended so providing another perspective to the findings resulting in opportunity for system level changes. Partners have included patients GP, care home staff, Local Authority.

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
Nov – 2025	122	4	126
Dec – 2025	89	8	97
Total	7716	190	7906

Decision Required

Briefing – no decision required	✓
Discussion – no decision required	

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 20/01/2026 N/A N/A Bimonthly – January 2026
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

Alert, Advise and Assure Highlight Report

Finance and Performance Committee, 22 December 2025

Meeting Chair and Report Author Melanie Hall / Val Glenton

Quorate Yes

Policies and expiry date:

ALERT: Alert to matters that need the Board's attention or action, eg areas of non-compliance, safety or threat to the Trust's strategy

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Accountability Framework Meeting / Board Performance Report	FPC/25/149 FPC/25/150	Managing Director / Deputy CEO Director of Finance	There remained a significant number of patients who were waiting over 52 weeks for treatment and the majority were waiting on the neurodevelopmental pathways. The Committee discussed the recent Board workshop and the developments underway in the Board Performance Report which would assist the FPC in focussing on progress against improvement plans.	BAF3.2

T H R I V E

ADVISE: Advise the Board of areas subject to on-going monitoring or development or where there is negative assurance

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Finance Report Month 8 2025/26	FPC/25/144	Director of Finance	Capital - £6.7m of capital had been spent of a £19.7m plan and a significant value of expenditure was expected in the final quarter of the year. The Finance and Capital Teams were working to identify schemes that could be brought forward from 2026/27 and any schemes that were not prioritised this year that could be completed by year end.	BAF 5.3
LPT & NHFT Collaborative, Commissioning and Contracting Gp	FPC/25/148	Group Director of Strategy and Partnerships	The IMPACT collaborative had highlighted risks to delivering a break even position, this was not expected to affect LPT in 2025/26. Quality and safety issues were being managed by the collaborative. The position would be monitored closely over the next few months and reviewed in terms of risk share across the providers.	BAF 5.4
Accountability Framework Meeting	FPC/25/149	Managing Director / Deputy CEO	Access to the Integrated Clinical Environment (ICE) system continued to detrimentally impact on clinical teams electronically accessing pathology and radiology results. This matter was being monitored through AFM and solution testing was now being carried out.	BAF 3.2 BAF 3.3

ASSURE: Inform the Board where positive assurance has been received

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Board Assurance Framework	FPC/25/141	Director of Governance and Risk & Group Director of Strategy and Partnerships	Assurance was received that robust systems were in place to secure an effective risk framework. A deep dive took place into BAF risk 2 (*partnerships and collaboratives*) currently scored at 8 and FPC was informed of a number of examples of effective partnership working which included; • A group relationship with NHFT; • Development of the first provider collaborative in LLR through the LDA collaborative; • Development of mental health neighbourhood services;	BAF 2

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
			• Facilitation of grants to local VCSE organisations through the MH collaborative; • LOROS and community services working collaboratively as a team; • LPT's Chat Health Service which was sold to many UK organisations; • Development of a Section 75 agreement with Leicester City Council for the Healthy Together Programme. FPC noted that further assurance could be provided in the BAF by confirmation of relevant partnership agreements.	
Policy Report	FPC/25/142	Director of Governance and Risk	FPC had 29 policies within its remit, it now had responsibility for the new Social Value Procurement Policy which was currently progressing through the approval process. All policies were in date, 3 were currently in their review period. The committee received assurance on the work taking place to improve the policy system, the plan was to introduce policy compliance measures. Annual compliance reports would be prepared for each level one committee at year end.	N/A
Finance Report Month 8 2025/26	FPC/25/144	Director of Finance	FPC received assurance on its plans to achieve a break even financial position for 2025/26. The key points to note were; • The Trust was reporting a £1.6m deficit which was in line with plan. • All operational areas had improved their position with the exception of LDA however, expenditure was expected to reduce in quarter four. • A notable improvement had been seen in the DMH position and catering spend. • CIP performance was in line with the year-to-date plan which was delivery of £15.8m total savings. • The cash position continued to be above plan. Whilst the Committee still noted on-going risks within the LLR system, the risks within LPT were reducing and were evidenced to be well-managed.	BAF 5.4
Business Pipeline report	FPC/25/147	Group Director of Strategy and Partnerships	The Business Pipeline provided strong assurance on current and future tenders, bids and risks. FPC noted the progress on the School Age Immunisation Service which had been a previous risk. The Committee also requested a deeper dive on neighbourhood activity which would either be covered at a future FPC meeting or be the subject of a joint workshop with Quality and Safety.	N/A

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Transformation & QI Delivery Group	FPC/25/151	Managing Director / Deputy CEO	FPC noted the huge amount of transformation work taking place across all clinical directorates.	N/A
Patient Led Assessment of the Care Environment (PLACE)	FPC/25/153	Chief Finance Officer	A summary position of the PLACE was presented providing assurance that overall, the Trust was in a very good position. The key points to note were; • LPT had reported 100% for cleanliness in the 2024 assessment and that position had been maintained this year. • Food scores had consistently improved due to changes in food supplier and menu development. Only a few years ago it had been reported at 60-70% and in 2025 it was reported at 95.18%. • There was recognition that some areas were in need of redecoration and FPC was informed of plans to undertake this work via an in-house team.	BAF 5.2
Premises Assurance Model	FPC/25/154	Chief Finance Officer	PAM was a self-assessment tool used across estates and facilities to demonstrate compliance against a wide range of statutory, regulatory and operational matters. LPT was in a good position, it had scored reasonably well across the five domains as it had done over the past few years.	BAF 5.2

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
LPT & NHFT Collaborative, Commissioning and Contracting Group	FPC/25/148	Group Director of Strategy and Partnerships	• The CAMHS Enhanced Care Referral Team had been recognised as a national exemplar with outcomes of 36% of assessed young people avoiding admission. • The STOMP / STAMP Team (*Stopping Over Medication of People with LDA / Supporting Treatment and Appropriate Medication in Paediatrics*) had received a national commendation. • Department for Education funding for SEND and the inclusion programme in LLR had been confirmed for a further two years to March 2028.	N/A

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Accountability Framework Meeting	FPC/25/149	Managing Director / Deputy CEO	The Looked After Children's Health Team had created a care leavers code and icon to be added to the YPs SystmOne health record at the point they left care to ensure they received appropriate support in the future.	N/A
Transformation & QI Delivery Group	FPC/25/151	Managing Director / Deputy CEO	A new streamlined system had been introduced in FYPCLDA to replace a statutory assessment process which was found to be inefficient. This had resulted in a reduction in clinical time, improved communication with partner organisations and reduction in administrative burden.	N/A
Triple A Reports - Data Quality and Data Privacy Groups	FPC/25/158	Director of Finance	• The Integrated Information Team had been acknowledged by directorate leads for its support on a number of initiatives including service level dashboards and community currencies. • 100% of Freedom of Information requests had been responded to within the timeframe of 20 working days in October and compliance for responding to requests was at an average of 97% across the whole year.	N/A

Leicestershire Partnership NHS Trust

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

For presentation at the **TRUST BOARD MEETING 27 January 2026**

Contents

Executive dashboard - overall performance against targets

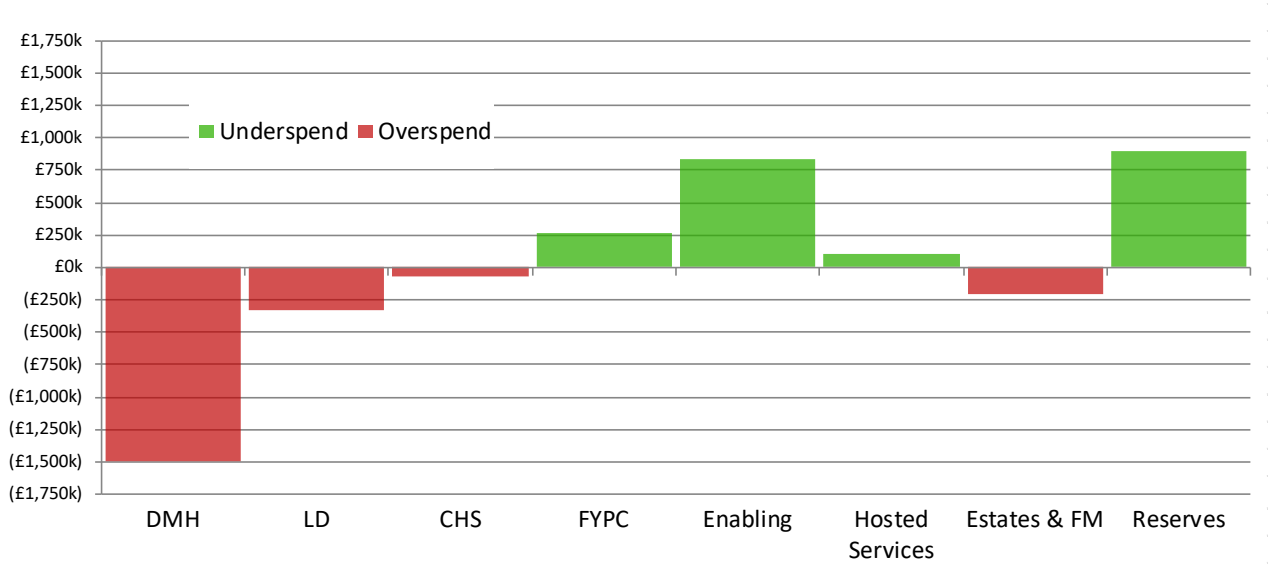
Statutory targets	Year to date	Year end f'cast	Comments	Further detail
1. Income and Expenditure break-even.	A	A	The Trust is reporting a YTD deficit of £1.34m at the end of December (in line with plan). The forecast year end position is currently a surplus of £0.3m, also in line with plan, but with £1.9m likely net risks	APP. A
2. Remain within Capital Resource Limit (CRL).	G	G	The YTD capital spend for December is £8.2m, which is within funding limits.	APP. 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 December is in line with plan, as is the forecast year end surplus (but with £1.9m likely net risks)	SUMMARY REPORT
5. Achieve Efficiency Savings targets.	G	A	Savings at 31st December are £18.7m, 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.	APP. B
6. Manage agency staff spend in line with plan	G	G	YTD agency spend at the end of December is £7.7m, which is lower (£1.2m) than planned YTD spend. Forecast year end spend is £9.9m, £1.2m lower than plan.	APP. 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 targets.	APP. 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 £20.6m at the end of December. This is £6.6m above planned cash levels. The planned cash forecast for the year is £13.2m.	APP. 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. December's cash level of £20.6m was 18 days.	APP. F
10. Deliver capital investment in line with plan	A	G	YTD capital expenditure is £8.2m, which is £1.928m (19%) below planned levels for Month 9. See 'Capital Section' in summary report.	APP. E

Summary report – financial position as at 31 December 2025

YEAR TO DATE POSITION

- The overall year-to-date income and expenditure plan (being a planned deficit of £1,343k) has been achieved at the end of December.
- Within the wider position, the collective operational budget position has continued to improve during December, with the total net year-to-date operational budget overspend reducing to £893k (November = £1,146k overspend).
- The net operational budget overspend is offset by equivalent non-recurrent and short term underspend 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 £1,498k overspent, an improvement of £37k from M8. The directorate benefitted from an FP10 recharge to FYPC of £130k. However, this benefit has been offset by industrial action costs £30k, one-off pay arrears of £37k and R&R payment arrears for Phoenix staff totalling £55k. Bank costs went up by £106k and included a £45k charge from LD for a patient at the Agnes Unit. The income position improved by a further £40k relating to out of county ICB funding for a patient at Mill Lodge. The out of county placements forecast for December was 186 bed days however actual placements were 59 bed days, reflecting the continued improvement in the management of these placements.

- **The Community Health Service** is reporting an overall overspend of (£69k) for the first 9 months of the year, representing a favourable movement of £28k from the previous month, maintaining the improving monthly trend linked to the reduction of agency. Budgets within the management service line have been profiled into the position to reflect the opening of Gracedieu ward, the full re-opening of Dalgliesh ward and the pressures of supernumerary costs for newly recruited staff within Community Nursing. Non-pay budgets are overspending, due to pressures within the continence products, mattress rental and drug budgets. This pressure, however, is partly being supported by the over-recovery of income relating to R&D, Road Traffic Accident and Out of County ICB income.

- **The FYPC** financial position at month 9 is a £273k underspend, a further favourable movement compared to last month. The year end forecast has been revised to a £400k underspend. Agency costs reduced again during the month mainly related to the CAMHS CRT service. Bank costs increased in the month on each of the inpatient areas. Non-pay budgets overspent within the month due to VPN costs recharged from HIS, and due to Medical equipment cost pressures within the Diana service. The income position improved in the month due to high occupancy on Welford ward and additional funds received from the Local Authorities. The actual CIP savings were below plan at month 9 but it is expected that the CIP for the year will be delivered due to additional agency and mobile phone savings.

- **The LDA** financial position at month 9 is an overspend of £332k, an increase from last month. The year end forecast has been adjusted to show a £400k overspend for the year. The pay budget was overspent mainly related to negative budgets linked to the Agnes Unit and LDA management budget, increased bank costs and the impact of additional SDF costs not anticipated in the original plan for the year. Non pay budgets reported a small overspend at month 9 and the income position was close to break-even. The CIP was showing under delivery for month 9 but forecasts full delivery for the year albeit achieved via significant non-recurrent savings.

- **Enabling budgets** are underspent by £833k as at M9. This is a positive movement of £70k compared to M8 (£763k underspent). The impact of holding vacancies due to the vacancy pause continues to help towards this underspend. Additional income in relation to members of staff sharing roles within our group model with NHFT has also been included in the position.

- **Estates budgets** are overspent by £208k as at M9. This is a negative movement of £4k compared to last month (£204k adverse variance). This was predominantly due to recent rent reviews for some of the sites at LPT resulting in increased costs. However, savings from Catering Services have continued to materialise and have helped offset these additional costs. Pay costs also continue to show an overall favourable variance of £605k as at M9 due to vacancy slippage.

- **The Central Reserves position** is underspent by £1.2m. This is mainly due to the up-front release of balance sheet flexibility as per planning assumptions. The reserves underspend offsets the operational overspend, enabling the delivery of the on-plan positions at the end of M8.

FORECAST INCOME AND EXPENDITURE POSITION

- The forecast for the end of the year remains in-line with plan, which is a surplus of £311k. This forecast is based on a best case risk-adjusted scenario, but increased confidence in the delivery of the break-even position has closed the gap between likely and best case forecasts considerably. The range of risk adjusted scenarios is included in **Appendix G**.

- The monthly surplus / deficit planned positions are shown in the table below. The YTD £1,343k planned deficit can be seen in M9. Subsequent monthly positions are expected to continue to improve each month across the remaining months of the year in order to deliver the £311k surplus by 31st March.

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

- In the year end forecast, net likely risks total £1.9m (down from £3.0m reported last month). Whilst this represents consistent month-on-month improvement it shows that there are still risks to delivery of the forecast £0.3m year end surplus, with 'best case' outcomes required in key areas.

ICS FINANCIAL POSITION

- There is no longer a formal ICS combined system finance report produced. The last reported position was provided for the period to the end of M8, which reported an overall net ICS deficit of £27.9m which represented a £16.8m adverse variance against plan (UHL £15.5m adverse, LPT nil variance and ICB £1.3m adverse).

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

APPENDICES

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 31 Dec 2025	YTD Actual M9 £000	YTD Budget M9 £000	YTD Var. M9 £000
Revenue			
Total income	331,791	324,580	7,211
Operating expenses	(330,582)	(323,370)	(7,211)
Operating surplus (deficit)	**1,210**	**1,210**	**0**
Investment revenue	900	900	0
Other gains and (losses)	0		0
Finance costs	(1,481)	(1,481)	0
Surplus/(deficit) for the period	**629**	**629**	**0**
Public dividend capital dividends payable	(1,972)	(1,972)	0
I&E surplus/(deficit) for the period (before tech. adjs)	**(1,343)**	**(1,343)**	**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	**(1,343)**	**(1,343)**	**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:	**(1,343)**	**(1,343)**	**0**
Trust EBITDA £000	**10,359**	**10,359**	**0**
Trust EBITDA margin %	**3.1%**	**3.2%**	**-0.1%**

APPENDIX B – Efficiency savings performance

At the end of month 9, CIP performance is reported in line with the year-to-date plan which is delivery of £18.7m total savings. There are some shortfalls within directorate targets, however the directorate position has further improved since month 8, and any shortfalls are being offset by Corporate schemes over-delivery.

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. As national funding is not available for NHS Trusts, 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

	M9 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	4,485	4,159	(326)	6,210	6,209	(1)	4,454	1,755
CHS	4,150	4,150	0	5,404	5,404	0	4,859	545
FYPCLDA	3,443	3,344	(99)	4,730	4,726	(4)	4,152	574
Estates	1,384	1,408	24	2,399	2,399	0	1,422	977
Enabling & HIS	1,345	1,349	4	1,779	1,779	(0)	1,502	276
Corporate	3,842	4,240	398	7,836	7,841	5	2,169	5,672
Unallocated								
Grand total CIPs	**18,650**	**18,650**	**0**	**28,358**	**28,358**	**0**	**18,559**	**9,800**

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 Actual	25/26 M9 £000s Actual	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	-212	-214	-211	-230	-230	-3,055	-3,726
Nursing - Qualified	-3,192	-266	-167	-123	-118	-126	-127	-103	-131	-124	-122	-101	-96	-94	-1,142	-1,433
Nursing - Unqualified	-144		-2	0	-4	-8	-3	-2	-8	-6	-14	-8	-5	-3	-47	-63
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**	**-342**	**-351**	**-320**	**-331**	**-327**	**-4,263**	**-5,241**
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	4	6	-2	-2	-2	-52	-58
Nursing - Unqualified	-36		0	0	-1	0	0	-1	-1	0	-1	0	0	0	-4	-4
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**	**4**	**5**	**-2**	**-2**	**-2**	**-56**	**-62**
Consultant Costs	-370	-31	-30	-16	-23	-24	-14	-26	-6	0	0	0	0	0	-139	-139
Nursing - Qualified	-7,723	-644	-358	-329	-264	-258	-225	-221	-217	-205	-167	-182	-182	-182	-2,243	-2,789
Nursing - Unqualified	-1,129		-31	-12	-7	-4	-2	-3	-4	-7	-13	-25	-10	-5	-83	-123
Other clinical staff costs	-326	-27	-27	3	-6	-3	-4	-9	-6	-7	-6	-5	-5	-5	-66	-81
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**	**-218**	**-186**	**-212**	**-197**	**-192**	**-2,530**	**-3,131**
RISK OF INCREASED AGENCY - GRACEDIEU WARD:											**-15**	**-100**	**-100**	**-100**	**-15**	**-315**
FYPC																
Consultant Costs	-438	-37	-22	-22	-22	-22	-29	-18	-14	-2	12	0	-20	-20	-139	-179
Nursing - Qualified	-1,406	-117	-94	-70	-76	-62	-22	-91	-40	-38	7	-25	-25	-25	-487	-562
Nursing - Unqualified	-40		0	-1	-4	-3	-1	-6	-3	0	-1	-2	-2	-2	-19	-25
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**	**-41**	**18**	**-27**	**-47**	**-47**	**-645**	**-766**
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	-4	-1	-1	-1	-1	-17	-20
Non clinical staff costs	-297	-25	-6	-4	-7	-10	-36	-19	-11	-86	-35	-40	-40	-40	-215	-335
Sub-total - Enab/Host	**-202**	**-17**	**-6**	**-5**	**-6**	**-10**	**-34**	**-33**	**-11**	**-90**	**-36**	**-41**	**-41**	**-41**	**-232**	**-355**
Consultant Costs	-5,983	-499	-488	-493	-456	-491	-407	-299	-283	-214	-202	-211	-250	-250	-3,333	-4,044
Nursing - Qualified	-12,868	-1,072	-628	-539	-475	-449	-376	-417	-401	-363	-277	-310	-305	-303	-3,924	-4,842
Nursing - Unqualified	-1,349	-112	-33	-13	-16	-14	-6	-12	-17	-13	-29	-35	-17	-10	-153	-215
Other clinical staff costs	-499	-42	-47	-20	-31	4	4	-30	36	-11	-7	-6	-6	-6	-102	-120
Non clinical staff costs	-297	-25	-6	-4	-7	-10	-36	-19	-11	-86	-35	-40	-40	-40	-215	-335
Total - excluding Gracedieu risk:	**-20,996**	**-1,750**	**-1,203**	**-1,069**	**-985**	**-960**	**-820**	**-777**	**-676**	**-687**	**-551**	**-602**	**-618**	**-609**	**-7,727**	**-9,556**
Total including Gracedieu risk:			**-1,203**	**-1,069**	**-985**	**-960**	**-820**	**-777**	**-676**	**-687**	**-566**	**-702**	**-718**	**-709**	**-7,742**	**-9,871**

Agency spend for December (month 9) is £0.57m. The average monthly agency spend last financial year was £1.75m.

