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NHS
Leicestershire Partnership
NHS Trust

Public Trust Board – 26 May 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: Angela Hillery, Chief Executive Officer

Current Declarations:	Declaration Reference	Date Interest Arose
Loyalty interests – Member and Chair of LLR MH Executive Board	6873	01.04.26
Loyalty interests – Member and Chair of Northamptonshire MHLDA Executive Board	6872	01.04.26
Loyalty interests – Mentorship role to various individuals within the NHS	6871	01.04.26
Loyalty interests – Member of Midlands & East CEO Forum	6808	11.02.26
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
Hospitality – NHS Providers - Two-day ticket to NHS Providers RECHARGE Conference 2025	6671	11.11.25
Hospitality – NHS Providers - Pre-conference dinner for NHS Providers RECHARGE Conference 2025, honouring Claire Murdoch	6670	10.11.25
Hospitality - Royal Society of Medicine Travel expenses	6436	22.07.25
Loyalty Interests - Executive Reviewer for Care Quality Commission	6435	21.07.25
Loyalty Interest - Member of Royal College of Speech & Language Therapists	6434	21.07.25
Loyalty Interest - Invited to be part of CQC/NHSP Trust Well Led Reference Group	6433	21.07.25
Loyalty Interest - Member of RCSLT Senior Leaders Network	6357	01.05.25
Loyalty Interest - Member of Advisory Group supporting NHSE- led by Sam Allen CEO (Management and leadership)	6046	30.10.24
Gifts – REACH Network	6006	31.10.24
Hospitality - UNAM-UK CIC	5754	13.07.24
Gifts – Proud2beOpsConference	4502	07.11.23
Hospitality – NHS Providers	4393	21.02.24
Loyalty Interests - Dale Hillery (husband) - property surveyor	4273	01.04.23
Loyalty Interests - Director of 3Sixty (On behalf of NHFT)	4108	01.04.23
Loyalty Interests - Member of NHS Employers Workforce Policy Board	4106	01.04.23
Loyalty Interests - Member of National Mental Health Programme Board	4105	01.04.23
Loyalty interests – Member of Midlands region CEO representative for national health working group	4104	01.04.23
Outside Employment – NHFT – Joint CEO	4068	14.11.23

Current Declarations:	Declaration Reference	Date Interest Arose
Loyalty Interests – Member of one or more LLR integrated care system boards or other ICB for a and Northants ICB forums	4031	25.10.23
Loyalty Interests - Member of East Midlands Alliance MH & LD CEO Group	4030	25.10.23
Loyalty interests – sister employed by William Blake charity	4029	25.10.23
Other – Meal at APNA Conference	3935	28.09.23

Board Member: Jean Knight, Deputy Chief Executive Officer/Managing Director

Current Declarations:	Declaration Reference:	Date Interest Arose:
Loyalty Interests – Daughter Det. Constable Northamptonshire Police	6595	01.09.25
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

Board Member: Hetal Parmar, Non-Executive Director

Current Declarations:	Declaration Reference:	Date Interest Arose:
Outside Employment – Chief Operating Officer at a Multi Academy Trust in the Education Sector (Bradgate Education Partnership)	6893	13.04.26
Outside Employment – Coaching and consulting, including as Associate and as a Schools Resource Management Advisor and Coach via the Department for Education	6848	24.03.26
Outside Employment – Washwood Heath Multi Academy Trust	3097	04.09.23

Board Member: Liz Anderson, Non-Executive Director

Current Declarations:	Declaration Reference:	Date Interest Arose:
Loyalty Interests – President of UK Centre for the Advancement of Interprofessional Education (CAIPE)	6755	01.01.26
Outside Employment – University of Leicester Professor	4285	12.09.23

Board Member: Josie Spencer, Non-Executive Director

Current Declarations:	Declaration Reference:	Date Interest Arose:
Loyalty Interests – Leicestershire Police	5584	01.04.24

Board Member: Chris Skelton, Non-Executive Director

Current Declarations:	Declaration Reference:	Date Interest Arose:
Outside Employment – First Housing Limited (NED)	6812	01.01.26
Outside Employment – Trent and Dove Housing Association (NED)	6811	01.01.26
Outside Employment – ExtraCare Retail Limited (Director)	6810	01.01.26
Outside Employment – The ExtraCare Charitable Trust (Director)	6809	01.01.26