YTD spend is £7.74m; this is lower (by £1.18m) than the planned YTD spend.

Agency spend for the year is forecast to be £9.9m, which is lower than the planned £11.1m.

The opening of Gracedieu ward to support system winter pressures is expected to result in additional agency requirements (reflected in the year end forecast). Excluding the Gracedieu estimate would give year end forecast expenditure of £9.6m.

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. 3 of the 4 in-month performance targets were met in December.

Better Payment Practice Code	December (Cumulative)		November (Cumulative)	
	Number	£000's	Number	£000's
Total Non-NHS trade invoices paid in the year	29,268	84,297	25,949	70,843
Total Non-NHS trade invoices paid within target	27,526	81,895	24,248	68,490
% of Non-NHS trade invoices paid within target	**94.05%**	**97.15%**	**93.44%**	**96.68%**
Total NHS trade invoices paid in the year	677	58,099	582	50,963
Total NHS trade invoices paid within target	631	56,525	541	49,507
% of NHS trade invoices paid within target	**93.21%**	**97.29%**	**92.96%**	**97.14%**
Grand total trade invoices paid in the year	29,945	142,396	26,531	121,806
Grand total trade invoices paid within target	28,157	138,420	24,789	117,997
% of total trade invoices paid within target	**94.03%**	**97.21%**	**93.43%**	**96.87%**

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

The cumulative performance for the number of Non-NHS invoices for the first nine months of the year is 94.05%, however the position is improving (Month 8: 93.44%). The in-month performance for December was 98.76% (November was 98.06%).

Cumulatively, 88% of Non NHS invoices not paid within the target period are in the estates & facilities directorate. 1,530 of the total 1,742 invoice paid late relate to catering and estates invoices (with the majority relating to catering invoices). The Estates & Facilities position improved in Month 9: 26 invoices were paid late in December, compared to 38 invoices in November.

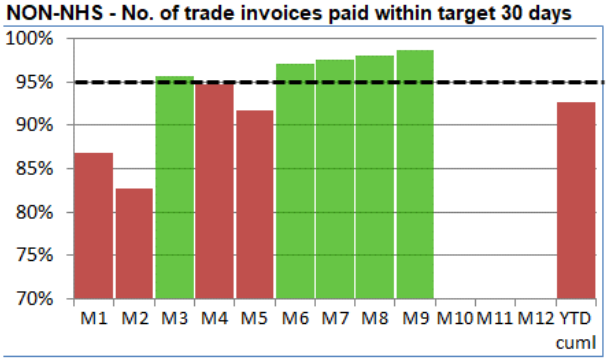
Non-compliant target – Number of NHS invoices:

The cumulative performance for the number of NHS invoices for the first nine months of the year is 93.21% This is an improvement compared to the previous month's performance of 92.96%.

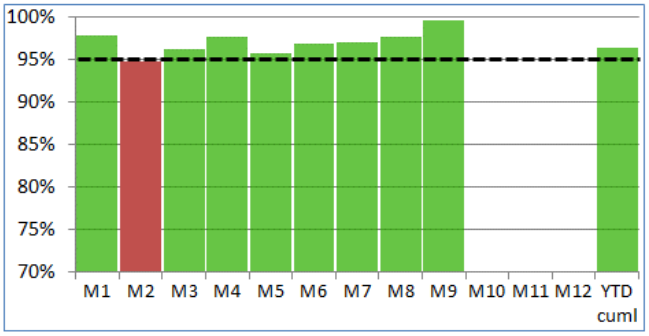
Due to the relatively low volume of NHS invoices paid during the year, only a small number of late invoices will make the performance non-compliant. So far this year, 677 NHS invoices have been paid in total, with 46 invoices being paid outside of the target period of 30 days. 5 of the 46 non-compliant invoices were paid late in December, and were within the Enabling functions.

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

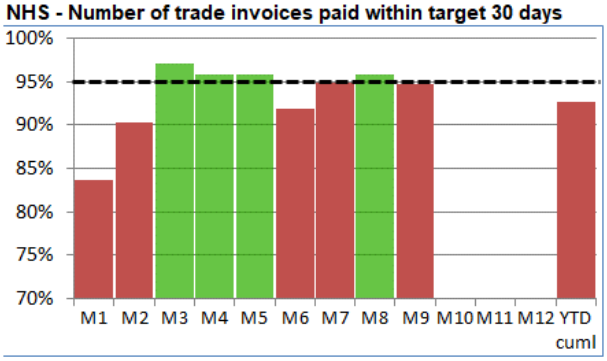
NON-NHS - No. of trade invoices paid within target 30 days



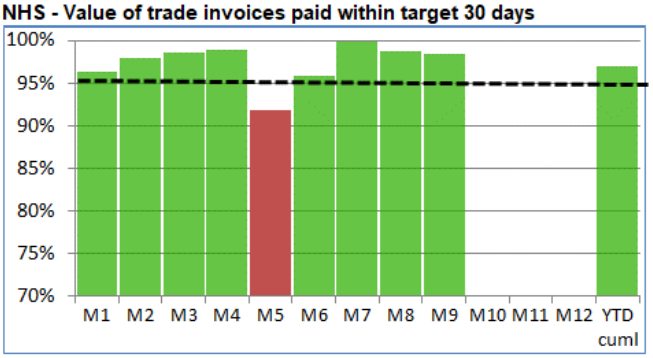
NON-NHS - Value of trade invoices paid within target 30 days



NHS - Number of trade invoices paid within target 30 days



NHS - Value of trade invoices paid within target 30 days



APPENDIX E - Capital Programme 2025/26 update

Trust Board approved an opening capital plan of £13.5m. In addition, the plan includes £5m of PDC funding received 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 the following additional capital support: GB Energy funding of £456k, £82k to support cyber security initiatives, a further £315k for estates clinical infrastructure risk and £166k was awarded this month for pharmacy software. Our System capital limit also increased by £687k resulting in a revised capital forecast of £18.58m.

	Annual Revised Plan	Dec Actual	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation	13,066	9,149	12,198	(868)
Cash reserves	2,840	(363)	4,136	1,296
Capital borrowings repayments	(4,447)	(3,181)	(4,188)	259
Total System operational capital	**11,459**	**5,605**	**12,146**	**687**
IFRS-16 new leases	**2,000**	**1,415**	**2,000**	**0**
MH OAPS - Acacia Ward Refurb	1,200	23	200	(1,000)
MH OAPS - Thornton Ward refurb	1,300	60	500	(800)
MH OAPS - Acute wards bathroom refurb	270	96	271	1
GB Energy	118	304	574	456
Estates Critical Infrastructure Risk (CIR)	2,129	496	2,443	314
Cyber security	0	54	82	82
Pharmacy software (medicine on admissions)	0	0	166	166
National Programmes (PDC)	**5,017**	**1,033**	**4,236**	**(781)**
PFI capital lifecycle costs	**202**	**152**	**202**	**0**
Total Capital funds	**18,678**	**8,204**	**18,584**	**(94)**
Application of Funds				
Estates	**£'000**	**£'000**	**£'000**	**£'000**
Strategic schemes	(1,497)	(3)	(157)	1,340
Capital staffing	(567)	(387)	(581)	(14)
Estates backlog programme	(3,470)	(713)	(3,673)	(203)
Estates rolling programme	(2,107)	(897)	(2,424)	(317)
Medical devices	(170)	0	(170)	0
Directorate investment	(7,430)	(3,711)	(7,527)	(97)
PFI Agnes Unit capital lifecycle costs	(202)	(151)	(202)	0
	(15,443)	**(5,862)**	**(14,734)**	**709**
IM&T investment	**(1,235)**	**(927)**	**(1,850)**	**(615)**
Operational Capital	**(16,678)**	**(6,789)**	**(16,584)**	**94**
IFRS16 - Right of Use Leases	**(2,000)**	**(1,415)**	**(2,000)**	**0**
Total Capital Expenditure	**(18,678)**	**(8,204)**	**(18,584)**	**94**
(Over)/underspend	**0**	**0**	**0**	**0**

Capital expenditure to date:

Capital expenditure up to the end of December totals £8.2m, which is £1.93m (19%) below planned levels for Month 9. The majority of spend relates to the Belvoir Unit refurbishment, Hinckley Hub lease conversion costs and the capitalisation of the associated lease. Expenditure will escalate in the final quarter of the year, bringing it back up to planned levels.

Capital changes since last month:

The total capital envelope has increased by £166k since the previous month, as detailed below:

	Opening Plan	Changes	Revised Plan	Comments
	£'000	£'000	£'000	
M09 Position	**(18,418)**	**(166)**	**(18,584)**	
Changes to Plan over £100k				
EPMA SystemC:Meds on admission software		-166		PDC allocation £166k for Pharmacy Software
BMS Strategy		-176		Increase bid total
Staff room upgrade		129		Works not expected to complete
Agnes Unit & Short Breaks		350		Phase 1b works not achievable in 2025/26
Acacia Full Refurbishment - The Willows		260		Adjustment to planned spend
Thornton Ward Refurbishment		-100		Adjustment to planned spend
Slippage		-303		Slippage on schemes
		-6		
Net Value of individual schemes changes less than £100k		-160		Smaller changes to schemes
Net change in Month		**-166**		

Capital forecasts

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: December 2025	2024/25 31/03/25 Audited £'000's	2025/26 31/12/25 December £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	132,331	132,850
Intangible assets	4,422	3,355
IFRS16 - Right of use (ROU) assets	18,538	18,340
Trade and other receivables	920	920
Total Non Current Assets	**156,211**	**155,465**
CURRENT ASSETS		
Inventories	436	443
Trade and other receivables	8,747	10,796
Short term investments	0	0
Cash and Cash Equivalents	19,547	20,640
Total Current Assets	**28,730**	**31,879**
Non current assets held for sale	**0**	**0**
TOTAL ASSETS	**184,942**	**187,344**
CURRENT LIABILITIES		
Trade and other payables	(28,128)	(32,312)
Borrowings	(4,481)	(4,527)
Provisions	(3,298)	(2,855)
Other liabilities	(6,755)	(7,769)
Total Current Liabilities	**(42,662)**	**(47,463)**
NET CURRENT ASSETS (LIABILITIES)	**(13,932)**	**(15,584)**
NON CURRENT LIABILITIES		
Borrowings	(39,939)	(38,883)
Provisions	(899)	(899)
Total Non Current Liabilities	**(40,838)**	**(39,782)**
TOTAL ASSETS EMPLOYED	**101,442**	**100,099**
TAXPAYERS' EQUITY		
Public Dividend Capital	108,228	108,228
Retained Earnings	(24,744)	(26,087)
Revaluation reserve	17,958	17,958
Other reserves	0	0
TOTAL TAXPAYERS EQUITY	**101,442**	**100,099**

Non-current assets

Property, plant, and equipment (PPE) amounts to £132.9m, and includes capital additions of £6.8m, offset by depreciation charges.

Right of Use (ROU) leased assets total £18.3m.

Current assets

Current assets of £31.9m mainly includes cash of £20.6m, and receivables of £10.8m.

Current Liabilities

Current liabilities amount to £47.5m with trade and other payables making up £32.3m of this balance.

Other liabilities of £7.8m relate to deferred income, of which the majority relates to Provider Collaborative income and Secure Digital Environment (SDE) funding, carried forward from 2024/25 to support future service delivery.
Net current assets / (liabilities) show net liabilities of £15.6m.

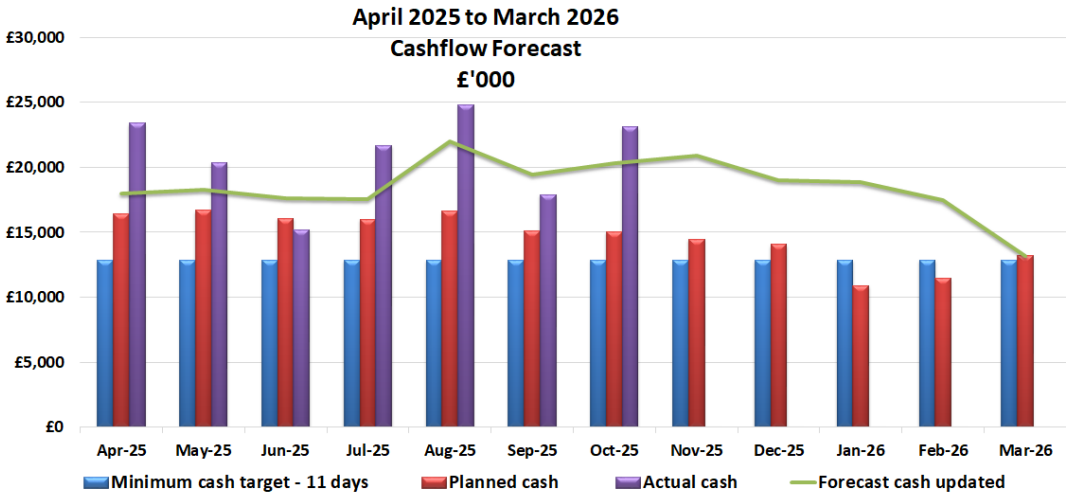
Taxpayers' Equity

November's deficit of £1.34m is reflected within retained earnings.

Public dividend capital balance is £108.2m at the end of December. This will increase in Quarter 4 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 December is £20.64, an increase of £1.1m since the start of the financial year. This delivers 18 operating days cash, 6 days above the planned level of 12 days for December.



The forecast closing cash balance as at the 31st of March 2026 remains at £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 being used 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 is 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	19,843	20,672	17,731	13,172
Actual cash	23,383	20,358	15,205	21,682	24,806	17,885	23,111	20,580	20,640	-	-	-

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

Receivables

Current receivables (debtors) total £10.8m, an increase of £2m since the start of the year. Most of this increase relates to outstanding contract recharges with other NHS providers.

Receivables	Current Month December 2025					
	NHS	Non	Emp's	Total	% Total	% Sales Ledger
	£'000	£'000	£'000	£'000		
Sales Ledger						
30 days or less	1,434	1,549	0	**2,983**	**25.46%**	**45.5%**
31 - 60 days	1,665	54	18	**1,737**	**14.83%**	**26.5%**
61 - 90 days	941	7	3	**951**	**8.12%**	**14.5%**
Over 90 days	41	642	207	**890**	**7.60%**	**13.6%**
	4,081	2,252	228	**6,561**	**56.00%**	**100.0%**
Non sales ledger	1,844	2,391	0	**4,235**	**36.15%**	
Total receivables current	**5,925**	**4,643**	**228**	**10,796**	**92.15%**	
Total receivables non current		920		920	**7.85%**	
Total	**5,925**	**5,563**	**228**	**11,716**	**100.00%**	**0.0%**

Debt greater than 90 days stands at £890k; this is a reduction of £2k 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 9 is 7.6% (last month: 7%). The reason the % performance has deteriorated despite the debt value reducing is due to the decrease in overall debt balances compared to the previous month.

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 9). Trust Board recently approved a £171k debt write-off relating to Central Nottinghamshire Clinical Services (CNCS) Ltd, due to the company going into liquidation. The write-off was fully provided for, with no impact on the financial position. It will be actioned in Month 10.

Payables

The current payables position in month 9 is £32.3m – an increase of £4.2m since the start of the year. Other liabilities of £7.8m relate to deferred income, mainly for 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

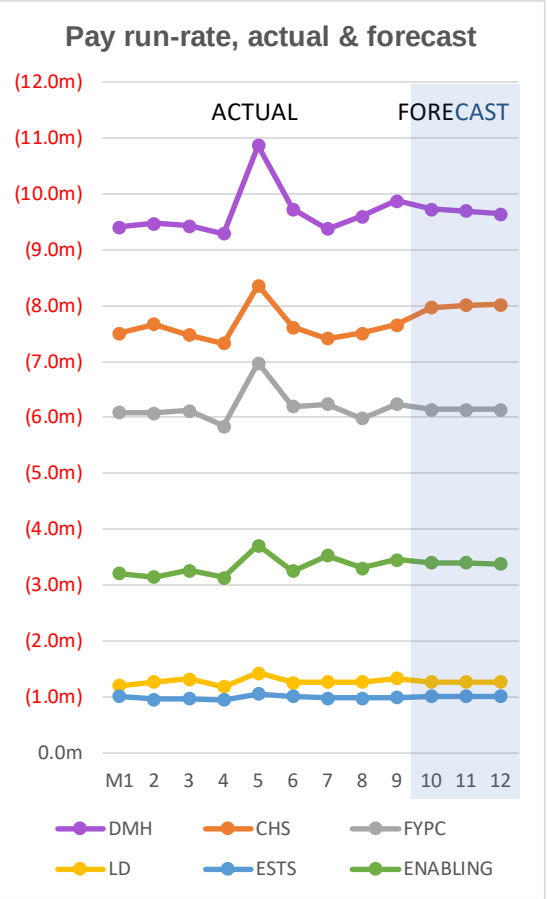
Current and non-current borrowings total £43.4m. PFI, property leases and the capital investment loan make up this balance, which reduces each month when corresponding payments are made or increases when new lease liabilities arise. The new Hinckley Hub lease is responsible for an increase in borrowings of £1.4m since the start of the year.

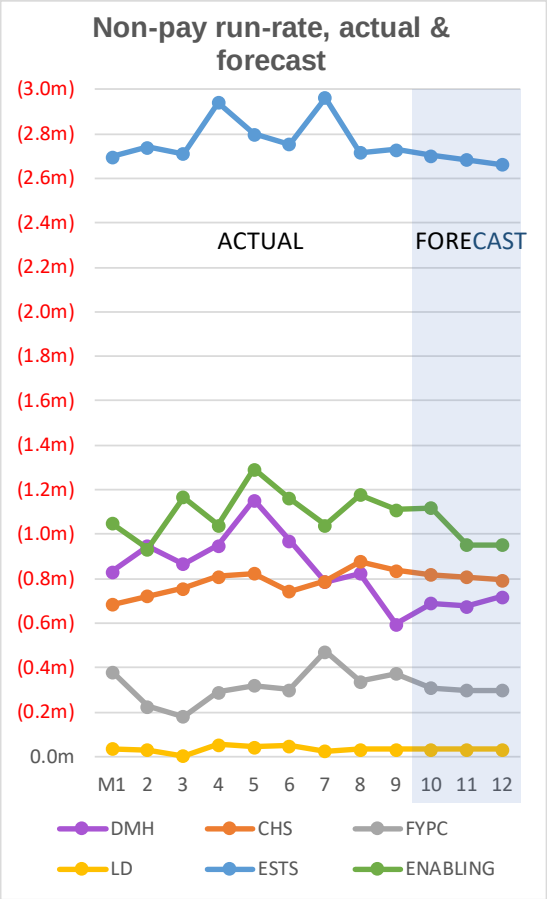
APPENDIX G – Directorate expenditure run-rates, forecast & actual

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 9 although the DMH position anticipates some reduction in cost in the final quarter which is supporting their improved forecast. Also, the CHS pay position reflects some cost increases relating to the opening of Gracedieu Ward. 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, but 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 (including Gracedieu costs)	0	0	(69)	(300)
FYPC	500	400	400	0
LD	(300)	(400)	(400)	(500)
ESTS	50	0	(40)	(240)
ENABLING	1,275	1,270	1,211	500
HOSTED	150	125	100	(100)
TOTAL DIRECTORATE FOT VARIANCE:	**432**	**(245)**	**(438)**	**(2,507)**

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:	752	752	752	568
£2m NON-REC INCOME TARGET:	1,588	1,588	1,148	800
DIFFICULT DECISIONS / FURTHER NON-RECURRENT TARGETS:	(100)	(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:	**631**	**251**	**(685)**	**(1,217)**
Other mitigation identified to date				
Interest receivable minor gain over budget:	400	375	350	300
Slippage on internal investments:	260	260	260	230
Sub-total 'mitigations' (reserves) position:	**1,291**	**886**	**(75)**	**(687)**
Pay award funding shortfall:	**(1,402)**	**(1,402)**	**(1,402)**	**(1,402)**
TOTAL CORPORATE PRESSURES / MITIGATIONS:	**(111)**	**(516)**	**(1,477)**	**(2,089)**
TOTAL TRUST	**321**	**(761)**	**(1,915)**	**(4,596)**

**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

The Trust is currently reporting an estimated underlying income and expenditure deficit of £12.6m. The table below shows how the in-year forecast of £0.3m surplus moves to the £12.6m underlying deficit when non-recurrent gains are removed from the recurrent position.

CALCULATION OF HIGH LEVEL UNDERLYING POSITION 2025/26 - @ M9	£000
2025/26 Forecast outturn reported at M9:	**311**
FOT non-recurrent CIPs*	(9,800)
Net impact of recurrent CIP FYE	860
Confirmed shortfall in 25/26 pay award funding	(1,402)
Additional non-recurrent gains required to deliver 25/26 plan	(1,920)
Recurrent impact of ceasing temporary vacancy pause	(600)
FORECAST YEAR END UNDERLYING POSITION (deficit) at M9:	**(12,551)**

*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.
Eliminating the underlying deficit position is a core element of planning for 2026/27 and across the life of the medium term financial plan.

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:	19th January 2026
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

T H R I V E

O

Leicestershire Partnership NHS Trust

Public Trust Board - 27January 2026

Board Performance Report – December 2025 (Month 9)

Purpose of the Report

To provide the Trust Board with an overview of Trust performance against an agreed set of KPI's for December 2025 (M9 of 2025/26).

Analysis of the Issue

The report has been presented to the Accountability Framework Meeting ahead of Trust Board.

Proposal

The following should be noted by the Accountability Framework Meeting in their review of the report and looking ahead to the next reporting period:

- A data quality issue which had been identified in relation to the longest waiter in Adult ADHD as shown in Board Performance Report. This has now been resolved and will be reflected in next month's report.

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

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

- Trend moving from *common cause* to *special cause improving with lower values*
    - Occupancy Rate - Mental Health Beds (excluding leave)
- Trend moving from *common cause* to *special cause concerning with higher values*
    - CAMHS - Treatment waits (excl ND) - No of waiters
    - No. of episodes of prone (Unsupported) restraint
    - Sickness Absence
    - Sickness Absence Costs
- Trend moving from *special cause concerning with higher values* to *common cause*
    - No. of Complaints

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.

All other metrics remain unchanged**.**

Decision Required

Decision required – detail below

The Trust Board is asked to:

- Approve the Performance Report.

Governance Table

For Board and Board Committees:	Trust Board
Paper sponsored by:	Sharon Murphy, Director of Finance and Performance
Paper authored by:	Pardeep Dhami, Information Analyst Prakash Patel, Head of Information Anne Senior, Associate Director
Date submitted:	19.01.26
Name and date of other committee / forum at which this report / issue was considered:	This report will be presented to the January Accountability Framework Meeting prior to sharing at Trust Board.
Level of assurance gained if considered elsewhere	☐Assured ☐ Partially assured ☐ Not assured
Date of next report:	
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)	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 or 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

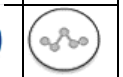
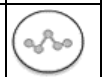
NHS
Leicestershire Partnership
NHS Trust

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%	Nov-25	52.5%	54.9%	F	
Memory Clinic (18 week Local RTT) - Incomplete pathway	>=92%	Nov-25	54.6%	54.0%	F	L
ADHD (18 week local RTT) - Incomplete pathway	>=92%	Nov-25	7.8%	8.2%	F	H
CINSS (6 weeks) - Incomplete Pathway	>=95%	Nov-25	50.6%	46.9%	F	
Speech Therapy - Voice, Respiratory and Dysfluency - Routine (6 weeks) - Incomplete Pathway	>=95%	Nov-25	21.9%	20.7%	F	L
Community Paediatrics (18 weeks) - Incomplete pathway	>=92%	Nov-25	9.0%	9.3%	F	L
Childrens Audiology (6 week wait for diagnostic procedures) - Incomplete pathway	>=99%	Nov-25	35.7%	37.6%	F	H
Adult General Psychiatry - Community Mental Health Teams and Outpatients – Treatment waits - No of Waiters	0	Dec-25	1	0	F	L
Cognitive Behavioural Therapy - Treatment waits - No of waiters	0	Dec-25	49	42	F	
Dynamic Psychotherapy - Treatment waits - No of waiters	0	Dec-25	1	2	F	
Therapy Service for People with Personality Disorder - Treatment waits - No of waiters	0	Dec-25	107	132	F	
Medical/Neuropsychology - Treatment waits - No of Waiters	0	Dec-25	85	88	F	H
ADHD (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	Nov-25	6464	6250	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	Nov-25	9	11	F	L
Community Paediatrics - assessment waits over 52 weeks - No of waiters	0	Nov-25	6585	6380	F	H
Community Paediatrics Treatment (excl ND) - No of waiters	0	Dec-25	16	29	F	L
All Neurodevelopment (inc CAMHS, SALT, PAEDS) - Treatment waits - No of waiters	0	Dec-25	1575	0	F	H
CAMHS - Treatment waits (excl ND) - No of waiters	0	Dec-25	116	91	F	H
All LD - Treatment waits - No of waiters	0	Dec-25	4	2	F	L
Children's SALT Communication & Dysphagia - No of waiters	0	Dec-25	1892	1808	F	H
Children's Physiotherapy - No of waiters	0	Dec-25	10	10	F	H
Adult Eating Disorders Community - Treatment waits - No of waiters	0	Dec-25	0	2	?	L
Safe staffing - No. of wards not meeting >80% fill rate for RNs - Day	0	Dec-25	2	3	F	
Vacancy Rate	<=10%	Dec-25	10.2%	10.1%	F	L
Sickness Absence	<=5.0%	Nov-25	6.0%	6.0%	?	H
Agency Costs	<=£922,333	Dec-25	£566,036	£686,388	F	L

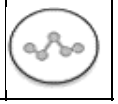
EXCEPTION REPORTS - Consistently Achieving Target						
Indicator	**Monthly Target**	**Data As At**	**Current Reporting**	**Previous Reporting**	**SPC Assurance**	**SPC Trend**
MRSA Infection Rate	**0**	**Dec-25**	**0**	**0**		
Clostridium difficile infection rate	**<=12**	**Dec-25**	**0**	**3**		
Gatekeeping	**>=95%**	**Dec-25**	**97.5%**	**98.7%**		
Normalised Workforce Turnover (Rolling previous 12 months)	**<=10%**	**Dec-25**	**7.3%**	**7.2%**		
Core Mandatory Training Compliance for substantive staff	**>=85%**	**Dec-25**	**98.6%**	**98.4%**		
Staff with a Completed Annual Appraisal	**>=80%**	**Dec-25**	**94.8%**	**94.6%**		
% of staff from a BME background	**>=22.5%**	**Dec-25**	**33.1%**	**32.9%**		
% of staff who have undertaken clinical supervision within the last 3 months	**>=85%**	**Dec-25**	**94.0%**	**94.2%**		

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	Adult ED Community 52 wks	*Waiting Times* : ADHD / Children's Audiology / CMHT 52 Wks / TSPPD 52 wks / MHSOP Memory Clinic 52 Wks / Community Paediatrics Treatment 52 Wks / LD 52 Wks Agency Cost / Vacancy Rate
	Common Cause 	MRSA Infection Rate / Clostridium difficile infection rate Gatekeeping Staff with a Completed Annual Appraisal		*Waiting Times:* Adult CMHT / Stroke & Neuro / CBT 52 wks / DPS 52 wks Safe staffing - Day
	Special Cause - Concern 			*Waiting Times:* Speech Therapy / Memory Clinic / Community Paediatrics / Medical_Neuro 52 wks / ADHD 52 weeks / Community Paediatrics 52 wks assessment / All Neurodevelopment 52 Wks / CAMHS - Treatment waits / Children's SALT Communication & Dysphagia 52 Wks / Children's Physiotherapy 52 wks

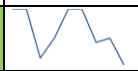
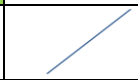
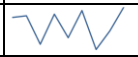
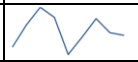
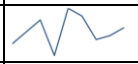
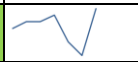
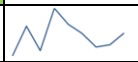
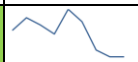
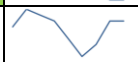
SUMMARY

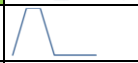
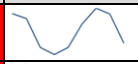
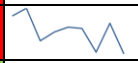
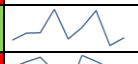
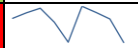
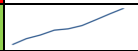
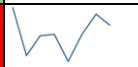
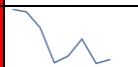
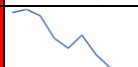
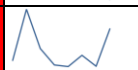
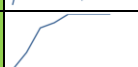
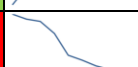
WORKFORCE						
Indicator	**Monthly Target**	**Data As At**	**Current Reporting Period**	**Previous Reporting Period**	**SPC Assurance**	**SPC Trend**
Normalised Workforce Turnover (Rolling previous 12 months)	**<=10%**	**Dec-25**	**7.3%**	**7.2%**		
Vacancy Rate	**<=10%**	**Dec-25**	**10.2%**	**10.1%**		
Sickness Absence (in arrears)	**<=5.0%**	**Nov-25**	**6.0%**	**6.0%**		
Agency Costs	**<=£922,333**	**Dec-25**	**£566,036**	**£686,388**		

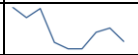
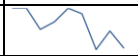
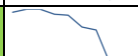
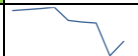
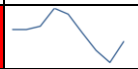
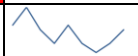
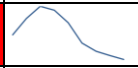
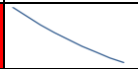
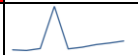
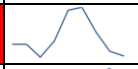
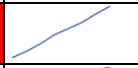
QUALITY & SAFETY						
Indicator	**Monthly Target**	**Data As At**	**Current Reporting Period**	**Previous Reporting Period**	**SPC Assurance**	**SPC Trend**
Safe staffing - No. of wards not meeting >80% fill rate for RNs - Day	**0**	**Dec-25**	**2**	**3**		
Safe staffing - No. of wards not meeting >80% fill rate for RNs - Night	**0**	**Dec-25**	**1**	**1**		

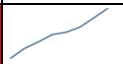
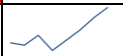
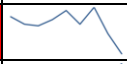
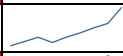
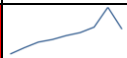
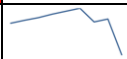
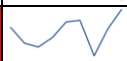
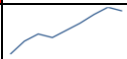
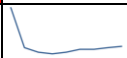
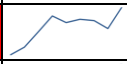
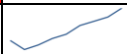
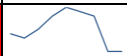
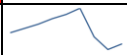
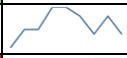
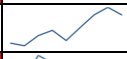
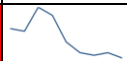
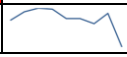
FINANCE (Metrics TBC)

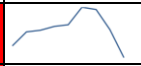
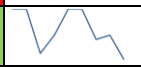
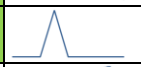
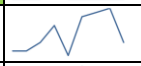
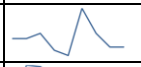
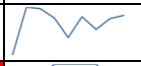
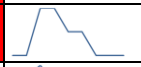
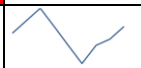
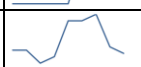
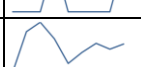
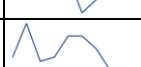
Board Performance Report
Summary Dashboard

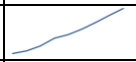
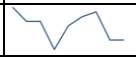
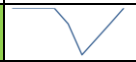
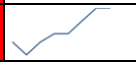
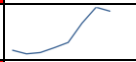
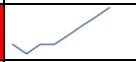
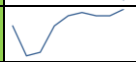
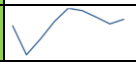
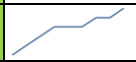
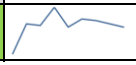
Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Quality Account	TRUST	Monthly	The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period	>=95%	Dec-25	97.5%	98.7%				
	TRUST	Yearly	The Trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period		24/25	6.6	6.3				
	TRUST	Monthly	The percentage of inpatients discharged with a subsequent inpatient admission within 30 days - 0-15 years		Dec-25	0.0%	0.0%				
	TRUST	Monthly	The percentage of inpatients discharged with a subsequent inpatient admission within 30 days - 16+ years		Dec-25	7.6%	6.2%				
	TRUST	Monthly	The number of patient safety incidents reported within the Trust during the reporting period		Dec-25	1774	1802				
	TRUST	Monthly	The rate of patient safety incidents reported within the Trust during the reporting period		Dec-25	68.1%	68.2%				
	TRUST	Monthly	The number of such patient safety incidents that resulted in severe harm or death		Dec-25	12	10				
	TRUST	Monthly	The percentage of such patient safety incidents that resulted in severe harm or death		Dec-25	0.7%	0.6%				
	MHSDS	Monthly (a quarter in arrears)	72 hour Follow Up after discharge (Aligned with national published data)	>=80%	Oct-25	93.0%	86.0%				
NHS Oversight	TRUST	Monthly	2-hour urgent response activity	>=70%	Dec-25	86.4%	86.9%				
	TRUST	Monthly	Daily discharges as % of patients who no longer meet the criteria to reside in hospital		Dec-25	26.3%	24.1%				
	TRUST	Monthly	Out of Area Placement - Inappropriate Bed Days	0	Dec-25	0	0				
	ICB	Monthly	Reliance on specialist inpatient care for adults with a learning disability and/or autism		Dec-25	29	29				
	ICB	Monthly	Reliance on specialist inpatient care for children with a learning disability and/or autism		Dec-25	1	4				
		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		Q2	2	2				
	MHRA	Monthly	National Patient Safety Alerts not completed by deadline		Dec-25	0	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	Dec-25	0	0				
	TRUST	Monthly	Clostridium difficile infection rate	<=12	Dec-25	0	3				
	UHL	Monthly (In Arrears)	E.coli bloodstream infections		Nov-25	0	0				
	GOV	Monthly (YTD)	Percentage of people aged 65 and over who received a flu vaccination		Nov-25	71.6%					
			VTE Risk Assessment								
Operational Planning	TRUST	Monthly (3 month rolling)	Average Length of Stay in Adult Acute MH Beds	<=53.5	Dec-25	60.0	67.5				
	TRUST	Monthly	Average Length of stay - Community Hospitals	<=23.5	Dec-25	22.3	24.7				
	TRUST	Monthly	Community Care Contacts - CHS	Plan=81609	Dec-25	84464	83048				
	TRUST	Monthly	Community Care Contacts - FYPC	Plan=8292	Dec-25	8969	10403				
	TRUST	Monthly	Community Services Waiting List over 52 weeks	Target =0 Plan=6963	Dec-25	6782	6585				
Access Waiting Times - DMH	TRUST	Monthly (In Arrears)	Adult CMHT Access (6 weeks routine) - Incomplete pathway	>=95%	Nov-25	52.5%	54.9%				
	TRUST	Monthly (In Arrears)	Memory Clinic (18 week Local RTT) - Incomplete pathway	>=92%	Nov-25	54.6%	54.0%				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - Incomplete pathway	>=92%	Nov-25	7.8%	8.2%				
	TRUST	Monthly (In Arrears)	Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral - complete pathway	>=60%	Nov-25	80.0%	59.3%				
Access Waiting Times - CHS	TRUST	Monthly (In Arrears)	CINSS (6 weeks) - Incomplete Pathway	>=95%	Nov-25	50.6%	46.9%				
	TRUST	Monthly (In Arrears)	Speech Therapy - Voice, Respiratory and Dysfluency - Routine (6 weeks) - Incomplete Pathway	>=95%	Nov-25	21.9%	20.7%				
Access Waiting Times - FYPCLDA	TRUST	Monthly (In Arrears)	CAMHS Eating Disorder (one week) - Complete pathway	>=95%	Nov-25	100.0%	100.0%				
	TRUST	Monthly (In Arrears)	CAMHS Eating Disorder (four weeks) - Complete pathway	>=95%	Nov-25	100.0%	100.0%				
	TRUST	Monthly (In Arrears)	Community Paediatrics (18 weeks) - Incomplete pathway	>=92%	Nov-25	9.0%	9.3%				
	TRUST	Monthly (In Arrears)	Childrens Audiology (6 week wait for diagnostic procedures) - Incomplete pathway	>=99%	Nov-25	35.7%	37.6%				

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)		Dec-25	3.0%	8.3%				
	TRUST	Monthly	(5-18yrs) Percent of RHAs sent to LA in month within 12 months of previous assessment (City/County/Rutland)		Dec-25	92.1%	95.5%				
	TRUST	Monthly	(0-4yrs) Percent of RHAs sent to LA in month within 6 months of previous assessment (City/County/Rutland)		Dec-25	100.0%	92.0%				
52 Week Waits - DMH	TRUST	Monthly	Adult General Psychiatry - Community Mental Health Teams and Outpatients – Treatment waits - No of Waiters	0	Dec-25	1	0				
	TRUST	Monthly	Adult General Psychiatry - Community Mental Health Teams and Outpatients – Treatment waits - Longest Waiter		Dec-25	58	0				
	TRUST	Monthly	Cognitive Behavioural Therapy - Treatment waits - No of waiters	0	Dec-25	49	42				
	TRUST	Monthly	Cognitive Behavioural Therapy- Treatment waits - Longest waiter (weeks)		Dec-25	84	81				
	TRUST	Monthly	Dynamic Psychotherapy - Treatment waits - No of waiters	0	Dec-25	1	2				
	TRUST	Monthly	Dynamic Psychotherapy - Treatment waits - Longest waiter (weeks)		Dec-25	57	56				
	TRUST	Monthly	Therapy Service for People with Personality Disorder - Treatment waits - No of waiters	0	Dec-25	107	132				
	TRUST	Monthly	Therapy Service for People with Personality Disorder - Treatment waits - Longest waiter (weeks)		Dec-25	202	198				
	TRUST	Monthly	Medical/Neuropsychology - Treatment waits - No of Waiters	0	Dec-25	85	88				
	TRUST	Monthly	Medical/Neuropsychology- Treatment waits - Longest Waiter		Dec-25	131	155				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	Nov-25	6464	6250				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - assessment waits over 52 weeks - Longest waiter (weeks)		Nov-25	422	418				
	TRUST	Monthly (In Arrears)	MHSOP Memory Clinics (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	Nov-25	9	11				
	TRUST	Monthly (In Arrears)	MHSOP Memory Clinics (18 week local RTT) - assessment waits over 52 weeks -Longest waiter (weeks)		Nov-25	75	71				

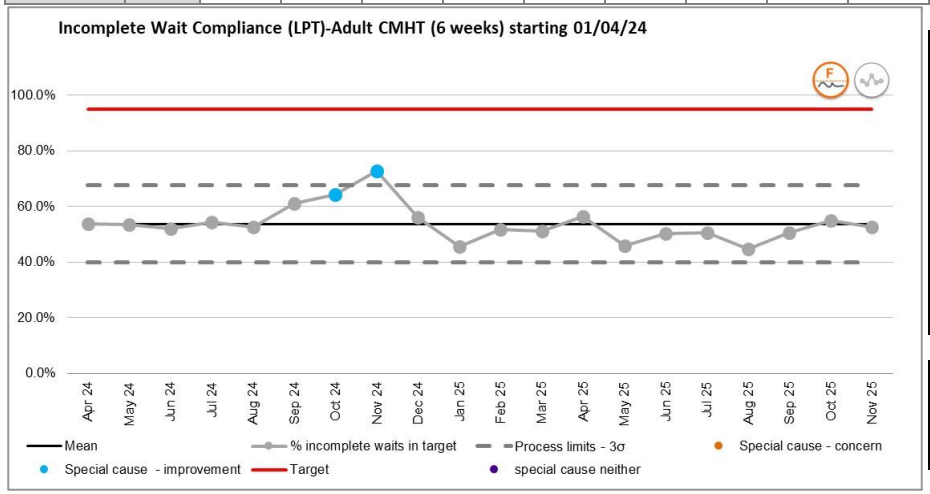
Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
52 Week Waits - FYPCLDA	TRUST	Monthly (In Arrears)	Community Paediatrics - assessment waits over 52 weeks - No of waiters	0	Nov-25	6585	6380				
	TRUST	Monthly (In Arrears)	Community Paediatrics - assessment waits over 52 weeks - Longest waiter (weeks)		Nov-25	202	198				
	TRUST	Monthly	Community Paediatrics Treatment (excl ND) - No of waiters	0	Dec-25	16	29				
	TRUST	Monthly	Community Paediatrics Treatment (excl ND) - Longest waiter		Dec-25	169	154				
	TRUST	Monthly	All Neurodevelopment (inc CAMHS, SALT, PAEDS) - Treatment waits - No of waiters	0	Dec-25	1575	1893				
	TRUST	Monthly	All Neurodevelopment (inc CAMHS, SALT, PAEDS) - Treatment waits - Longest waiter (weeks)		Dec-25	193	243				
	TRUST	Monthly	CAMHS - Treatment waits (excl ND) - No of waiters	0	Dec-25	116	91				
	TRUST	Monthly	CAMHS - Treatment waits (excl ND) - Longest waiter (weeks)		Dec-25	92	94				
	TRUST	Monthly	All LD - Treatment waits - No of waiters	0	Dec-25	4	2				
	TRUST	Monthly	All LD - Treatment waits - Longest waiter (weeks)		Dec-25	55	54				
	TRUST	Monthly	Children's SALT Communication & Dysphagia - No of waiters	0	Dec-25	1892	1808				
	TRUST	Monthly	Children's SALT Communication & Dysphagia - Longest waiter		Dec-25	129	125				
	TRUST	Monthly	Children's Physiotherapy - No of waiters	0	Dec-25	10	10				
	TRUST	Monthly	Children's Physiotherapy - Longest waiter		Dec-25	91	86				
	TRUST	Monthly	Children's Continence - No of waiters	0	Dec-25	0	0				
	TRUST	Monthly	Children's Continence - Longest waiter		Dec-25	19	23				
	TRUST	Monthly	Audiology - No of waiters	0	Dec-25	1	1				
	TRUST	Monthly	Audiology - Longest waiter		Dec-25	52	55				
	TRUST	Monthly	Adult Eating Disorders Community - Treatment waits - No of waiters	0	Dec-25	0	2				
	TRUST	Monthly	Adult Eating Disorders Community - Treatment waits - Longest waiter (weeks)		Dec-25	36	75				