Board Member: Tim Harrison, Non-Executive Director

Current Declarations:	Declaration Reference:	Date Interest Arose:
Loyalty Interests - NHFT	6847	01.12.25
Outside Employment – Granta Medical Practices (CEO)	6799	01.12.25

Board Member: Faisal Hussain, Chair of the Trust

Current Declarations:	Declaration Reference:	Date Interest Arose:
Loyalty Interests – Raising Health Charity	3200	01.07.22
Loyalty Interests – Spinal Injuries Association Enterprise	3146	25.08.22
Loyalty Interests – Spinal Injuries Association	912	24.02.22
Loyalty Interests – Seacole Group	911	24.02.22
Loyalty Interests – Disabled NHS Directors Network	910	24.02.22
Loyalty Interests – APNA NHS Network	909	24.02.22

Board Member: Melanie Hall, Non-Executive Director

Current Declarations:	Declaration Reference:	Date Interest Arose:
Outside Employment - Synlab plc and Mid & South Essex NHS FT–Chair	6780	01.04.25
Outside Employment - Northamptonshire Healthcare NHS FT	6779	01.04.25

Board Member: Kate Dyer, Director of Governance and Risk

Current Declarations:	Declaration Reference:	Date Interest Arose:
Outside Employment – CQC Executive Peer Reviewer	6917	01.04.26
Loyalty Interests – Independent Member of the Audit and Risk Committee - Rutland County Council	6690	20.11.25

Board Member: David Williams, Executive Director of Strategy and Partnerships

Current Declarations:	Declaration Reference:	Date Interest Arose:
Hospitality – Commercial Company - £50	6423	26.06.25
Hospitality – Commercial Company - £40	6176	18.03.25
Volunteer Run Director – Parkrun	5955	02.11.24
Hospitality – Yale University	4138	01.12.23
Loyalty Interests – LPT Charity Raising Health	3934	27.09.23
Outside Employment – Raising Health Charity Trustee	3138	01.04.22
Outside Employment – Northamptonshire Healthcare NHS Foundation Trust	3137	01.04.22
Outside Employment – Director (as part of work with NHFT): Northampton GP and Community Alliance	465	01.04.21

Board Member: Sarah Willis, Group Chief People Officer

Current Declarations:	Declaration Reference:	Date Interest Arose:
Outside Employment – Group Chief People Officer at NHFT	6916	01.04.26

Board Member: Sam Leak, Executive Director of Community Health Services, Families, Young People and Children's Services, Learning Disabilities and Autism

Current Declarations:	Declaration Reference:	Date Interest Arose:
Loyalty Interest – NHFT	3730	01.04.23
Loyalty Interest – Age UK Northamptonshire	3729	01.04.23

Board Member: Tanya Hibbert, Executive Director of Mental Health

Current Declarations:	Declaration Reference:	Date Interest Arose:
Nil Declaration	6915	N/A

Board Member: Sharon Murphy, Chief Finance Officer

Current Declarations:	Declaration Reference:	Date Interest Arose:
Loyalty Interest – Member of Charitable Funds Committee	5770	01.04.24
Loyalty Interest – Raising Health Charity Trustee	3191	01.04.22

Board Member: Linda Chibuzor, Group Chief Nurse

Current Declarations:	Declaration Reference:	Date Interest Arose:
Outside Employment – Director - National Mental Health, Learning Disabilities Nurse Directors Forum	6704	01.05.25
Outside Employment – Trustee - Churches Housing Association of Dudley and District (CHADD)	6703	15.09.25
Outside Employment – Executive Reviewer - Care Quality Commission (CQC)	6702	03.12.25

Board Member: Bhanu Chadalavada, Chief Medical Officer

Current Declarations:	Declaration Reference:	Date Interest Arose:
Shareholdings and other Ownership Interests – Abhani Ltd	6907	27.04.26
Outside Employment – Four Elements Medical Services LTD	4045	01.11.23

Board Member: Paul Sheldon, Group Chief Commissioning Officer

Current Declarations:	Declaration Reference:	Date Interest Arose:
Loyalty Interests – Wife is Senior Finance Manager at Black Country ICB	4275	01.04.23
Outside Employment - Northamptonshire Healthcare FT - Joint role with LPT and NHFT	4116	19.09.23