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%	Dec-25	82.0%	85.5%				
	TRUST	Monthly	Occupancy Rate - Community Beds (excluding leave)	>=93%	Dec-25	91.1%	92.8%				
	TRUST	Monthly	Delayed Transfers of Care	<=3.5%	Dec-25	6.7%	6.4%				
	TRUST	Monthly	Gatekeeping	>=95%	Dec-25	97.5%	98.7%				
	TRUST	Monthly	Admissions to adult facilities of patients under 18 years old	0	Dec-25	0	0				
Quality & Safety	TRUST	Monthly	No. of Complaints		Dec-25	23	31				
	TRUST	Monthly	No. of Concerns		Dec-25	39	39				
	TRUST	Monthly	No. of Compliments		Dec-25	202	197				
	TRUST	Monthly	Safe staffing - No. of wards not meeting >80% fill rate for RNs - Day	0	Dec-25	2	3				
	TRUST	Monthly	Safe staffing - No. of wards not meeting >80% fill rate for RNs - Night	0	Dec-25	1	1				
	TRUST	Monthly	Care Hours per patient day		Dec-25	11.8	11.6				
	TRUST	Monthly	No. of Long term Segregations		Dec-25	2	2				
	TRUST	Monthly	No. of episodes of seclusions >2hrs		Dec-25	5	7				
	TRUST	Monthly	No. of episodes of prone (Supported) restraint		Dec-25	1	1				
	TRUST	Monthly	No. of episodes of prone (Unsupported) restraint		Dec-25	1	0				
	TRUST	Monthly	Total number of Restrictive Practices		Dec-25	259	240				
	TRUST	Monthly (In Arrears)	No. of Category 2 pressure ulcers developed or deteriorated in LPT care		Nov-25	126	102				
	TRUST	Monthly (In Arrears)	No. of Category 3 pressure ulcers developed or deteriorated in LPT care		Nov-25	11	16				
	TRUST	Monthly (In Arrears)	No. of Category 4 pressure ulcers developed or deteriorated in LPT care		Nov-25	11	13				
	TRUST	Monthly (In Arrears)	No. of repeat falls		Nov-25	58	62				

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		Dec-25	91	85				
	TRUST	Monthly	LD Annual Health Checks completed - YTD		Dec-25	56.1%	48.1%				
	TRUST	Monthly	LeDeR Reviews completed within timeframe - Allocated		Dec-25	4	4				
	TRUST	Monthly	LeDeR Reviews completed within timeframe - Awaiting Allocation		Dec-25	14	11				
	TRUST	Monthly	LeDeR Reviews completed within timeframe - On Hold		Dec-25	15	14				
HR Workforce	TRUST	Monthly	Normalised Workforce Turnover (Rolling previous 12 months)	<=10%	Dec-25	7.3%	7.2%				
	TRUST	Monthly	Vacancy Rate	<=10%	Dec-25	10.2%	10.1%				
	TRUST	Monthly (In Arrears)	Sickness Absence	<=5.0%	Nov-25	6.0%	6.0%				
	TRUST	Monthly (In Arrears)	Sickness Absence Costs		Nov-25	£1,257,341	£1,274,361				
	TRUST	Monthly (In Arrears)	Sickness Absence - YTD	<=5.0%	Nov-25	5.5%	5.4%				
	TRUST	Monthly	Agency Costs	<=£922,333	Dec-25	£566,036	£686,388				
	TRUST	Monthly	Core Mandatory Training Compliance for substantive staff	>=85%	Dec-25	98.6%	98.4%				
	TRUST	Monthly	Staff with a Completed Annual Appraisal	>=80%	Dec-25	94.8%	94.6%				
	TRUST	Monthly	% of staff from a BME background	>=22.5%	Dec-25	33.1%	32.9%				
	TRUST	Monthly	Staff flu vaccination rate (frontline healthcare workers)		Dec-25	45.5%					
	TRUST	Monthly	% of staff who have undertaken clinical supervision within the last 3 months	>=85%	Dec-25	94.0%	94.2%				

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

DMH	Target	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
	>=95%	56.1%	45.6%	51.7%	51.1%	56.4%	45.9%	50.2%	50.5%	44.6%	50.5%	54.9%	52.5%
No of Referrals		319	251	310	338	413	348	314	448	344	439	539	474



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
53.7%	40.0%	68.0%

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 to most appropriate service(s) to meet their needs; enhanced 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.

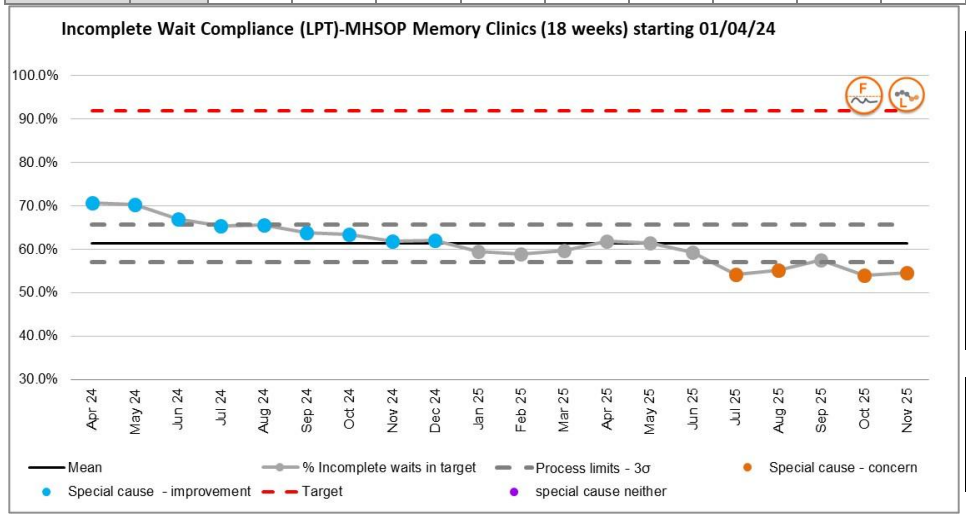
Work continues to progress caseloads review programme. Medical workforce transformation plan workstreams will review caseload and patient cohorts in outpatient clinics with the expected outcome of reduced consultant caseloads, bringing these within agreed thresholds, and supporting increased retention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

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

DMH	Target	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
	>=92%	62.1%	59.4%	58.9%	59.7%	61.9%	61.5%	59.2%	54.1%	55.1%	57.6%	54.0%	54.6%
No of Referrals		197	184	196	253	218	207	240	184	203	279	267	224



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
61.3%	57.0%	66.0%

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

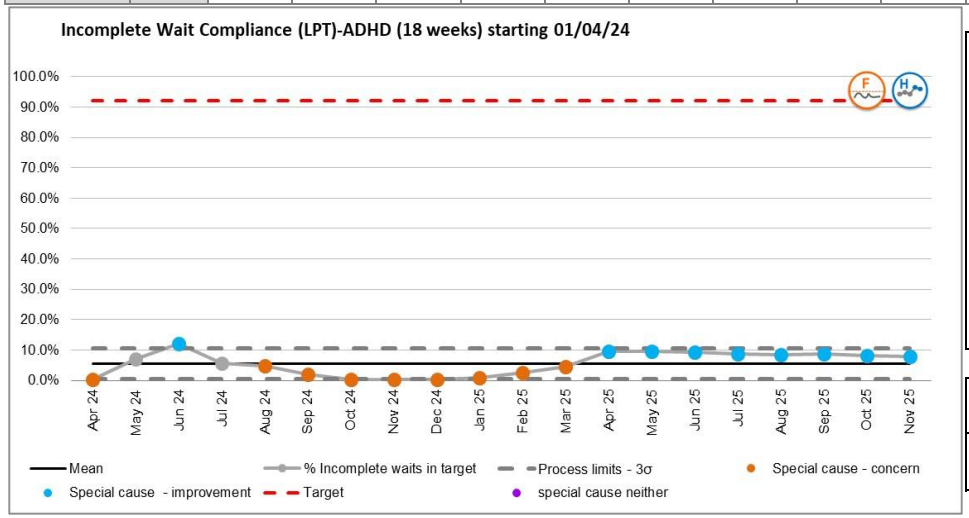
Implementation of One Stop Clinic (Rapid Access Clinics) commenced March 2025 with noted improvement in numbers waiting and length of wait where patients are seen and diagnosed in clinic. Has enabled assessment and diagnosis on-the-day. Advanced pathway clinics pilot commenced June 2025, for patients 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 2025. A review of both models taking place in Q4 to assess effectiveness in improving the patient experience and waiting times and establish future plans for this approach.

All patients waiting receive wellbeing calls following initial 8 week wait and 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. High levels of referral continue to challenge available capacity.

Some long term sickness affecting the medical and nursing capacity since October 2025. Seeking locum cover for consultant sickness to support capacity

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

DMH	Target	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
	>=92%	0.3%	0.9%	2.5%	4.5%	9.5%	9.6%	9.4%	8.7%	8.4%	8.8%	8.2%	7.8%
No of Referrals		258	314	292	311	247	216	268	266	239	299	251	257



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.

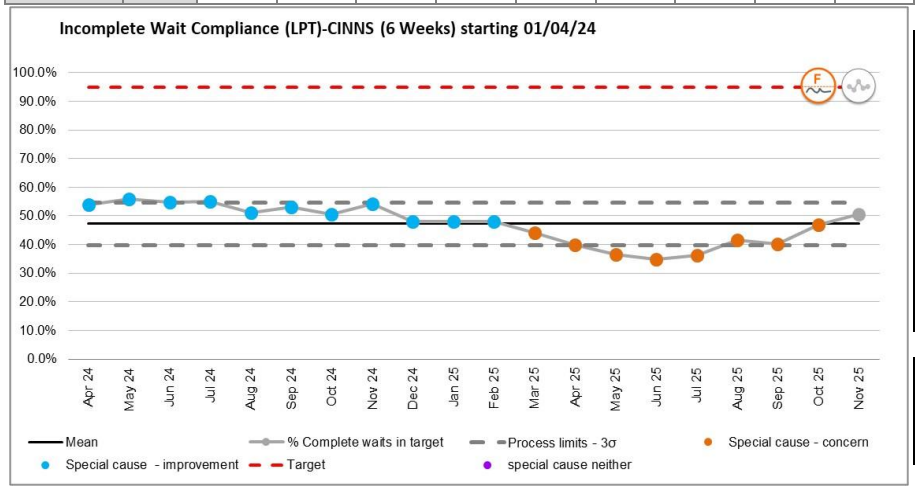
Mean	Lower Process Limit	Upper Process Limit
5.5%	0.1%	11.0%

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. This latter service will go live in January - new provider now confirmed with comms plan to be overseen by ICB. The service continues to work with the Communications Team to develop and make available 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	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
	>=95%	48.0%	48.1%	47.9%	44.0%	39.9%	36.6%	34.9%	36.3%	41.5%	40.2%	46.9%	50.6%
No of Referrals		170	222	174	210	203	219	180	189	205	165	188	178



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
47.2%	40.0%	55.0%

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

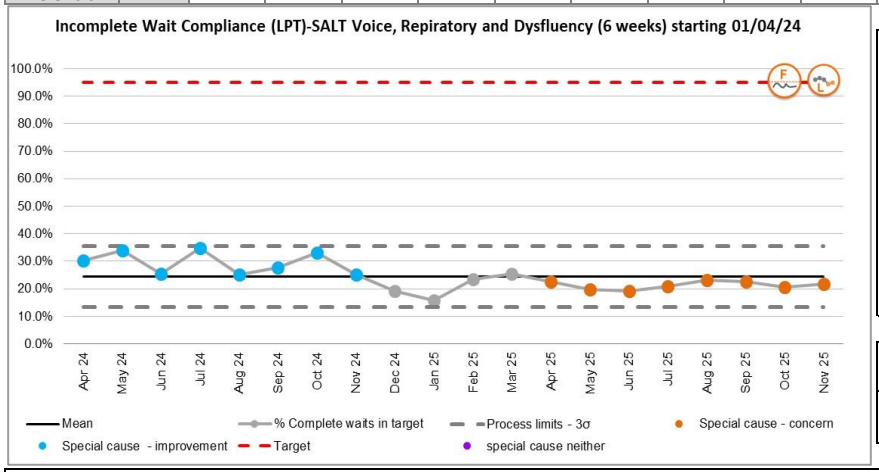
Achieved:
- New internal referral process between Allied Health Professionals within the CINSS team been implemented to ensure new slots are not prioritised for internal service referrals between CINSS AHPs i.e. OTs and Physios.
- Service Time Out to review impact of job plans and other service changes .
- OT Memory Group has commenced.

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. Data shows the service has over achieved its trajectory to reduce the number of patients waiting. N.B. Whilst incomplete compliance will improve, complete compliance will initially 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:
- Dictation sortware options to be explored and piloted in the service to create more clinical capacity. Paper with recommendations will go to DMT in January.
- Review alternative options for safeguarding related activity and liaison with other agencies especially social care.
- Review holistic template requirements to identiify any efficiencies.
- Review equipment list allowed for trusted assessment to identify any efficiencies in the ordering of equipment process.
- Work with onboarding team to help with OT workforce challenges and bank recruitment.

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

CHS	Target	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
	>=95%	19.2%	15.7%	23.4%	25.4%	22.6%	19.7%	19.3%	20.8%	23.2%	22.5%	20.7%	21.9%
No of Referrals		67	68	78	100	72	73	58	63	81	81	72	56



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
24.5%	13.0%	36.0%

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

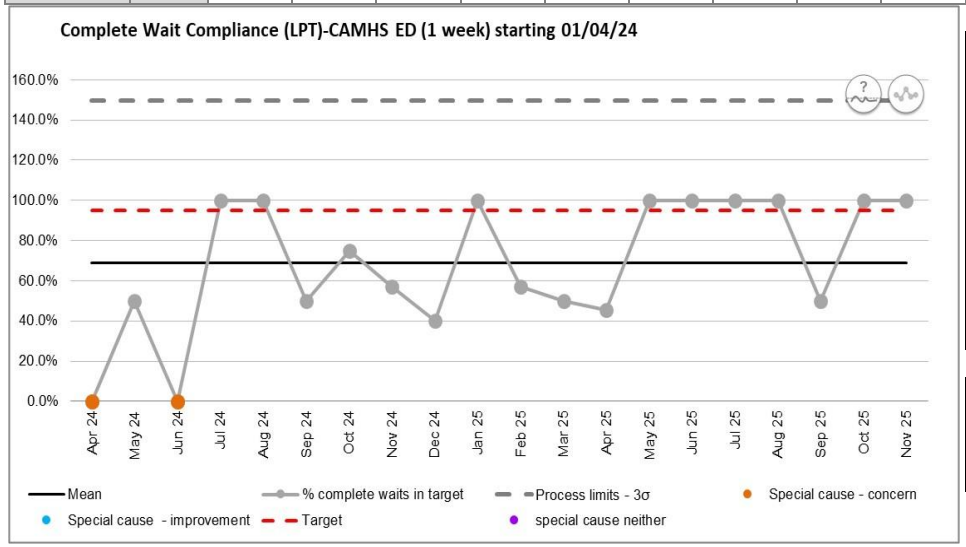
ACHIEVED:
- Additional admin support to book patients in to appointments will release clinical capacity and ensure all capacity is utilised to reduce numbers and length of wait. Montitored via weekly SPC charts.
- Admin processes have been streamlined.
- DNA/Cancellation Policy has been reviewed and processes in place to ensure followed at all times.
- Opt-in letters to all voice patients has led to 50% of this waiting list cohort being discharged (N.B. the this cohort is the smaller proportion of the waiting list with majority in the respiratory cohort).

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 sent to longest waiters on the respiratory waiting list in staggered batches. These are working age adults and SBAR & EQIA completed to ensure effective risk management. Anticipate c30% will be discharged due to no longer wanting/needing to be seen.
- PTL process changes to strengthen waiting list management

NEXT STEPS:
- 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 February 2026 - note new timescale due to operational issues and unplanned sickness negatively affecting clinical capacity.
- Consider increased use of digital communication for appointment offers, self-help, service information. Scoping of options with the Business Team to be complete by end of Q4.
- Consider increasing use of video and telephone follow-ups to reduce cancellations / non-attendance and increase productivity. Scoping to be completed by end of Q4.
- Introduce individualised job plans. To be completed by end of Q4.

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

FYPCLDA	Target	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
	>=95%	40.0%	100.0%	57.1%	50.0%	45.5%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%
No of Referrals		4	5	5	8	8	2	2	3	3	4	5	1



Analytical Commentary

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

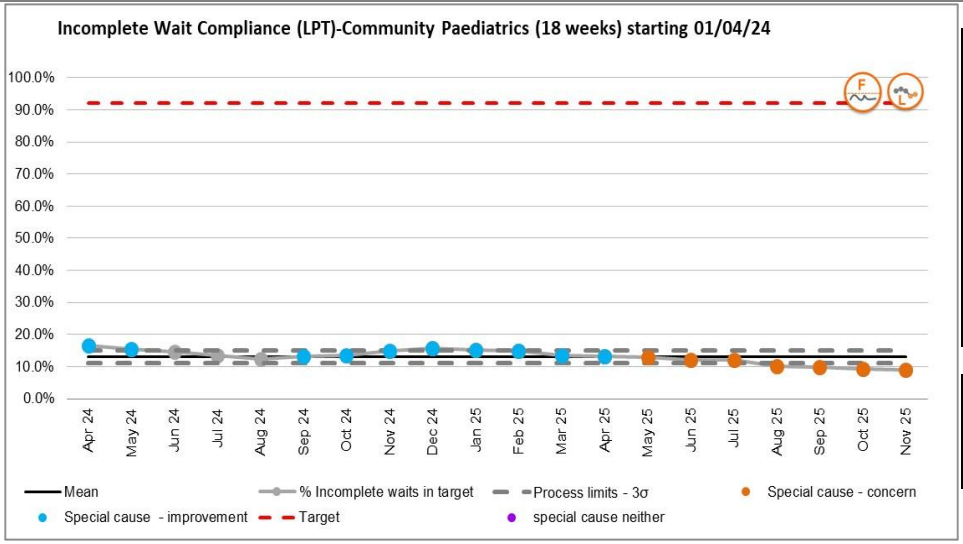
Mean	Lower Process Limit	Upper Process Limit
68.7%	-12.0%	150.0%

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

Daily PTL's in place for monitoring performance, with oversight through service line governance meeting. This has supported 100% delivery against this target.

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

FYPCLDA	Target	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
	>=92%	14.8%	15.6%	15.2%	15.0%	13.6%	13.2%	13.0%	12.0%	10.2%	9.8%	9.3%	9.0%
No of Referrals		300	366	318	345	271	269	286	290	137	215	295	226



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.

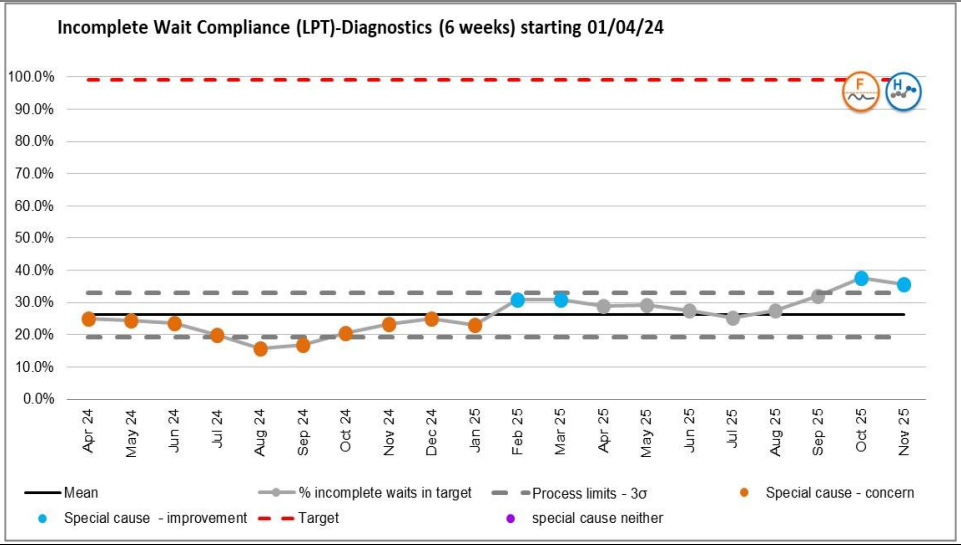
Mean	Lower Process Limit	Upper Process Limit
13.1%	11.0%	15.0%

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

This multidisciplinary pathway (with multi-referral point for access) 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 to return to an 18 week treatment wait for core services (agreed with ICB and NHSE) is working towards delivery by end of February 2026. KPI delivery for core offer at 94% for December, ahead of trajectory.

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

FYPCLDA	Target	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
	>=99%	24.9%	23.0%	31.0%	30.8%	29.0%	29.2%	27.5%	25.3%	27.5%	32.0%	37.6%	35.7%
No of Referrals		282	333	302	310	310	293	243	206	201	246	271	205



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.

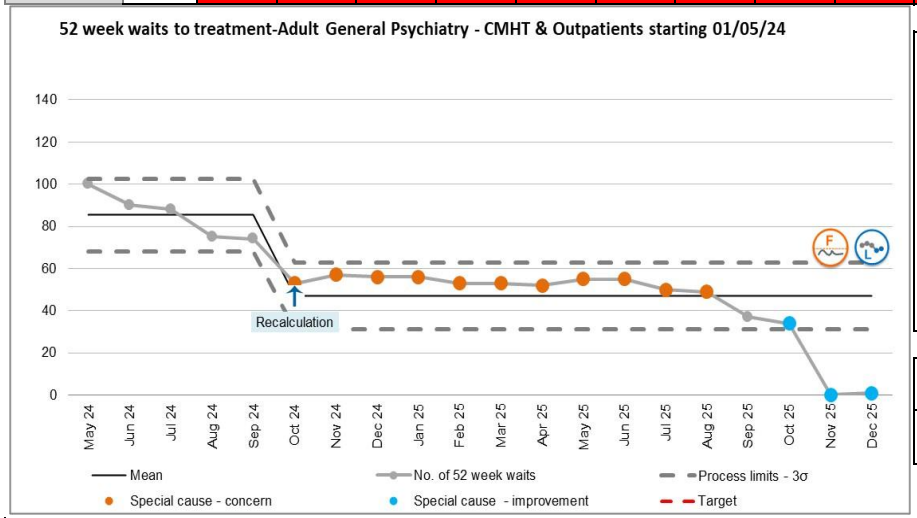
Mean	Lower Process Limit	Upper Process Limit
26.1%	19.0%	33.0%

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

The service formally identified as 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. Non-compliant with planned trajectory, rationale shared with ICB / NHSE alongside revised trajectory to deliver agreed improvement (no change to milestones). Refurbished estate at Beaumont Leys and Hynca Lodge with appointments now booked for CYP to be seen in these venues. IQIPS benchmarking assessment outcome received, detailed action plan created pulling together actions from system bronze cell, steering group, and benchmarking to support servce improvement. Contract with Health Now (IS provider) extended to end of March 2026, providing additional capacity to support reduced waits.

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

	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
DMH	0	56	53	53	52	55	55	50	49	37	34	0	1



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.

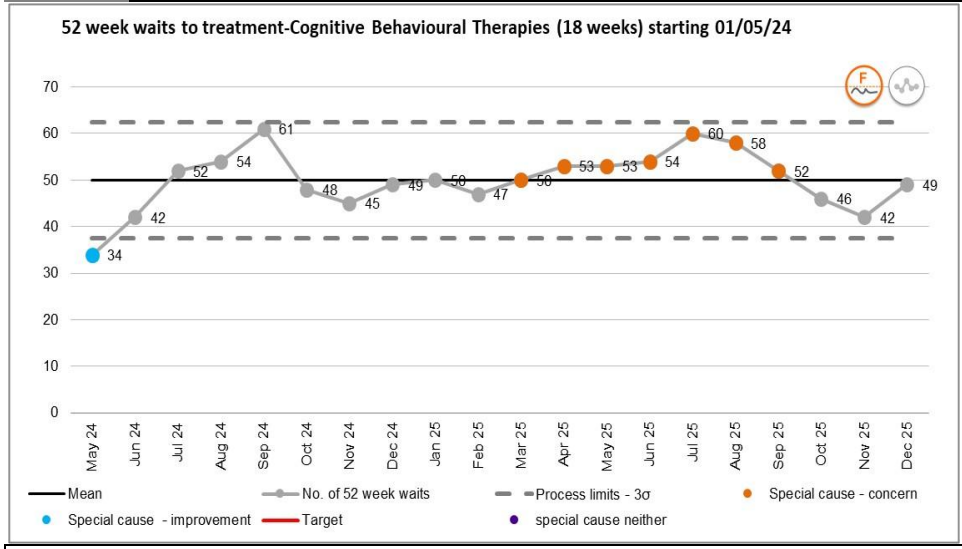
Mean	Lower Process Limit	Upper Process Limit
47.1	31.4	62.9

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

Internal processes reviewed and amended with waits for treatment now recorded and reported in line with NHS guidance and Trust's Access to Treatment Policy. Has reduced number of over 52 week waits for treatment to 1 at the end of December 2025. The majority of those previously reported as waiting were identifed as receipt of treatment and awaiting planned follow-up and are now correctly recorded and reported. Those identified as awaiting treatment have been prioritised for intervention.

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

	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
DMH	0	50	47	50	53	53	54	60	58	52	46	42	49



Analytical Commentary

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

Mean	Lower Process Limit	Upper Process Limit
50	37.5	62.4

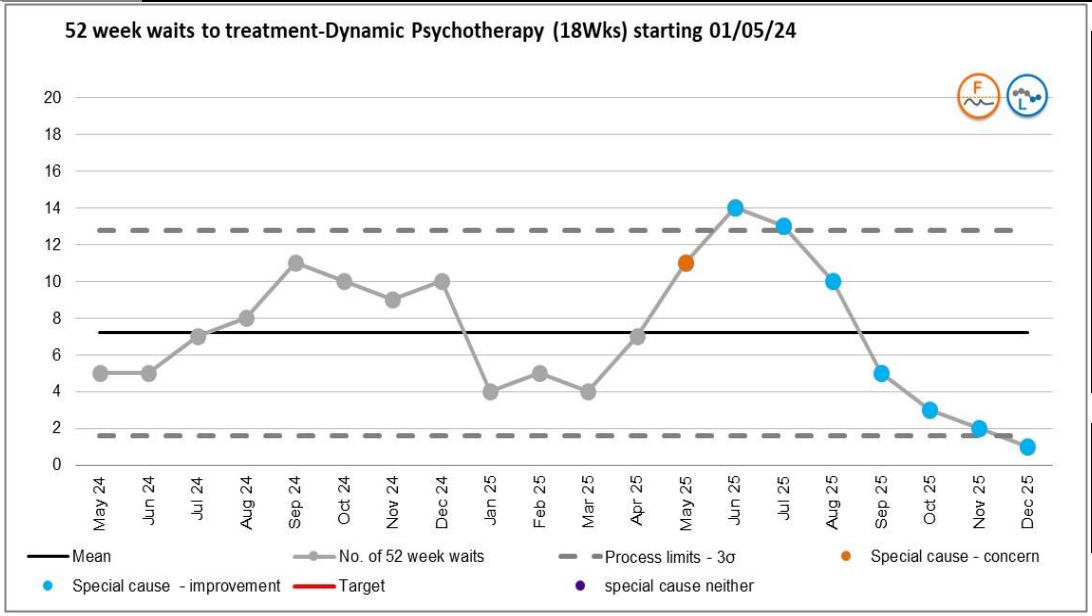
Operational Commentary (e.g. referring to risk, finance, workforce)

CBT represented at Neighbourhood Team psychological consulter meetings and continue to monitor and evaluate the therapist resource utilised for attending MDTs, Psychological Consulter meetings, and daily huddles and work /requests that circumvent those meetings and come directly to individual therapists. Team continue to strive to balance supporting the NMHT and delivering CBT assessment and treatment to patients waiting. This consulter approach reduces referrals for people not ready or not appropriate for a CBT intervention and this work to manage the flow of referrals into the service is beginning to take effect. Continuing to gather more accurate performance data with support from the business team to plan and allocate resources in a fair and considered fashion and to fully understand the team capacity.

Continuing to make good progress on the number of patients waiting over 52 weeks for CBT treatment has reduced from 46 in October 2025 to 42 in November and is below

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

	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
DMH	0	4	5	4	7	11	14	13	10	5	3	2	1



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
7.2	1.6	12.8

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

The longest waiter (57 weeks) for individual psychotherapy has now commenced therapy with a further two people waiting over 52 weeks on the brief psychotherapy list have now been offered appointments.

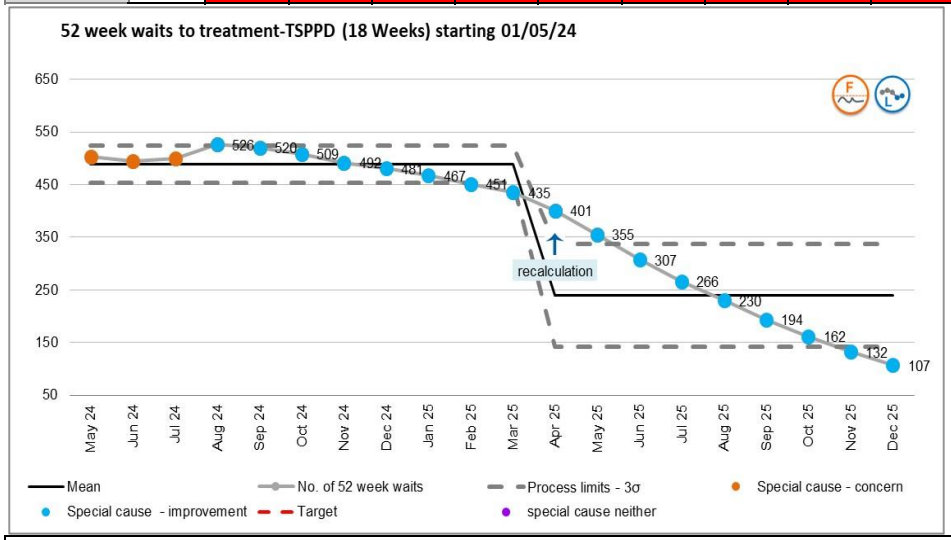
Two MBTi groups commenced September 2025 and will complete in March 2026. To reduce the build up of referrals between groups start dates for future groups will be staggered to mitigate the risk of extended waits.
A team member left the service in November and their patients have been reallocated to other team members, which has reduced capacity as a with a vacancy in the team.

The team continue to ensure patients are informed at assessment that appointment offers are limited and specific times etc. cannot be guaranteed, and we are writing to patients who decline offers to say that they will have one more offer and then may be discharged.

As input of DPS staff into the Neighbourhood Teams increases (attending daily huddles, doing joint assessments, increased meetings) it is anticipated that treatment capacity will be

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

	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
DMH	0	467	451	435	401	355	307	266	230	194	162	132	107



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
239.3	141.6	337.1

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

Development of training support to community services to enhance the primary care offer (small scale). Develop foundational training in Trauma Informed Care, first cohort to be delivered in 2026 however further work required to determine resource availability for ongoing delivery from July 2026

All TSPPD referrals to come through Neighbourhood Teams and align with 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 roles / remit continues

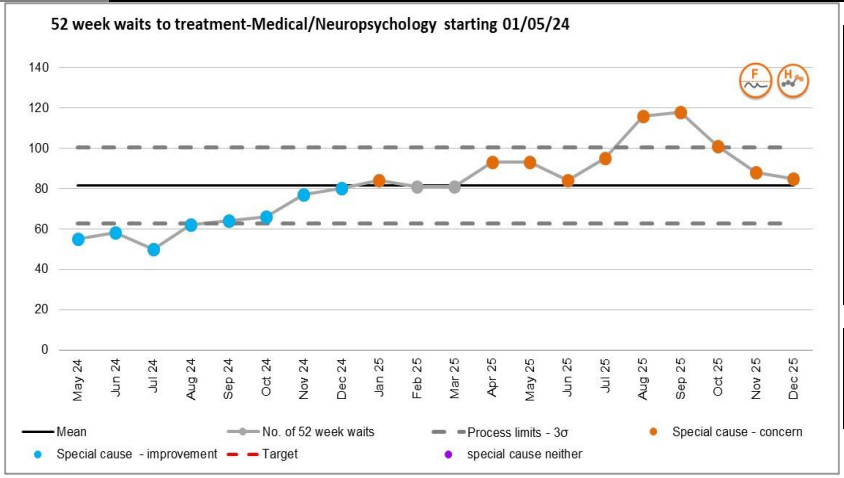
Continue delivering clinical model for the current TSPPD waiting list before transforming provision. Action due for completion December 2026

Design new Neighbourhood Team clinical model to be tailored to meet the needs personality difficulties. Action due 2026/27.

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

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

	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
DMH	0	84	81	81	93	93	84	95	116	118	101	88	85



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
81.6	62.5	100.6

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

Medical Psychology

Numbers waiting have continued to reduce since the end of November 2025. 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 (exceeding 52 weeks), but those breaching 52 week waits in this service are reducing and we aim to have all patients with a wait below 52 weeks by the end of March 2026. Within the pain psychology service waits remain over 2 years (104 weeks) for some patients, but the impact of recent changes should begin to show their impact over the next three to six months.

There are no lengthy waits for assessment or treatment within specialisms with dedicated funding, however high demand for the renal service risks growing waits going forward. Waits as a result of excess demand are compounded by sickness absence which increases pressure on other parts of the service.

New processes to manage waits in the pain service (all new referrals are now offered group intervention or signposting as an alternative / interim intervention) are now in place with the aim of reducing the treatment waiting list, the impact will be regularly reviewed. For patients already on the treatment waiting list the clinical pathway has been reviewed to ensure patients remain appropriate for the service.

For general medical referrals, as well as assessing number of sessions offered, the service is trialing 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 May 2025 (1 patient) with remainder waiting from June onwards; Waiting list plan for Jan-Mar with trajectory for waiting list to reduce to approx 24 weeks by end of Q4 .

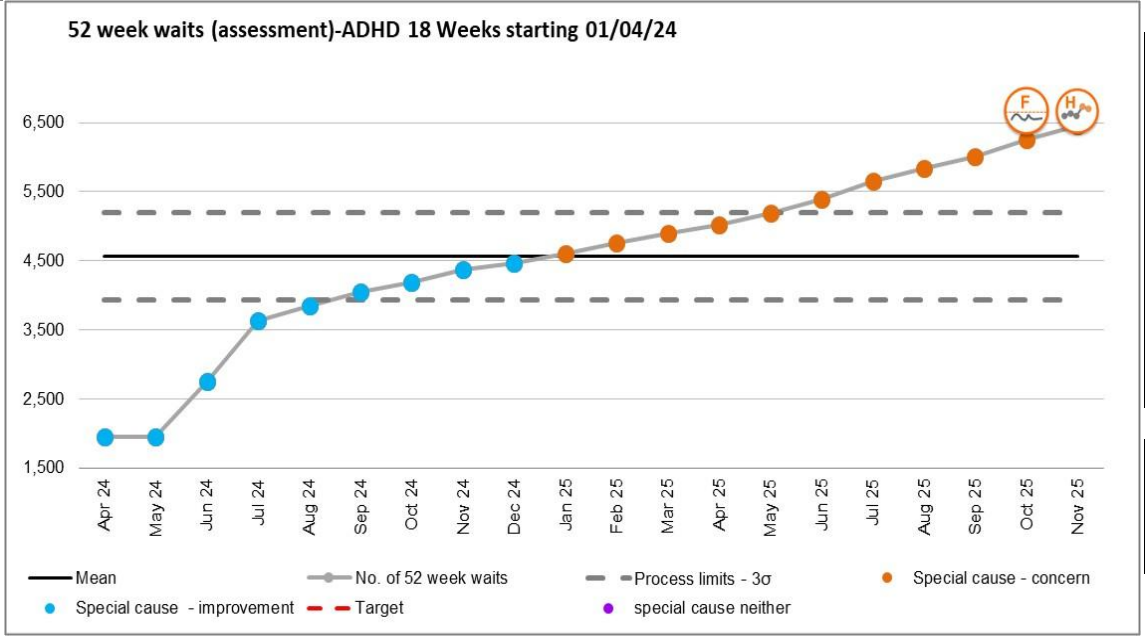
Assistant Psychologist providing telephone triage to support waiting list validation, contact is made with those on the waiting list for over 6 months to ensure treatment remains relevant. This ensures the waiting list is accurate and holds only those who still wish to access the service, reducing DNAs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

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

	Target	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
DMH	0	4467	4607	4757	4898	5014	5190	5398	5661	5833	6006	6250	6464



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
4565.0	3932.3	5197.7

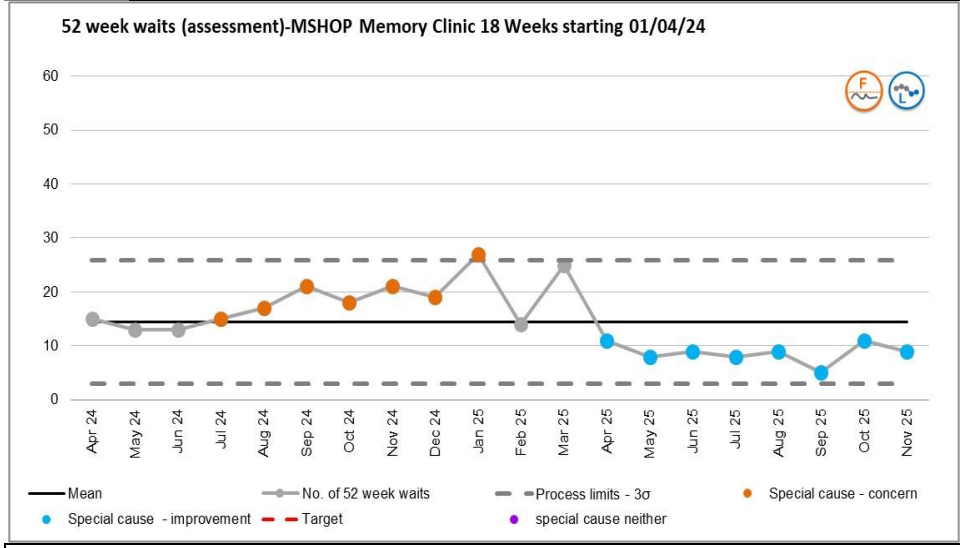
Operational Commentary (e.g. referring to risk, finance, workforce)

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. This latter service will go live in January - new provider now confirmed with comms plan to be overseen by ICB. The service continues to work with the Communications Team to develop and make available 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	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
DMH	0	19	27	14	25	11	8	9	8	9	5	11	9



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
14.4	2.9	25.9

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

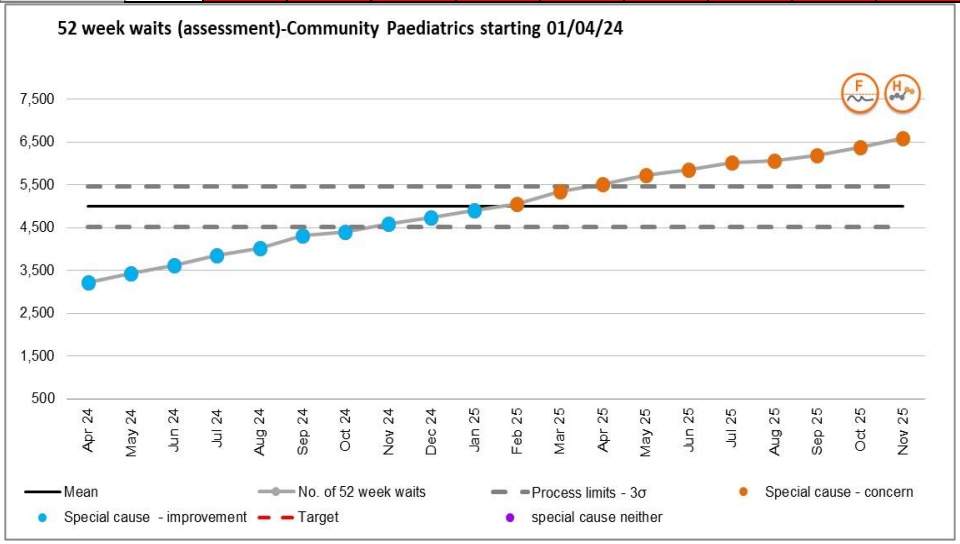
Implementation of One Stop Clinic (Rapid Access Clinics) commenced March 2025 with noted improvement in numbers waiting and length of wait where patients are seen and diagnosed in clinic. Has enabled assessment and diagnosis on-the-day. Advanced pathway clinics pilot commenced June 2025, for patients 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 2025. A review of both models taking place in Q4 to assess effectiveness in improving the patient experience and waiting times and establish future plans for this approach.

All patients waiting receive wellbeing calls following initial 8 week wait and 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. High levels of referral continue to challenge available capacity.

Some long term sickness affecting the medical and nursing capacity since October 2025. Seeking locum cover for the consultant sickness to support capacity.

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

	Target	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
FYPCLDA	0	4740	4895	5044	5335	5509	5723	5858	6022	6067	6182	6380	6585



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.