Board Member: Anne Rackham, Group Chief Delivery and Integration Officer

Current Declarations:	Declaration Reference:	Date Interest Arose:
Loyalty Interests – Personal friend works at NHFT (SALT)	6910	29.04.26
Loyalty Interests – Husband works at NHFT: LD Clinical Service Manager	6909	29.04.26

Decision Required

Briefing – no decision required

Governance Table

For Board and Board Committees:	Public Trust Board 26 May 2026
Paper sponsored by:	Kate Dyer, Director of Governance and Risk
Paper authored by:	Sonja Whelan, Corporate Governance Coordinator
Date submitted:	19 May 2026
Name and date of other committee / forum at which this report / issue was considered:	Not applicable
Level of assurance gained if considered elsewhere	☐Assured ☐ Partially assured ☐ Not assured
Date of next report:	July 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)	Not applicable
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 31 March 2026 at 9.30am via Microsoft Teams

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

In Attendance:
Sam Leak, Executive Director of Community Health Services and Interim Executive Director of Families, Young People and Children's Services, Learning Disabilities and Autism
Tanya Hibbert, Executive Director of Mental Health
Sarah Willis, Group Chief People Officer
Kate Dyer, Director of Governance and Risk
Chris Skelton, Associate Non-Executive Director
Kamy Basra, Associate Director of Communications and Culture

TB/25-6/128	**Apologies for Absence** Apologies for absence were received from David Williams and Paul Sheldon.
TB/25-6/129	**Service Presentation: Community Heart Failure Service (Community Health Services Directorate)** Sam Leak introduced the service presentation which would focus on the Community Heart Failure Service. The team presenting included Alison Shaw (Cardio-Respiratory Service Lead), Seeta Tivey (Heart Failure Specialist Nurse Team Lead), Gemma Slack (Heart Failure Specialist Nurse), Matthew Garrod (Heart Failure Specialist Nurse), Alicia Foulds (Heart Failure Specialist Nurse) and Sandy Pandya (Heart Failure Specialist Nurse). Seeta Tivey opened the presentation by explaining that the community heart failure service was delivered by a team of specialist heart failure nurses, all of whom were experienced registered nurses with clinical backgrounds in areas such as coronary care, high dependency and intensive care, and undertake additional specialist training; completion of which was an essential requirement for specialist practice within the team. Most nurses were non-medical prescribers or working toward this qualification, enabling them to optimise medications effectively. Staff also undertook education in consultation skills and

	palliative care where relevant. Their role included conducting holistic assessments, optimising evidence based-medications, offering symptom monitoring and education, delivering non-pharmacological interventions, and providing both clinic-based and home-based appointments. The team worked across organisational boundaries and the strength of those partnerships being central to patient care to help ensure stability, safety and reduced risk of preventable hospital admissions was emphasised. The common symptoms of heart failure were described and the distinction between heart failure with reduced ejection fraction and preserved ejection fraction was explained; with most evidence-based treatments applying to reduced ejection fraction (which made up the majority of the community caseload). The national prevalence figures were highlighted as 1 million people in the UK living with heart failure, with approximately 200,000 new diagnoses each year – these figures underlined the importance of effective long-term management to reduce deterioration and avoidable hospital admissions. The service is nurse-led and received referrals only after a confirmed diagnosis via appropriate cardiology pathways. The importance of applying referral criteria rigorously to avoid delays for patients who may require device therapy or other specialist interventions outside the scope of community management, was stressed. To maintain patient safety during high demand, the service conducts a first response contact within three days of referral. This was particularly important for recently discharged patients, as national audit data indicated that the first thirty days post discharge carried significant risk of readmission or early mortality if medications were not reviewed promptly. Early contact enabled the team to explain diagnoses, reinforce medication adherence and identify early signs of deterioration. The team operate a single point of access which provides straightforward contact for patients and professionals. Although not an urgent service, the single point of access is designed to rapidly signpost emergencies to '999' while ensuring routine calls are returned on the same day where possible. The service also included ongoing management and pathways, integrated and specialist support and quality, learning and improvement, for example, involvement in research and service improvement including the 4x4 Project (which focuses on rapid optimisation of the four core heart failure medications within four weeks). Leicestershire was the first of fourteen national sites to complete its project phase. Also highlighted was that successful optimisation leads to improved quality of life, reduced breathlessness and decreased hospital utilisation and the team also supported non-pharmacological approaches, including management of dysfunctional breathing; thus ensuring patients understand their condition and how best to manage symptoms. Patients are discharged once they are stable and confident in self-management and the team provided a traffic-light symptom leaflet to help patients recognise and act early on signs of deterioration. The team's longer-term vision included reinstating professional education programmes and promoting a public awareness acronym for heart failure –