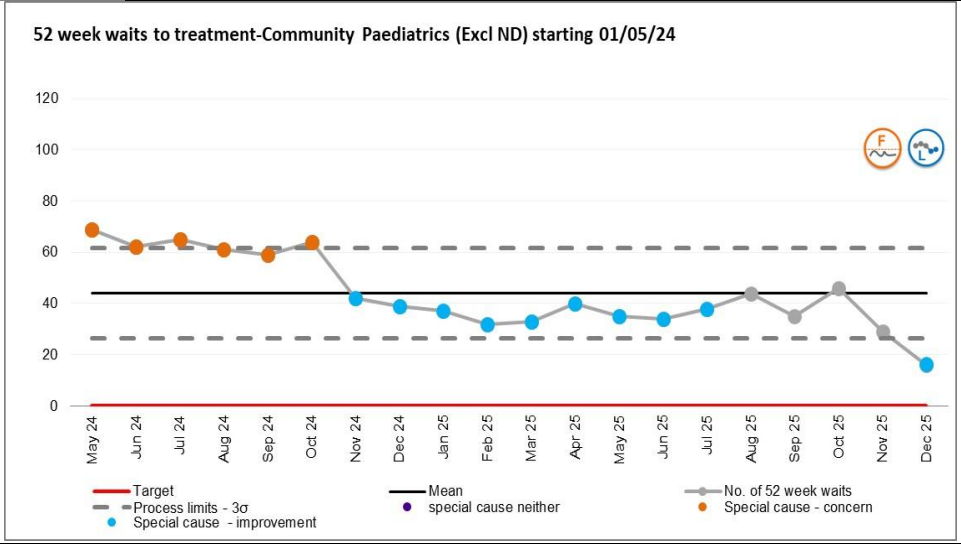
Mean	Lower Process Limit	Upper Process Limit
4987.6	4515.7	5459.5

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. This has slowed down the rate of increase but not reversed the trend of increasing numbers waiting over 52 weeks; with increasing numbers now waiting in excess of 3 years. With the skill mix in place, we continue to review and revise 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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
FYPCLDA	0	37	32	33	40	35	34	38	44	35	46	29	16



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.

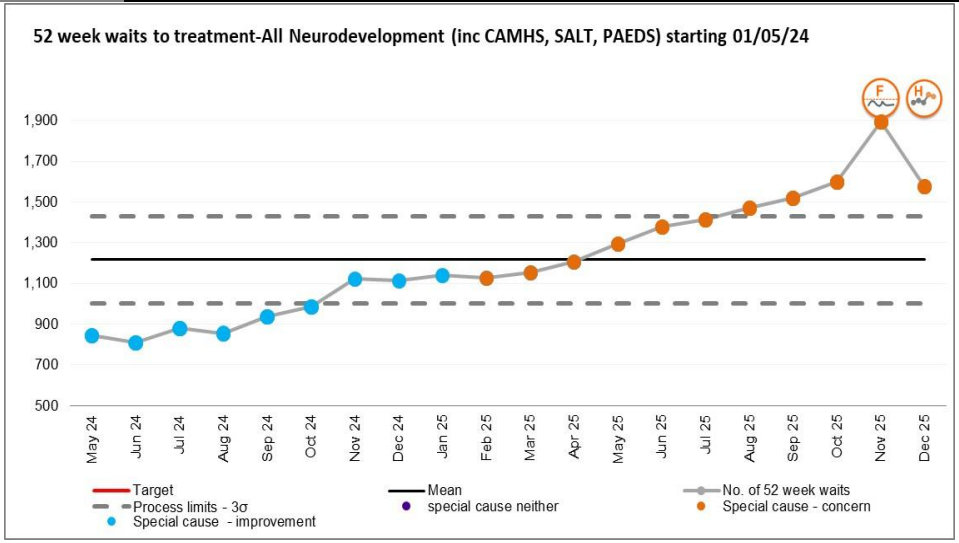
Mean	Lower Process Limit	Upper Process Limit
44.0	26.2	61.8

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+ with the anticipated outcome of freeing up space on nurse caseloads to allow CYP to transition from Paediatrician caseloads and so increase capacity.

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

	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
FYPCLDA	0	1140	1128	1155	1205	1294	1378	1415	1473	1518	1597	1893	1575



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.

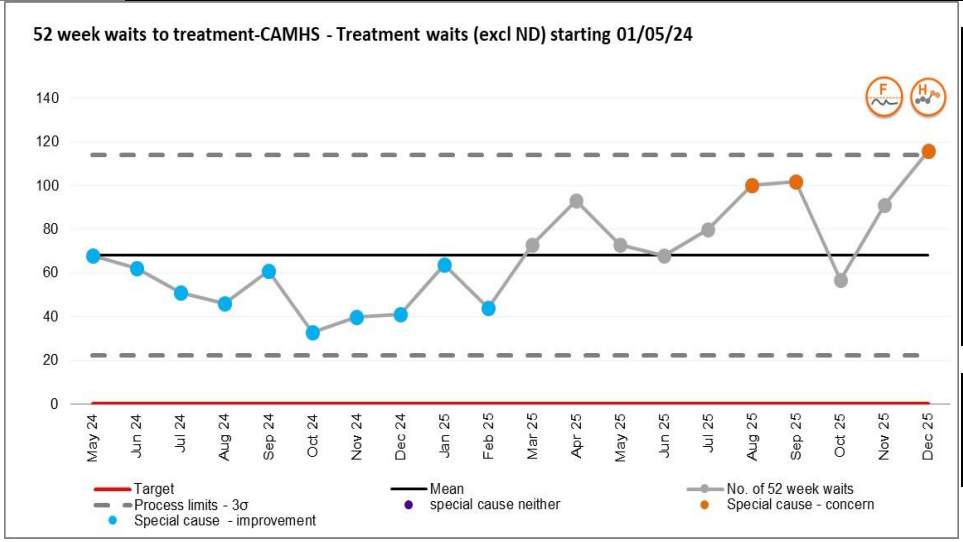
Mean	Lower Process Limit	Upper Process Limit
1215.7	1001.8	1429.6

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. 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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
FYPCLDA	0	64	44	73	93	73	68	80	100	102	57	91	116



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.

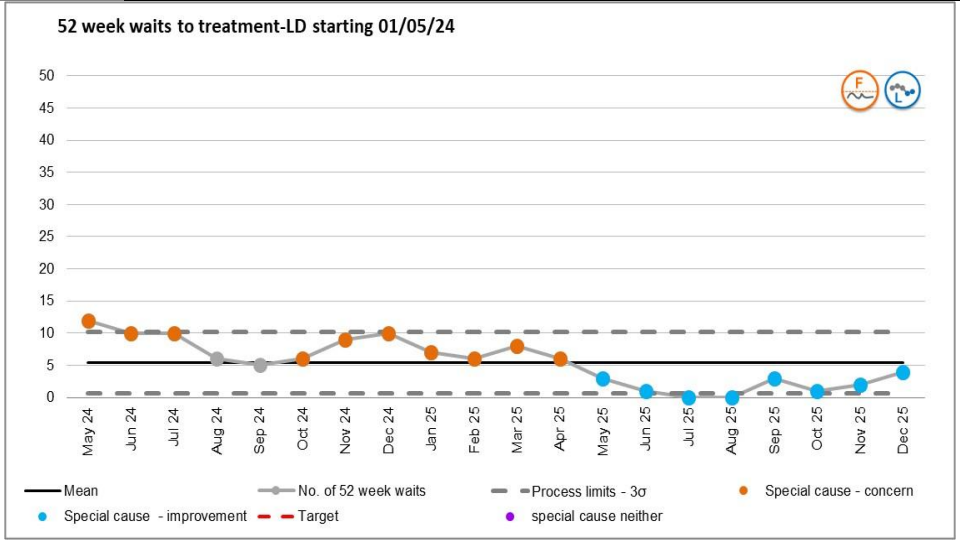
Mean	Lower Process Limit	Upper Process Limit
68.2	22.2	114.1

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

There are currently 116 CYP waiting over 52 weeks for treatment in CAMHS, this is an increase of 25 from last month, an increase in referrals with an acute presentation has impacted on the ability of picking up from the treatment waiting list.
41 CYP in Outpatient – 18 awaiting treatment, which is a decrease of 3; 23 awaiting psychiatric opinion, a decrease of 2. An overall decrease in treatment waits by 6 from last month.
2 waiting for Non-Medical Prescriber Clinic
1 service user waiting for Paediatric Psychology treatment – x2 cancellations by service user in November, planned appointment in January.
There are 72 waiters for group work - an increase of 52 since last month. All of these CYP waiting over 12 months have been reviewed, have a clear plan and appointments offered to start a group; the majority have an appointment in January 2026.

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

	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
FYPCLDA	0	6	8	6	3	1	0	0	0	3	1	2	4



Analytical Commentary

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

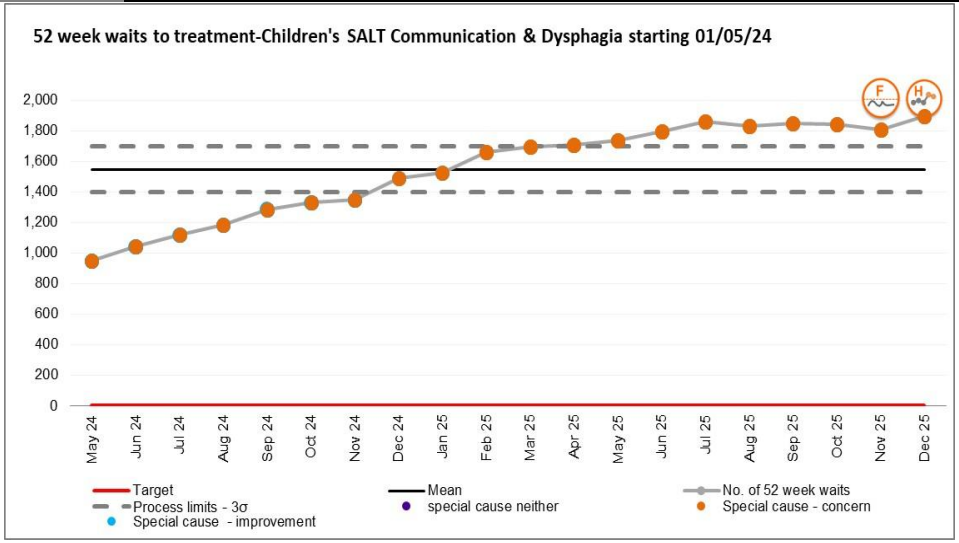
Mean	Lower Process Limit	Upper Process Limit
5.5	0.69	10.2

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

All patients have appointments and are expected to be seen by 19th Jan 2026.

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

	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
FYPCLDA	0	1524	1661	1692	1704	1734	1794	1858	1831	1845	1839	1808	1892



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
1545.8	1395.53	1695.97

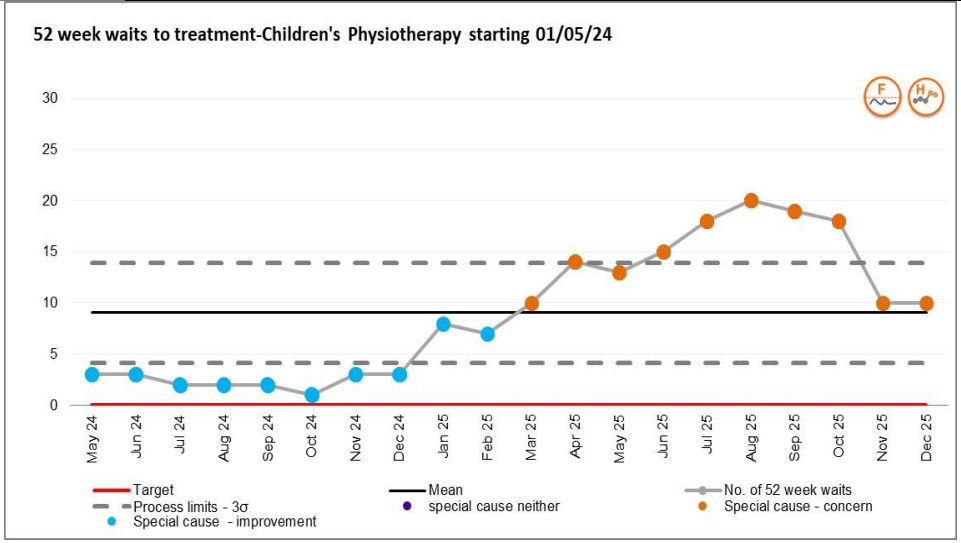
Operational Commentary (e.g. referring to risk, finance, workforce):

The waiting times for follow-up appointments have increased significantly since June 2023. This is due to:

Between 2019 - 2024, there was a significant increase in referrals to the service who were offered initial appointments within 18 weeks, which then led to a bottleneck for follow up intervention where demand outstrips capacity.
Less experienced workforce, requiring more training, supervision, and support. All new starters have a reduced job plan to allow time to develop their competencies.
The service delivery model has been improved, with CYP completing intervention blocks instead of irregular, one off reviews. Positive feedback from parents re intervention provided.
Weekly performance meeting with strengthened recovery actions established alongside weekly PTL. Escalations via FYPCLDA DMT meetings and local area SEND Partnership Boards.

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

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



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
9.1	4.2	14.0

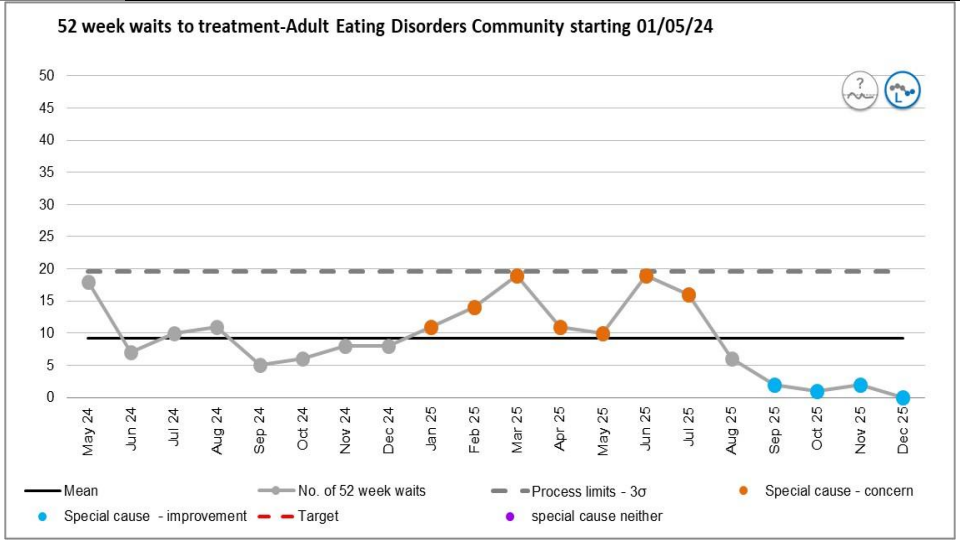
Operational Commentary (e.g. referring to risk, finance, workforce):

All waits are related to tone management.

Plan in place to create a tone management waiting list in community paediatric unit, with a phased approach for transitioning these CYP as they are reviewed. This will ensure waits are managed and reported in the most appropriate service.

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

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



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.

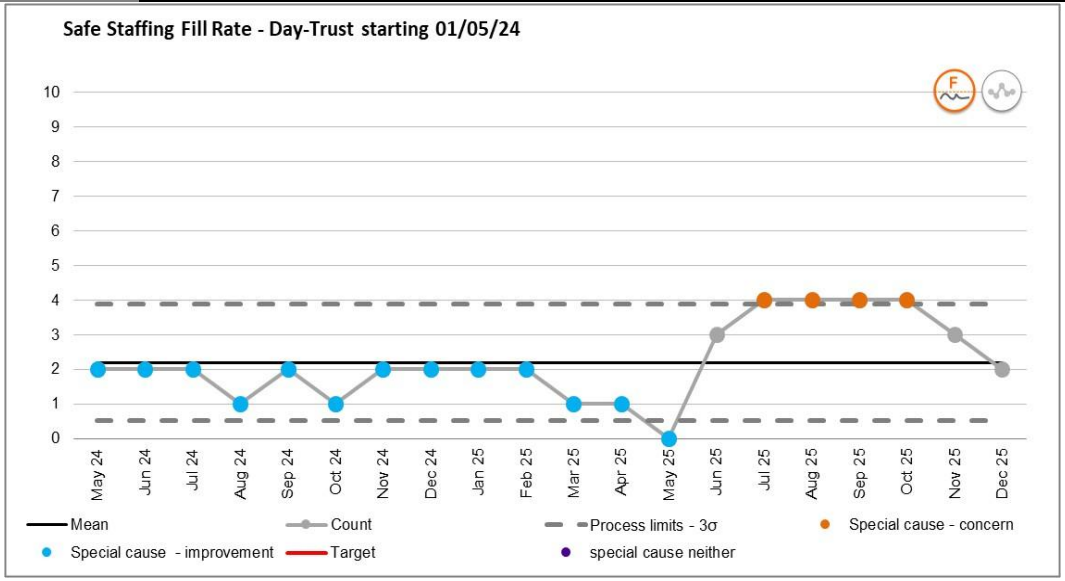
Mean	Lower Process Limit	Upper Process Limit
9.2	-1.2	19.6

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

Met target this period and the service continue to monitor and plan to further reduce waiting lists through PTL and waiting list meetings.

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

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



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
2.2	0.5	3.9

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

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

LD

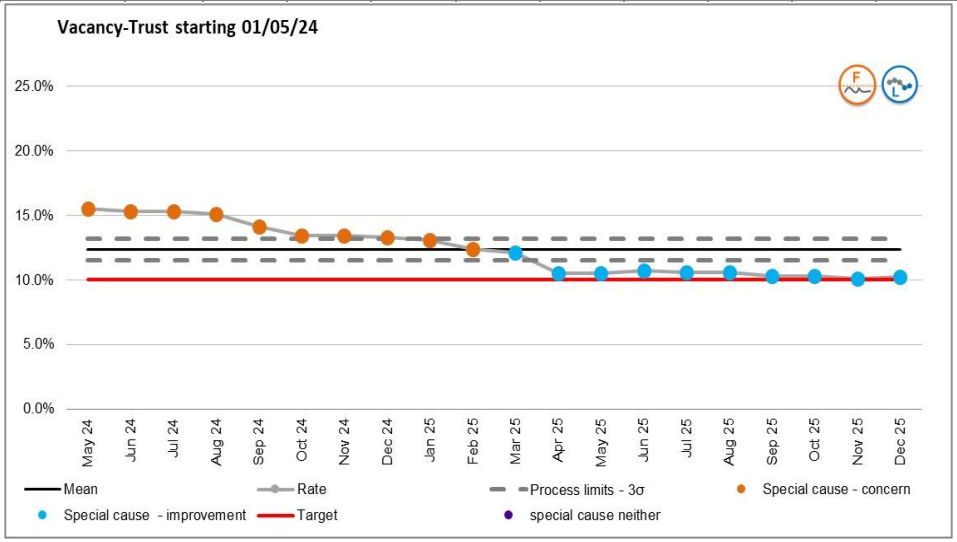
1 Grange - Grange offers planned respite care and the staffing model is dependent on individual patient need, presentation, and associated risks. This fluctuates the fill rate for RN on days and is mitigated by senior HCSW cover and cross cover by Gillivers and Agnes Unit.

DMH

Gwendolen - Planned staffing is for 3 RN on the day shift , where staffing reduced to 2 RN and supported by Medicines Administration Technician and additional Health care support worker (as needed).