	‘BEAT’ (breathlessness, exhaustion, ankle swelling, time to seek help). Alison Shaw then provided an overview of the Friends and Family Feedback which continued to be overwhelmingly positive. The feedback was shared monthly with staff to maintain morale and reinforce high standards of care. The Chair thanked the team for a comprehensive overview of the service and highlighted the holistic nature of the service, the emphasis on ensuring patients are directed to the correct pathway at the outset and the significant role the team played in preventing avoidable admissions and supporting the wider system. Questions were then invited. Josie Spencer expressed her appreciation for the clarity and breadth of the presentation, stressing the complexity and fragility of the patient group and how impressed she was by the team’s ability to support individuals safely at home. Angela Hillery added her thanks and reflected on the alignment between the service’s approach and the ambitions of the NHS 10 Year Plan; noting that themes such as digital support, preventative care and care closer to home were clearly embedded through the team’s practice. Seeta Tivey reiterated the importance of accurate referral and triage and explained that significant time could be lost when patients were referred inappropriately and ensuring correct referral from the outset enabled the team to use their capacity effectively and deliver the right care to those who would most benefit from it. Liz Anderson also offered reflections, stating that as someone with both academic and nursing experience, she was overwhelmed by the level of expertise within the team. As Leicester was a major national centre for cardiovascular care, she expressed concern about the potential volume of patients referred into the community service and asked how the team managed high demand and how patients discharged outside the region were supported if they did not return. In response, Seeta explained that patient numbers were indeed substantial but effective triage was critical to ensuring the right patients entered the service. Hetal Parmar expressed appreciation for both the level of specialist qualification required of the nursing team and the high quality of care provided. He welcomed the service’s system wide approach, particularly in relation to ensuring appropriate referrals. He also supported the development of a public facing acronym as described earlier to improve awareness of heart failure symptoms and support the reduction of health inequalities. Linda Chibuzor highlighted the emotional impact of receiving a heart failure diagnosis, particularly for working age adults who may be otherwise active and functional. She praised the team for their ability to provide psychological support, offer information in manageable stages and tailor care to individual needs and circumstances. The service’s impact extended beyond Leicestershire Partnership NHS Trust (LPT), reflecting a broader population health approach that enabled people to maintain wellbeing and independence for as long as possible. Bhanu Chadalavada thanked the team and reflected on how heart failure

	management has advanced and highlighted the importance of the team's work on patient self-management, confidence-building and research contribution. Bhanu then asked whether the service was seeing a younger cohort of patients, particularly given the higher prevalence of diabetes and heart disease in South Asian communities. Seeta confirmed that the patient group was diverse and did include younger adults and reiterated that heart failure prevalence continued to rise and remained a significant and expanding area of need. Alison Shaw introduced herself and other members of the team and highlighted recent achievements within the service with two members of the team, Gemma Slack and Alicia Foulds, having received Daisy Awards in recognition of their exceptional dedication and outstanding care provided. Gemma Slack was then invited to present her reflections and experiences of working within the service. Gemma began by outlining the previous approach to the first response triage system, explaining that historically, two clinical staff members spent a full day reviewing referrals. These referrals could originate from consultants, patient initiated calls, or GPs. Staff would decide whether to accept, decline, or onward refer cases where another service was more appropriate. Accepted referrals were placed onto a waiting list, and the team endeavoured to meet NICE guidance by seeing patients promptly. However, the team felt they were missing significant opportunities at the triage stage, particularly around safety netting, identifying concerns following hospital discharge, and prioritising patients' needs more effectively. She explained that during Covid-19, the team had learned valuable lessons about flexible working and this learning helped shape a new approach to triage. Rather than processing written referrals, the team now contacted patients directly, usually on the same day, and always within three days (unless the team were unable to reach the patient). Through this telephone contact, staff undertook a full, holistic assessment. Gemma described how this enabled the team to identify unmet needs such as care support that may have been overlooked or declined at discharge, medication misunderstandings, or the need for additional referrals, including palliative care or expedited contact for their service. While NICE recommends face-to-face contact within two weeks, the team proactively accelerates appointments when necessary by coordinating capacity across the wider team. It was emphasised that this approach goes beyond what is required and the team's commitment to continually improving care and exceeding expectations wherever possible was stressed. Matthew Garrod also provided his reflections following six months working within the team and explained how he was immediately struck by the strong sense of passion, focus and commitment. Reflecting on his experience in other regions, he emphasised the team's responsiveness, especially through the first response model described earlier and commended the way staff worked collaboratively toward a common goal, prioritising the needs of the patients. Matthew felt privileged to work within such a highly dedicated team and described the culture as supportive, patient-centred and committed to ensuring timely follow up and care delivery. Sandy Pandya reflected on her long association with the heart failure service and how she made a deliberate choice to rejoin the service in 2021 after spending time elsewhere. Since returning, she had been struck by how much the service

had grown and emphasised the strength of the team, the broad and impressive range of clinical skills and the strong sense of unity. She concluded by saying that the service represented not only the starting point of her professional journey but also a service that continued to deliver excellent care supported by a committed, highly skilled and stable workforce; something which she was proud to be part of.

Alicia Foulds expressed how humbled she felt to have received a Daisy Award and commented that, while it was encouraging to receive individual recognition, she viewed the award as a reflection of the whole team's strength and the high level of trust placed in staff to work autonomously with patients. She highlighted how the service fostered significant clinical autonomy, supported by managers and colleagues alike. This autonomy enabled nurses to make informed decisions in partnership with patients, which she believed contributed to a higher quality of care. She explained that feeling supported, trusted and listened to empowered staff to tailor their approach to the individual needs of each patient, rather than simply following routine processes. This environment encouraged confidence, flexibility, and the ability to speak up constructively within the wider multidisciplinary system, even when engaging with colleagues higher in the organisational hierarchy. Alicia reiterated that her recognition in receiving the Daisy Award was a direct result of the supportive and empowering environment within the service and highlighted that two out of approximately twenty staff members within the team had received the Award; something she described as highly unusual and a testament to the team's collective excellence and impact. She concluded by stating her pride in being part of such a committed and effective team.

Alison Shaw introduced a video contribution from 'Rob', a patient who had received care form the Heart Failure Service.

Rob introduced himself as an 84 year old living with his wife of nearly 60 years. He described the onset of changes to his treatment, including adjustments to his medication aimed at reducing strain on his heart. As part of this process, he was advised that he would benefit from upgrading his pacemaker to a dual channel device, although he was informed there was a significant waiting list. During the period of medication optimisation, Rob developed high potassium levels and reduced kidney function, resulting in a hospital admission for 4-5 days for monitoring and further medication management. Following his discharge, he was transferred to the hospital's virtual ward system which allowed him to report his daily symptoms from home. The virtual ward team monitored this information and contacted him promptly when needed. He stated he was very satisfied with this arrangement and found the team to be highly responsive. After several weeks, Rob was discharged from the virtual ward and transferred to the local nurse-led Heart Failure Team, a change he initially felt apprehensive about, having perceived it as a 'demotion' from the specialist team at Glenfield Hospital. However, he reported that his concerns were quickly alleviated after his first home visit from Alicia, with whom he established a strong and trusting relationship. He was confident in her expertise and reassured that the monitoring he now received was of the same quality as the care provided under the virtual ward. One minor concern was mentioned that when making contact, he had to do so indirectly via the call centre which he described as 'clunky',