EXCEPTION REPORT - Vacancy Rate

	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
TRUST	<=10%	13.1%	12.4%	12.1%	10.5%	10.5%	10.7%	10.6%	10.6%	10.3%	10.3%	10.1%	10.2%
DMH		16.4%	15.5%	14.9%	13.2%	13.4%	13.8%	12.3%	12.4%	13.1%	13.2%	13.3%	12.7%
CHS		12.9%	12.4%	12.8%	11.0%	10.2%	9.7%	10.0%	10.1%	9.9%	9.3%	8.5%	8.9%
FYPCLDA		12.7%	11.9%	11.3%	9.0%	9.0%	9.9%	10.6%	10.0%	9.3%	9.1%	9.3%	9.7%



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
12.3%	12.0%	13.0%

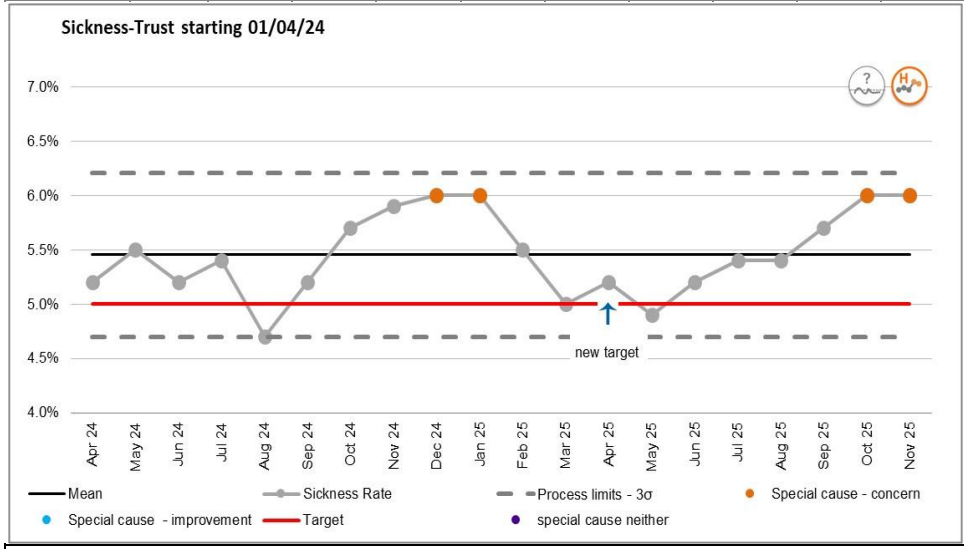
Operational Commentary (e.g. referring to risk, finance, workforce)

For Dec-25, the Trust vacancy rate is 10.2%. 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	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
TRUST	<=5.0%	6.0%	6.0%	5.5%	5.0%	5.2%	4.9%	5.2%	5.4%	5.4%	5.7%	6.0%	6.0%
DMH		6.3%	7.1%	6.4%	5.7%	6.2%	5.2%	5.9%	6.1%	6.1%	6.7%	7.1%	7.2%
CHS		6.9%	6.7%	5.8%	5.2%	5.3%	5.4%	5.9%	6.1%	6.3%	6.7%	6.5%	6.2%
FYPCLDA		5.5%	5.2%	5.1%	4.6%	4.7%	4.4%	4.8%	4.8%	5.1%	5.0%	5.5%	5.9%



Analytical Commentary

The metric is showing special cause variation of a concerning nature due to higher 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%	5.0%	6.0%

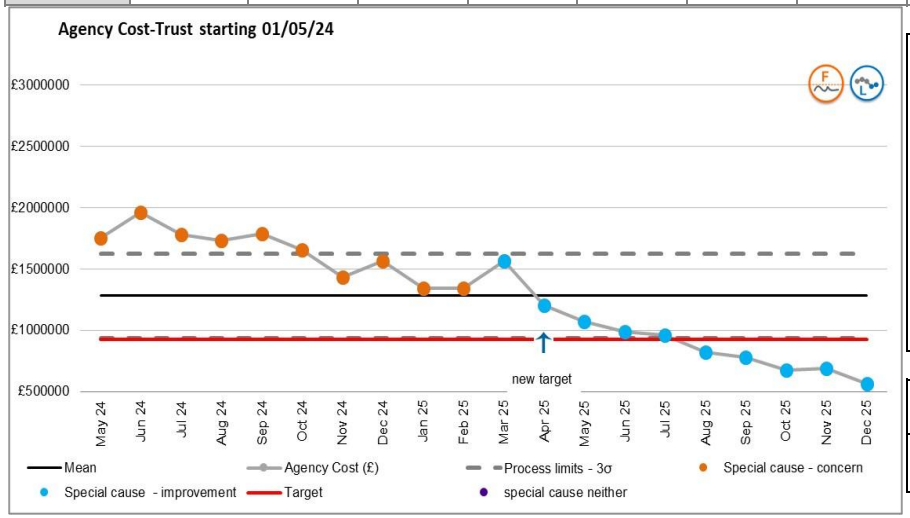
Operational Commentary (e.g. referring to risk, finance, workforce)

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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
TRUST	<=£922,333	£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	£686,388	£566,036
DMH		£570,697	£512,094	£876,766	£615,701	£585,755	£548,266	£561,694	£494,207	£362,080	£402,270	£341,512	£351,228
CHS		£779,216	£653,190	£538,428	£446,756	£353,928	£301,236	£289,274	£244,662	£258,596	£231,705	£218,083	£201,137
FYPCLDA		£197,407	£159,573	£143,524	£134,518	£123,986	£129,128	£98,711	£47,309	£123,270	£30,431	£37,010	-£22,530



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
1282487.9	939216.8	1625758.9

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		Oct-25	91.0%	83.0%	
MHSDS 72hr Follow-Ups - LPT	>=80%	Oct-25	93.0%	86.0%	
MHSDS CMHealth 2+ Contacts - LLR	0	Oct-25	15550	15435	
MHSDS CMHealth 2+ Contacts - LPT		Oct-25	15480	15360	
MHSDS CMH referrals-spells waiting for a full clock stop - LLR		Oct-25	9450	9420	
MHSDS CMH referrals-spells waiting for a full clock stop - LPT		Oct-25	9460	9440	
MHSDS CMH referrals-spells waiting more than 104 weeks for a 2nd contact - LLR		Oct-25	165	170	
MHSDS CMH referrals-spells waiting more than 104 weeks for a 2nd contact - LPT		Oct-25	175	180	
MHSDS open CMH referrals-spells waiting for a 2nd contact - LLR		Oct-25	3125	3100	
MHSDS open CMH referrals-spells waiting for a 2nd contact - LPT		Oct-25	3165	3135	
MHSDS CYP 1+ Contacts - LLR	17745	Oct-25	18740	18970	
MHSDS CYP 1+ Contacts - LPT		Oct-25	10850	10670	
MHSDS CYP referrals-spells waiting for a full clock stop - LLR		Oct-25	6345	6265	
MHSDS CYP referrals-spells waiting for a full clock stop - LPT		Oct-25	5720	5600	
MHSDS CYP referrals-spells waiting more than 104 weeks for a 1st contact - LLR		Oct-25	535	560	
MHSDS CYP referrals-spells waiting more than 104 weeks for a 1st contact - LPT		Oct-25	500	530	
MHSDS open CYP CMH referrals-spells waiting for a 1st contact - LLR		Oct-25	2350	2450	
MHSDS open CYP CMH referrals-spells waiting for a 1st contact - LPT		Oct-25	1980	2010	
MHSDS CYP ED Routine (Interim) - LLR		Oct-25	97.0%	91.0%	
MHSDS CYP ED Routine (Interim) - LPT	>=95%	Oct-25	97.0%	92.0%	
MHSDS CYP ED Urgent (Interim) - LLR		Oct-25	89.0%	82.0%	
MHSDS CYP ED Urgent (Interim) - LPT	>=95%	Oct-25	90.0%	82.0%	
MHSDS EIP 2 Week Waits - LLR		Oct-25	63.0%	60.0%	
MHSDS EIP 2 Week Waits - LPT	>=60%	Oct-25	61.0%	60.0%	
MHSDS Individual Placement & Support (IPS, Rolling 12 month) - LLR	792	Oct-25	760	765	
MHSDS Individual Placement & Support (IPS, Rolling 12 month) - LPT		Oct-25	760	765	
OAPs Bed Days (inappropriate only) - LLR		Oct-25	170	300	
OAPs Bed Days (inappropriate only) - LPT		Oct-25	130	215	
OAPs active at the end of the period (inappropriate only) - rolling quarter - LLR		Oct-25	0	0	
OAPs active at the end of the period (inappropriate only) - rolling quarter - LPT		Oct-25	0	0	
MHSDS Perinatal Access - (Rolling 12 month) - LLR	1220	Oct-25	1150	1135	
MHSDS Perinatal Access - (Rolling 12 month) - LPT		Oct-25	1165	1145	
MHSDS Restrictive Interventions per 1000 bed days - LLR		Oct-25	-	-	
MHSDS Restrictive Interventions per 1000 bed days - LPT		Oct-25	41	38	
MHSDS - Data Quality DQMI - LLR		Aug-25	69.3%	55.4%	
MHSDS - Data Quality DQMI - LPT	>=95%	Aug-25	93.0%	93.0%	
MHSDS - Data Quality SNoMED CT - LLR		Oct-25	97.0%	97.0%	
MHSDS - Data Quality SNoMED CT - LPT	>=100%	Oct-25	100.0%	100.0%	

P

Leicestershire Partnership NHS Trust

Alert, Advise and Assure Highlight Report

Charitable Funds Committee, 19 December 2025

Meeting Chair and Report Author - Faisal Hussain

Quorate Y

Policies and expiry date:

ALERT: Alert to matters that need the Board's attention or action, eg areas of non-compliance, safety or threat to the Trust's strategy

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Review and sign off Raising Health Governing Document	CFC/25/058	Magdalena Korytkowska	The Committee approved the updated Raising Health Governing Document and recommend that the Board approve the amended articles (appendices attached).	

T H R I V E

ADVISE: Advise the Board of areas subject to on-going monitoring or development or where there is negative assurance

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Raising Health Overhead Costs Review 2026/27	CFC/25/054	Jackie Moore	The Committee have started to review the current method of calculating the Charity running costs and to benchmark against other Charities. An update paper will be presented at the next Committee meeting.	

ASSURE: Inform the Board where positive assurance has been received

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Quarterly Finance Report including Pipeline Report, investment performance & legacies	CFC/25/052	Jackie Moore	• The overall fund balance for Quarter 2 closed at £2.47m. This is an increase of £58k (2%) since the start of the financial year. • Year to date expenditure totals £248k, with the majority of spend supporting patient wellbeing & amenities. • The balance sheet shows that the overall funds increased by £58k in the first six months of the year. • Fixed asset investments have increased by £136k due to the improvement in the investment return. • The closing cash balance at the end of Q2 is £418k which is a reduction of £74k since the start of the year.	
Annual Accounts and Annual Trustees Report for submission to the Charities Commission	CFC/25/055	Jackie Moore	The Committee approved the Annual Accounts and Annual Trustees Report. This accounts and annual report will be submitted to the Charities Commission by 31 January 2026 and the annual report will be published on the Raising Health page on the LPT website.	

Annual Accounts and Annual Trustees Report for submission to the Charities Commission	CFC/25/055	Jackie Moore	The Committee approved the Management Letter of Representation.	
Annual Assurance and Review of Policies and Procedures	CFC/25/057	Jackie Moore	The Committee received the report and is assured that the Charity's financial governance procedures are reviewed and updated regularly, to ensure they are fit for purpose and reflect current working practices.	

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Review of Charitable Funds Risk Register	CFC/25/050	Jackie Moore	We have received notification of a new legacy fund totalling £250k. Awaiting further details.	
Promoting Charitable Funds and Delivering the Strategy: Fundraising Managers' Report	CFC/25/051	Magdalena Korytkowska	Homeless Mental Health Team outreach events have been very successful. The latest event took place on 23 December 2025.	
Promoting Charitable Funds and Delivering the Strategy: Fundraising Managers' Report	CFC/25/051	Magdalena Korytkowska	Hinckley Hub - an open day took place on 8 October 2025 and was utilised to thank Wooden Spoon and Tea Bar Ladies for their support towards the sensory room.	

Promoting Charitable Funds and Delivering the Strategy: Fundraising Managers' Report	CFC/25/051	Magdalena Korytkowska	Gifts in Kind – we have received more than £20k Gifts in Kind donations, with the majority for the Christmas appeal.	
Promoting Charitable Funds and Delivering the Strategy: Fundraising Managers' Report	CFC/25/051	Magdalena Korytkowska	CAMHS digital innovation supporting waiting list – we have been given £117.5k through the NHS Charities Together Innovation grant to deliver this work.	
Promoting Charitable Funds and Delivering the Strategy: Fundraising Managers' Report	CFC/25/051	Magdalena Korytkowska	Carlton Hayes Charity – their last board meeting took place on 13 November 2025 and was attended by Magdalena Korytkowska, who received positive feedback about the overall work the Charity is undertaking.	

RAISING HEALTH (Charity number 1057361)

(the "Charity")

Business case in support of regulated alteration to the objects of the Charity

in support of a RESOLUTION OF THE TRUSTEE

Written Special Resolution to amend Governing Document for Raising Health document

1. Introduction

This statement is submitted on behalf of Leicestershire Partnership NHS Trust (the "**Trustee**") in support of a proposed regulated alteration to the objects of the Charity

On [insert date], the Trustee has adopted, pursuant to the statutory powers conferred by section 280A of the Charities Act 2011, a written resolution amending the Charity's governing document and adopting the appended revised and amended trust deed (the "**Revised Trust Deed**") as the governing document of the Charity to the exclusion of all others.

The Revised Trust Deed intends to amend the charitable objects of the Charity slightly as further described below. The Trustee is seeking the consent of the Charity Commission for this amendment to the objects clause to become effective pursuant to sections 280A(7) to 280A(10) of the Charities Act 2011.

As explained below, the Trustee is not seeking to materially amend the charitable objects of the Charity, but to ensure that the objects accurately reflect the areas of operations of the Trustee and the Charity, in one with the intentions of the founders of the Charity. It appears clear that the founders of the Charity intended for its area of benefit to include (i) the area of activity of the NHS trust appointed corporate trustee of the Charity, (ii) Leicestershire and (iii) Rutland. Changes to the organisation of NHS services in this area as well as local government restructurings have resulted in the need to update the objects clause to ensure that it continues to express the founder's intentions.

2. Nature of the amendment

The Trustee seeks to slightly amend the objects clause of the Charity's governing document to reflect an updated and accurate description of the geographical area in which its Trustee and the Charity operate.

3. Proposed revised objects clause

The Trustee proposes that the objects clause be amended to reflect as follow:

a. **the purposes of the Charity when it was established, if and so far as they are reasonably ascertainable:** The original objects clause read as follows:

> "*The trustees shall hold the trust fund upon trust to apply the income, and at their discretion. so far as may be permissible, the capital, for any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by or on behalf of Leicestershire Community (hereinafter referred to as "the objects")*."

b. **the desirability of securing that the purposes of the Charity are, so far as reasonably practicable, similar to the purposes being altered:** It is suggested that the amended objects read as follows [changes underlined]:

> *"The trustee shall hold the trust fund upon trust to apply the income, and at its discretion, so far as may be permissible, the capital, for any charitable purposes relating to the National Health Service, wholly or mainly for the service provided by Leicestershire <u>Partnership NHS</u>*

Trust or otherwise for the benefit of patients of the National Health Service across Leicester, Leicestershire and Rutland (hereinafter referred to as the "Objects")."

The corporate Trustee considers it highly desirable that the amended objects remain so far as reasonably practicable similar to the original objects of the Charity. This is being achieved by:

i. the Charity remaining a NHS charity furthering charitable purposes relating to the National Health Services; and

ii. the Charity's potential beneficiaries remaining unchanged, but

iii. the Charity's area of benefit being re-aligned with the current-day strategies, operations and specialisms of the NHS serving the Leicester, Leicestershire and Rutland community.

4. Justification for the amendment

The proposed amendment is necessary and justified for the following reasons:

- **the need for the Charity to have purposes which are suitable and effective in the light of current social and economic circumstances.** The amendments underlined above are necessary in order to ensure that the Charity can continue to benefit NHS patients in the 'Leicestershire community'. To note that this term was not defined under the Charity's original trust deed in 1996.

  Due to successive and ongoing re-structurings of the NHS provision in and around Leicestershire and the changing nature of patient care, the corporate Trustee considers that these changes are suitable and will be effective for the Charity to continue to support NHS patients in the Leicestershire community in accordance with the intentions of the original trust deed.

  The Charity was created by Trust Deed on the 10th July 1996 and was named "Leicestershire Health Authority Charitable Fund".

  To note that between 1974 and 1994, Rutland was a non-metropolitan district of Leicestershire under the Local Government Act 1972, which took effect in 1974. In 1994 Rutland County Council became a unitary authority and ceased to be formally part of Leicestershire County Council, even though it remains within the area of the relevant NHS trust. To also note that Leicestershire County Council retains responsibility for police, fire and emergency services in Rutland.

  On the 8th April 2004 the Charity was renamed as the "Melton, Rutland Harborough PCT Umbrella Fund".

  On 8th May 2007 the name of the Charity was formally changed in the governing document by a Supplemental Deed of Declaration to "Leicestershire County and Rutland PCT Umbrella Fund".

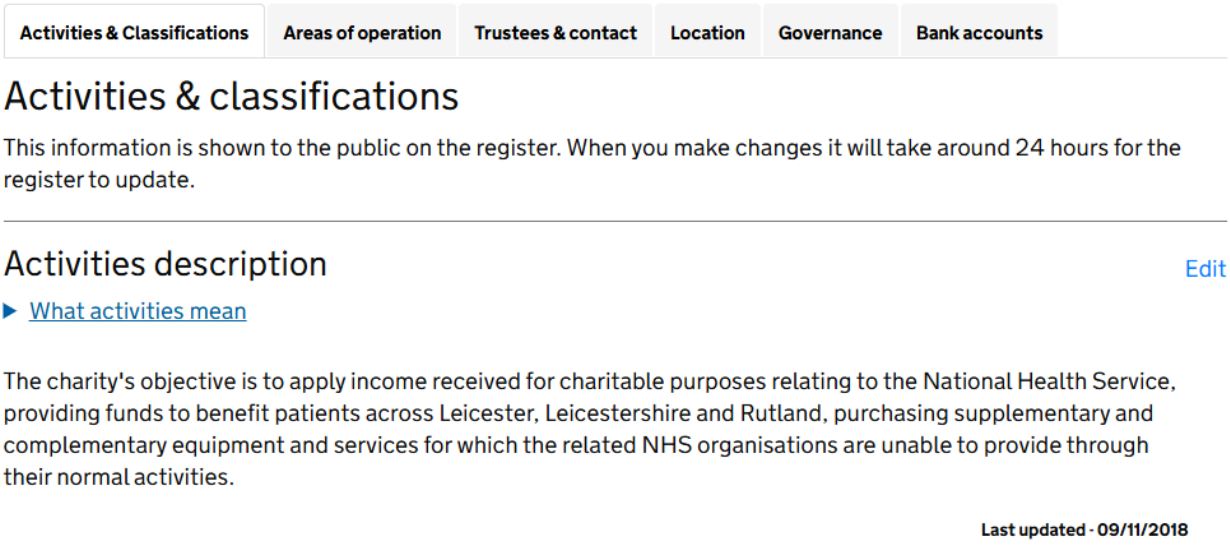
  On 22nd December 2011 the name of the Charity was formally changed via a Statutory Instrument 'Transfer of Trust Property' Order, from Leicestershire County and Rutland Primary Care Trust Charitable Fund to "Leicestershire Partnership NHS Trust Charitable Fund".

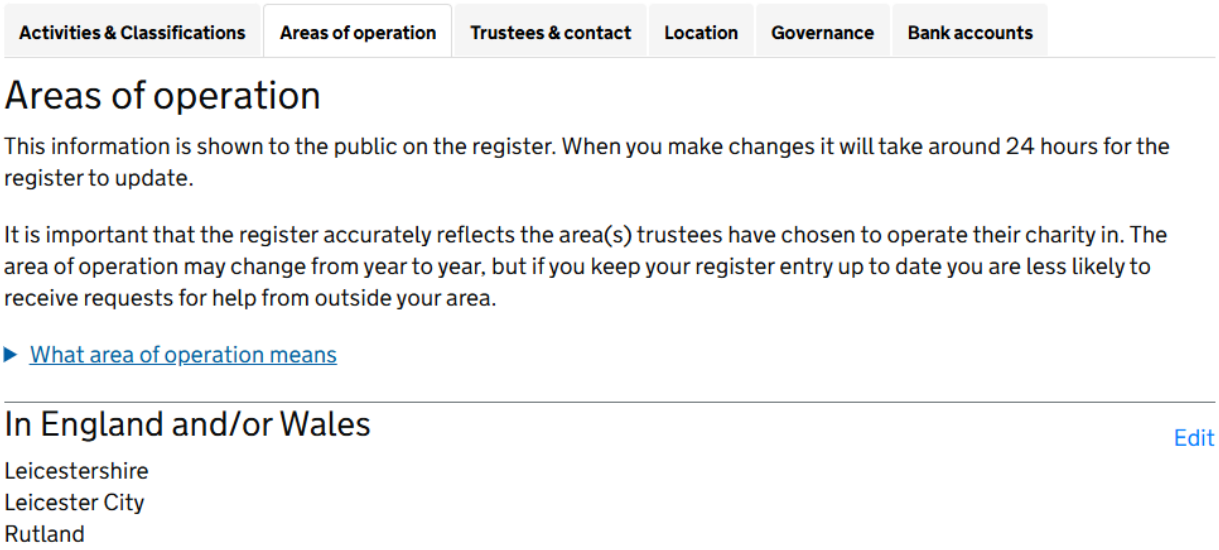
  Due to Transforming Community Services (TCS) community hospitals transfer from 1 April 2011 and the demise of the Primary Care Trust on 31st March 2013, Trustee arrangements transferred from Leicestershire County and Rutland Primary Care Trust (LCR PCT) to Leicestershire Partnership NHS Trust (LPT), the current Trustee

During 2016/17, the name of the Charity was amended to help increase its profile in support of its fundraising efforts. The Charity has been operating under this name ever since.

The Charity takes proactive steps to fundraise, using a variety of income generation streams, including reaching out to local people, businesses, trusts and foundations. It is important for the Charity's objects to reflect the operational reach of its Trustee in a consistent manner in order to allow it to maximise its fundraising, and outreach efforts.