	though he acknowledged the system still worked effectively due to Alicia's responsiveness. The home-based monitoring highly suited him and he was satisfied with his current care arrangements. The Chair thanked the team for an excellent and insightful overview of the Heart Failure Service. He reflected on the strong themes that had emerged, particularly the holistic way in which the service operated, the passion and commitment demonstrated by staff, and the positive experience of patients and noted the service clearly aligned with the organisation's THRIVE Strategy, referencing the effective use of technology, the focus on healthy communities, responsive service and the strong cultural foundations built on freedom, trust and flexibility. Melanie Hall expressed her appreciation to the team, stating that the reflections shared had clearly illustrated the strength of their teamwork and the robustness of their processes. She highlighted the strong combination of trust, autonomy and professional expertise within the team. Melanie further reflected on Rob's comments regarding the transition from hospital to community care, noting that such transitions can be challenging for patients. She commended the Heart Failure Team for their ability to support patients through this process to ensure they felt safe and confident in their care. Jean Knight also thanked the team and shared that the presentation and staff reflections epitomised what the organisation strived to achieve in delivering excellent patient care. The empowerment described by staff, particularly Alicia's reflection on autonomy, and how this translated directly into high-quality, patient-centred care was praised. The Chair asked whether the team felt supported in managing their workloads and health and wellbeing, acknowledging that the Board had a responsibility to ensure staff were appropriately supported. Gemma Slack confirmed the team felt well supported and explained that sickness absence levels within the service were low and team members regularly supported one another, particularly when colleagues were unwell or under pressure. She described how staff willingly shared tasks and adjusted workloads to help each other, and how operational processes, such as handing over planned care when staff were on leave, reduced the stress often associated with caseload-based services. The Chair concluded by expressing his gratitude to the whole team for their presentation, personal reflections and contributions, and for the excellent care they continued to provide.
TB/25-6/130	**Questions from the Public (verbal)** There were no public questions.
TB/25-6/131	**Declarations of Interest (Paper A)** The Board received this report and noted the declarations of interest contained within. There were no declarations of interest in respect of items on the agenda. **Resolved**: The Board received this report for information and assurance.

TB/25-6/132	**Minutes of the previous public meeting held 27 January 2026 (Paper B)** The minutes were approved as an accurate record of proceedings. **Resolved:** The Board approved the minutes.
TB/25-6/133	**Matters Arising (Paper C)** All items were confirmed as complete and presented for closure. **Resolved:** The Board approved the closure of all actions.
TB/25-6/134	**Trust Board Workplan 2025/26 (Paper D)** The Trust Board Workplan was presented for information. No questions or queries were received.
TB/25-6/135	**Chair's Report (Paper E)** The Chair presented this report which summarised Chair and Non-Executive Director (NED) activities and key events relating to the well-led framework for the period February to March 2026. Key points highlighted were: • Several Non-Executive Director (NED) visits to services had recently taken place. • The recent Midlands NHS Leadership event focused on digital transformation, and partners across the region were cognisant of digital poverty and ensuring the appropriateness of digital solutions to meet the needs of the communities we serve. • Updated committee membership details for NEDs have been finalised and will be included in the next Chair's Report. **Resolved:** The Board received this report for information.
TB/25-6/136	**Chief Executive's Report (Paper F)** Angela Hillery presented this report which provided an update on current national issues and policy developments affecting the Trust. The report was supplemented with further verbal updates on the wider national and regional landscape to ensure Board remained sighted on emerging external developments. Salient points were highlighted as:- • The NHS Providers and NHS Confederation had recently merged to form a single organisation. Reduced subscription costs were welcomed with additional efficiencies gained from operating as a Group. • Ongoing challenges at St Andrew's Healthcare with the most recent CQC report again rating the service as inadequate; conditions restricting admissions remained in place and a meeting of the East Midlands Alliance Chief Executives had been convened to consider potential impacts on patients. • Recent national publications on the neighbourhood health model and the Integrated Healthcare Organisations were welcomed. Hinckley Health Centre had been identified as one of the 27 first wave neighbourhood centres, representing a significant development for the local system. • Personnel changes within NHS England were highlighted.