- **Alignment with strategic purpose:** The Charity's strategy is expressly linked to supporting the NHS in the wider Leicestershire community, which means effectively the services provided by the NHS through the Trustee. The Trustee's statutory remit encompasses Leicester, Leicestershire, and Rutland. The omission of Rutland from the Charity's objects is therefore inconsistent with its foundational purpose.
- **Operational reality:** The Charity has, in practice, delivered services and undertaken charitable activities in relation to the NHS in the Leicestershire community including within Rutland for a number of years, given that Rutland has always been served by the relevant corporate trustee. The Trustee wishes to ensure that the wording of the objects expressly aligns with the geography of the NHS and local government.
- **Regulatory compliance and transparency:** The suggested updates to the objects ensure that the governing document accurately reflects the Charity's area of benefit and promotes transparency and accountability to the Charity Commission, beneficiaries, and the public.
- **No material change to charitable purpose:** The proposed amendment does not alter the Charity's overarching charitable purpose or its alignment with the public benefit requirement. It merely updates the geographical reference to ensure consistency with the Charity's actual area of operations and the remit of the NHS Trust that it primarily] supports in light of changes to NHS and local government organisations. Rutland as the operational area has been listed on the Charity Commission's webpage under "Activities & classifications" and "Areas of operations" (last updated 2018).





5. Conclusion

The proposed amendment is a proportionate and necessary step to ensure that the Charity's governing document accurately reflects its current and intended operations in accordance with the founder's intentions and Trustee's strategy. The amendment will enhance legal clarity, support regulatory compliance, and ensure continued alignment with the Charity's corporate trustee. The Trustee and the Charity therefore respectfully requests the Commission's consent to the proposed amendment.

Registered charity number: 1057361

RAISING HEALTH

(the "Charity")

RESOLUTION OF THE TRUSTEE

Relating to a Declaration of Trust made on 10 July 1996 as amended by supplemental deeds dated 8 April 2004 and 8 May 2007 and varied pursuant to Statutory Instrument 2011 No. 2748 (The NHS Bodies (transfer of Trust Property) Order 2011)

(the "**Trust Deed**")

THE TRUSTEE HEREBY RESOLVES to exercise its statutory power of amendment under section 280A of the Charities Act 2011 on the passing of this resolution to adopt the revised and amended trust deed (the "**Revised Trust Deed**") appended to this resolution as the governing document of the Charity to the exclusion of all others.

The Trustee **NOTES** that the Revised Trust Deed does not make any changes to the governing document of the Charity which would require the consent of the Charity Commission pursuant to section 280(A) subsections (7) and (8).

Resolutions of the Trustee passed on [insert date] 2025

……

Name:

Title:

For and on behalf of Leicestershire Partnership NHS Trust acting in its capacity of sole Trustee of the Charity

RAISING HEALTH

(registered with the Charity Commission for England and Wales under number 1057361)

THIS DECLARATION OF TRUST WAS MADE on 10/09/1996, AMENDED BY DEED on 14/10/2024, and further AMENDED BY A DEED on [insert date of deed] 2025 by Leicestershire Partnership NHS Trust (LPT) (the "**trustee**") NOW THIS DEED WITNESSES AS FOLLOWS:

A. Administration

The Trust's registered charity constituted by this deed (the "**Charity**") and its property (the "**charitable funds**") shall be administered and managed by the corporate trustee under the name of Raising Health or by such other name as the trustee from time to time decides.

B. Trustee

The trustee of the Charity and the charitable funds shall be Leicestershire Partnership NHS Trust or such other trustee or trustees as may be appointed by virtue of any legislation from time to time in force.

C. Objects and purpose

The trustee shall hold the trust fund upon trust to apply the income, and at its discretion, so far as may be permissible, the capital, for any charitable purposes relating to the National Health Service, wholly or mainly for the service provided by Leicestershire Partnership NHS Trust or otherwise for the benefit of patients of the National Health Service across Leicester, Leicestershire and Rutland (hereinafter referred to as the "**Objects**").

D. Powers

In furtherance of the Objects but not otherwise the trustee may exercise any of the following powers:

1. to raise funds and invite and receive contributions: Provided that in raising funds the trustee shall not undertake any substantial permanent trading activity and shall conform to any relevant statutory regulations;
2. to buy, take on lease or in exchange, hire or otherwise acquire any property necessary for the achievement of the Objects and to maintain and equip it for use;
3. subject to any consents required by law to sell, lease or otherwise dispose of all or any part of the property comprised in the trust fund;
4. subject to any consents required by law, to borrow money and to charge the whole or any part of the trust fund with repayment of the money so borrowed;
5. to co-operate with other charities, voluntary and statutory authorities operating in furtherance of the Objects or of similar charitable purposes and to exchange information and advice with them;
6. to establish or support any charitable trusts, associations or institutions formed for the Objects or any of them;
7. to employ such staff as are necessary for the proper pursuit of the Objects and to make all reasonable and necessary provision for the payment of pensions and superannuation to staff and their dependants;
8. to charge against the trust fund the proportion of the cost of administrative overheads incurred by the trustee both in the administration of the Charity and in the discharge of other functions which are attributable to the administration of the Charity;

9. to permit any investments comprised in the trust fund to be held in the name of any clearing bank, any trust corporation or any stock broking company which is a member of the Stock Exchange (or any subsidiary of such a stock broking company) as nominee for the trustee and to pay such nominee reasonable and proper remuneration for acting as such;
10. to invest the trust fund and any part thereof in the purchase of or at interest upon the security of such stocks, funds, shares, securities or other investments of whatsoever nature and whatsoever situate as the trustee in their discretion think fit but so that the trustee:
    - shall exercise such power with the care that a prudent person of business would in making investment for a person for whom they felt morally obliged to provide;
    - shall not make any speculative or hazardous investment (and, for the avoidance of doubt, this power to invest does not extend to the laying out of money on the acquisition of futures or traded options);
    - shall not have power under this clause to engage in trading ventures, and
    - shall have regard to the need for diversification of investments in the circumstances of the Charity and to the suitability of proposed investments.
11. to designate, at its discretion, particular funds out of the trust fund in order to give effect to the wishes of any donor to the Charity or for administrative or other purposes and power to vary and cancel such designation: Provided that any such designation or variation does not permit the use of any part of the trust fund other than for the Objects;
12. to accept and/or create and administer restricted funds for any purposes within the Objects of the Charity but so that any restricted funds shall be administered in accordance with the trusts attaching to them;
13. to accept and or transfer funds to other charities with objects similar to the Objects at the discretion of the trustee;
14. to transfer the trust fund or any part of the trust fund to itself as a body responsible for the maintenance of a health service hospital or provision of health services or to any other such body for or in connection with the acquisition, improvement or maintenance of any property: Provided that in making any such transfer the Charitable Funds Committee shall have regard to:
    - any restrictions or expressed wishes of the donors as to them terms and conditions on which such a transfer may be made; and
    - the general desirability of making the transfer subject to terms and conditions which will ensure that the property so acquired, improved or maintained will continue to be used for the purposes for which the funds were transferred;
15. to spend money on the insurance of any property comprised in the trust fund to its full value against such perils and upon such terms as the trustee thinks fit;
16. to make regulations from time to time, within the limits of this deed, for the management of the Charity and for the conduct of its business including the deposit of money at a bank and the custody of documents;
17. to do all such other lawful things as are necessary for the achievement of the Objects.

E. Accounts

The trustee shall comply with its obligations under Part VI of the Charities Act 1993 as amended by the Charities Act 2006 (or any statutory re-enactment or modification of those Acts) with regard to:

- the keeping of accounting records for the Charity;
- the preparation of annual statements of account for the Charity;
- the auditing or independent examination of the statements of account of the Charity; and

- the transmission of the statements of account of the Charity to the Commission.

F. Annual Report

The trustee shall comply with its legal obligations under the Charities Acts 1993 and 2006 (or any statutory re-enactment or modification of those Acts) with regard to the preparation of an annual report and its transmission to the Commission.

G. Annual Return

The trustee shall comply with its obligations under the Charities Acts 1993 and 2006 (or any statutory re-enactment or modification of those Acts) with regard to the preparation of an annual return and its transmission to the Commission.

H. Amendment of Trust Deed

1. The trustee may amend the provisions of this deed, provided that:
   - no amendment shall be made to clause B (Trustee) except to reflect a change of trusteeship determined and given legal effect;
   - no amendment may be made to clause C (Objects and purpose) or this clause, unless it appears to the trustee that the Objects can no longer provide a suitable and effective method of using the trust fund and no such amendment shall become effective without the prior consent in writing of the Commissioners; and
   - no amendment can be made which has the effect of the Charity ceasing to be a charity at law.
2. The trustee must send to the Commission a copy of any amendment made under this clause.

I. Dissolution

If it appears to the trustee that the Objects no longer provide a suitable and effective method of using the trust fund, the trustee shall in these circumstances, but only so far as the trusts attaching to any particular gift to the Charity may permit, hold the trust fund upon trust to apply the income and at their discretion, so far as may be possible, the capital for any charitable purpose relating to the National Health Service.

Q

Leicestershire Partnership NHS Trust

Public Trust Board 27 January 2026

FQIA Illustrative Designated Body Annual Board Report and Statement of Compliance

Purpose of the Report

To provide an annual overview of compliance with medical appraisal and revalidation for which LPT is the GMC Designated Body.

To provide an overview of the Responsible Officer (RO) regulations and assurance that the Trust is compliant with these

Analysis of the Issue

Leicestershire Partnership NHS Trust has a prescribed connection to 164 doctors, for the purpose of Medical Revalidation, with the General Medical Council.

Medical Revalidation commenced in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety, and increasing public trust and confidence in the medical system.

The figures contained within the attached report are correct as of 23rd September 2025 (as in line with submission date for NHSE). Numbers refer only to those doctors who have a prescribed connection with the Trust. Medical Trainees on the approved training programme are excluded as they are connected to Health Education East Midlands.

Dr Bhanu Chadalavada is the Responsible Officer (RO) for the Leicestershire Partnership NHS Trust. The RO is accountable for the quality assurance of the appraisal and clinical governance system in the Trust.

The RO ensures its medical appraiser workforce is sufficient to provide the number of appraisals needed each year. Appraisers are selected through a structured recruitment process, managed by the Associate Medical Director (Medical Governance) supported by the Medical Staffing and Revalidation Officers.

The medical appraiser workforce delivers appraisals that are fair and consistent by appraisers that have achieved a set of core competencies. Appraisers have access to leadership and advice on all aspects of the appraisal process from the Associate Medical Director (Medical Governance).

The Trust continues to use the SARD e-system (Strengthened Appraisal & Revalidation Database) to support the appraisal and revalidation process. Administrative support for the appraisal system

Monitoring Performance

Monitoring the performance of individual doctors is undertaken through both formal and informal processes. Doctors are encouraged through their appraisal process to regularly reflect on their work and performance. Each doctor is part of a peer group which provides the opportunity to discuss doctors' performance and future plans. Peer groups also discuss individual doctors CPD (Continuous Professional Development) needs which are finalised at appraisal.

Risk and Issues

The Trust has implemented SystmOne to support clinical staff and record keeping which could enable more accurate reporting of activity undertaken by individuals. It may be timely to review what data is available together with its appropriateness.

Decision Required

Decision required – the Board is asked to review and approve the submission data as outlined in the tables below - FQIA – Illustrative Designated Body Annual report and Statement of Compliance (as submitted to NHSE) as assurance for LPTs compliance.

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of: Leicestershire Partnership NHS Trust can confirm that:
1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	No actions from previous year
Comments:	
Action for next year:	None

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	None
Comments:	Operational Management is provided by the Medical Staffing & Revalidation Support Manager and Revalidation Support Officers. This is overseen by the medical directorate's business manager
Action for next year:	None

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	None
Comments:	The Medical Staffing & Revalidation Support Manager and Officers ensures the list of prescribed connections is updated monthly
Action for next year:	None

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	None
Comments:	Appraisal and Revalidation Policy has been reviewed and was ratified on 25.3.2024
Action for next year	None

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	No
Action from last year:	To work towards completion of Peer Review
Comments:	Currently working with neighbouring trust to complete a Peer review.
Action for next year:	To ensure completion.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year	None
Comments:	NHS locums are employees of LPT and as such are connected to LPT as the Designated Body, they are supported with an induction process, are provided with the same appraisal/revalidation process as for substantive doctors and can join CPD activities and meetings within the Trust. Medical Agency Locums are connected to their Agency RO for appraisal and revalidation. Medical Agency Locums working within the organisation are supported with a local induction. We undertake a monthly audit of all Medical Agency locums to ensure they continue to be connected to their agency RO, are compliant with the mandatory training, are in date for appraisal and revalidation.
Action for next year	To keep information up to date.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	None
Comments:	Information about the whole scope of practice is recorded in the e-appraisal system (SARD) and appraised by the appraiser. Information from external agencies is invited where required.
Action for next year:	None

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	None
Comments:	N/A
Action for next year:	None

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	None
Comments:	The Trust Medical Appraisal & Revalidation policy has been duly ratified, consulted and approved in March 2024
Action for next year:	None

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes
Action from last year	To continue with the recruitment of new appraisers
Comments:	Every 6 months there is an invite to recruit new appraisers, following which a new appraiser training session is held, or appraisers attend a MIAD webinar for new appraisers.
Action for next year:	Continue with the recruitment of new appraisers

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	Arrange training sessions for appraisers as required
Comments:	Training and development sessions are provided for appraisers twice a year, the most recent held in June 2025, with the next one planned in November 2025. In June 25, the session was opened to all substantive doctors.
Action for next year:	Arrange training sessions as required.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	None
Comments:	There is a quality assurance lead for appraisals that reviews a selection of appraisals each month using the ASPAT tool (Appraisal Summary and PDP Audit Tool) The Annual Report on Appraisal and Revalidation was submitted to Trust Board subcommittee in June 2024
Action for next year:	none

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	None
Comments:	All recommendations within the last 12 months have been submitted on time. There has been 36 positive recommendations and 5 deferrals over the last financial year
Action for next year:	None

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	None
Comments:	doctors are advised of the recommendation prior to the submission on GMC Connect. Deferral recommendations would be discussed with the doctor beforehand.
Action for next year:	None

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	None
Comments:	Associate Medical Director is responsible for Medical Governance. AMD role encompasses appraisal and revalidation, and management of concerns with help from other Associate medical directors and Clinical directors.
Action for next year:	None

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	To look further into ways of improving the system so data is provided in a timely manner

Comments:	There is a good system in place, whereby reports on complaints, compliments and Sis are provided to all doctors for recording on their appraisal record. Revalidation Team have a process to instruct Complaints team to send reports 2 months prior to appraisal.
Action for next year:	None

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	None
Comments:	Doctors with upcoming appraisal are provided with all relevant information for their appraisal.
Action for next year:	To continue to provide this information.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	None
Comments:	Managing concerns about medical staff policy was adopted in 25.3.2024; all concerns are managed according to the process set out in the policy.
Action for next year:	None

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	yes
Action from last year:	None
Comments:	All concerns are reported to People and Culture Committee (PCC) as part of HR report
Action for next year:	None

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	None
Comments:	The Trust uses the MPIT (Medical Practice Information transfer) form for this purpose
Action for next year:	None

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes
Action from last year:	None
Comments:	There is a Trust policy on managing concerns about medical staff. The policy is intended to protect employees from unfair treatment regardless of their backgrounds.
Action for next year:	None

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	None
Comments:	National reviews, enquiries and reports are discussed in appropriate forums/committees of the trust and learning is incorporated in policies/practice
Action for next year:	None

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Within the Medical workforce we are developing a leadership and organisational development programme tailored for grades/roles. The programme will also include training in key skills e.g. case investigators, corporate governance.
Comments:	The Trust has a: • 'Leadership and values programme' embedded within the organisation.

	• it utilises the 'Our Future Our Way' strategy for taking forward key organisational development strategies each year. • There is a monthly Senior Leadership Forum for all leaders (medical and non-medical). • Regular leadership masterclasses including those with an EDI focus for all leaders. The Medical workforce are encouraged to participate
Action for next year:	None

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	None
Comments:	For permanent staff employed by LPT NHS locum workers, we follow the NHS Employers standards, namely: https://www.nhsemployers.org/recruitment/employment-standards-and-regulation. Medical Agency locums – pre-employment background checks are undertaken by the Medical Locum, this is also in line with the NHS Employers standards.
Action for next year:	None

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	None
Comments:	The Trust has various systems and processes in place to ensure that clinical care is enhanced by professional standards e.g.: Professional-Registration-Policy-Exp-Nov-26.pdf (leicspart.nhs.uk) states that staff undertaking work which requires professional registration are responsible for ensuring that they are registered and that they comply with any codes of conduct applicable to that profession. It also states that all staff should act in accordance the Trust leadership behaviours for all and be able to evidence adherence in situations that involve professional registration. A fundamental approach to developing these Leadership behaviours for all is our ability to both given and receive feedback in a positive and insightful way. The feedback method is based on the defining: context, understanding, behaviour and effect (CUBE). Valuing high Standards Accreditation where teams can self-assess against the standards that are most important to them, service users and colleagues and include those within the Trust Step up to Great Strategy, CQC standards 'Are we safe, caring, effective, responsive and well-led', other core regulatory or professional standards. Encouraging staff to undertake research and quality improvement activities, which develops themselves, the profession and improves patient care.

Action for next year:	None

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	None
Comments:	Compassion is central to all things within the Trust and is demonstrated by the Trust vision 'Creating high quality, compassionate care and wellbeing for all'. The Trust has an ambition to be free from discrimination, where all staff are able to reach their potential. To that end the Trust has its EDI strategy as well as policies Equality, Diversity and Inclusion Policy and a range of staff support networks.
Action for next year:	None

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	None
Comments:	The Trust has a well-established and publicised 'Values and Leadership Behaviours for All' where all staff continually strive to live by the values of trust, respect, and integrity, where everyone is expected to take personal responsibility and to be always learning and improving.

	The Trust encourages people to speak up and this is complemented by a Freedom to Speak Up Guardian, to that end there is a Freedom to Speak Up Policy that also supports those who raise a concern. Staff are aware of these principles.
Action for next year:	None

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	None
Comments:	The Trust is a learning organisation and one of its leadership behaviours is 'always learning and improving' and there are various mechanisms for learning and improving within the organisation: Concerns and Complaints Policy has feedback and lessons learnt built into its processes. Doctors participate in the Multi Source Feedback as part of their revalidation process that seeks feedback from patients and colleagues. The Trust utilises 'Friends and Family Test' to seek feedback on patient experience and this is fed back through service lines. In the past year the Trust has begun a transition from 'Serious Incident Investigations' as part of their response to patient safety, to the Patient Safety Incident Response Framework in line with other NHS care providers. Within this process are opportunities for learning & reflection for those involved and for the wider organisation.
Action for next year:	None

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Yes
Action from last year:	None
Comments:	All Trust policies include a 'Due Regard Screening Template' that considers the impact of the policy against all protected Characteristics. Managing Concerns about Medical Staff policy is always adhered to while managing concerns about medical staff.
Action for next year:	None

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	None
Comments:	RO/ AMD attend regular network events and cascade information and learning from those meetings

Action for next year:	None

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	158
Total number of appraisals completed	129
Total number of appraisals approved missed	27
Total number of unapproved missed	2
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	41
Total number of late recommendations	0
Total number of positive recommendations	36
Total number of deferrals made	5
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	6
Total number of trained case managers	1
Total number of concerns received by the Responsible Officer[2]	1
Total number of concerns processes completed	-

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

Longest duration of concerns process of those open on 31 March (working days)	248
Median duration of concerns processes closed (working days)[3]	248
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	-
Total number of new doctors joining the organisation	13
Total number of new employment checks completed before commencement of employment	13
Total number claims made to employment tribunals by doctors	2
Total number of these claims that were not upheld[4]	-

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Peer review of neighbouring trust.
Actions still outstanding
Peer review of neighbouring trust was delayed. New trust identified to complete a peer review which is currently underway and due to be completed by October 2025
Current issues
None

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
• Continue with the recruitment of new appraisers • Continue to provide training sessions for appraisers.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
Medical appraisal and revalidation systems are well established in the Leicestershire partnership trust. We have a number of experienced appraisers who have been involved in appraisal process for some time. One new appraiser completed training in July 2025. We have repeatedly discussed well-being agenda in our six-monthly developments sessions and our appraisals are more focused on practitioners' health and development. We have revised our quality assessment tool accordingly and our new tool reflects new appraisal guidance.

Governance Table

For Board and Board Committees:	LPT Trust Board January 2026
Paper sponsored by:	Dr Bahnu Chadalavada
Paper authored by:	Dr Saquib Muhammad AMD Medical Governance
Date submitted:	20.01.26
Name and date of other committee / forum at which this report / issue was considered:	PCC September 2025
Level of assurance gained if considered elsewhere	☒Assured ☐ Partially assured ☐ Not assured
Date of next report:	Annual
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:	
False or Misleading Information (FOMI) considerations:	
Positive confirmation that the content does not risk the safety of patients or the public:	
Equality considerations:	