	• Draft CQC assessment frameworks had been released for consultation until 12 June 2026, forming part of the Regulator's transformation programme and moving towards more sector specific approaches. • The potential for industrial action was noted and both Jean Knight and Bhanu Chadalavada were monitoring developments and preparing to support staff as required. The Chair informed the Board that issues relating to St Andrew's Healthcare had also been discussed at the recent National Mental Health Chairs meeting where he had been able to reassure national colleagues that both Leicestershire Partnership NHS Trust and Northamptonshire Healthcare Foundation Trust were committed to supporting the system and working closely with NHS England to manage the situation. Tim Harrison sought clarification on the references in the report to mental health emergency departments and community based mental health centres, and queried whether the Trust had begun to consider the opportunities and requirements associated with these developments, particularly in the context of the emergency neighbourhood health centres. Angela Hillery confirmed that planning work was already underway and senior leaders including Tanya Hibbert, Sharon Murphy and Jean Knight were actively engaged in considering these developments and already involved in relevant discussions and preparatory processes. Tanya Hibbert added that the Trust had already secured capital funding for the first mental health neighbourhood centre and had submitted a further capital bid for a second centre within the 2026-27 planning cycle, which was consistent with national ambitions to develop a number of these centres by 2029. **Resolved**: The Board received this report for information.
TB/25-6/137	**Managing Director's Report (Paper G)** Jean Knight presented this report which provided an update on current local developments since the last Board meeting. Key points highlighted were: • The CQC report for the Mental Health Crisis Service and Place of Safety (inspected May 2025) had been published with the service rated at 'Good' across all domains. The rating included the Trust's urgent mental health care function. The teams involved were commended. • The Trust had retained Segment 2 under the National Oversight Framework (NOF) and achieved a green rating for provider capability self-assessment with work ongoing to maintain this position and progress toward Segment 1 where possible. • PLACE (patient-led assessment of the care environment) results – the Trust achieved 100% for cleanliness, marking the second consecutive year of achieving this score. • A presentation on change in demand in mental health services for secondary care was presented at the Leicester City Health and Wellbeing Board (HWB), which was positively received. • The NHS Staff Survey headline outcomes indicated performance above average for nine People Promise areas. • Celebrating Excellence Awards nominations were now open.

	• Tanya Hibbert and Bhanu Chadalavada were leading the Trust's operational planning to ensure service continuity around the expected industrial action involving medical staff. • NHS England had published guidance on community health services waiting times and the requirements were being reviewed to ensure full alignment. Josie Spencer commended the positive outcomes highlighted, particularly the CQC results and other organisational achievements and thanked staff for their hard work. Liz Anderson echoed this praise and congratulated staff on their efforts noting the importance of their contribution to the Trust's success in achieving outstanding PLACE cleanliness scores. Liz Anderson also reflected on visits to staff working out of hours and suggested NEDs should consider doing this. The Chair supported this point and encouraged NEDs to inform the Patient Involvement Team if they wished to arrange additional out of hours visits. Bhanu Chadalavada provided a short update relating to the forthcoming period of industrial action by medical staff. Learning from previous strikes had informed planning, ensuring that essential routine clinics and on-call rotas would be covered. Arrangements were being supported by SAS doctors and locally employed doctors, and discussions were ongoing with trainee doctors regarding optional continued participation during the industrial action. Chris Skelton sought clarification on the Friends and Family Test results, noting the exceptionally high scores and asking whether comparator data from other trusts was available. Jean Knight confirmed that comparative data was routinely reviewed, although she did not have the figures to hand and undertook to share benchmarking information outside the meeting. Also highlighted was the innovative digital approaches being used within CAMHS to increase service-user feedback, including QR code technology, which was being explored for wider rollout. The Board discussed the importance of ensuring visibility and engagement with staff working outside normal hours. In response to reflections raised by Liz Anderson, Tim Harrison highlighted that the Joint People and Culture Committee had already considered issues affecting staff who work remotely from managers or predominantly out-of-hours and emphasised the importance of recognising and celebrating their contribution. Jean Knight confirmed that planning was underway for the Trust's internal Freedom to Speak Up Month in October, during which visits would be scheduled to ensure engagement with staff working overnight and at weekends and dates would be shared with Board members who wished to participate. The Chair provided further assurance regarding engagement with staff working across different shift patterns. He noted that he had previously participated in roadshows involving Freedom to Speak Up, Raising Health, and Health and Wellbeing teams, which had visited sites during early morning handovers and evening periods. He welcomed the opportunity to align these activities with the forthcoming Freedom to Speak Up Month in October and confirmed he would work with the relevant teams to ensure coordinated staff engagement. The Chair also highlighted the Trust's recent Disability Confident accreditation and Veteran Award Accreditation and expressed the Board's thanks to all staff involved in these achievements, alongside the organisation's overall CQC rating of 'Good'.

	Action: Jean Knight to provide comparative Friends and Family Test benchmarking data from other trusts. **Resolved**: The Board received this report for information.
TB/25-6/138	**Environmental Analysis (verbal)** There was no business to report under this item.
TB/25-6/139	**Board Assurance Framework (Paper H)** Kate Dyer presented this report which provided the position for March, noting that this was the final update for the 2025-26 cycle. Key changes since the previous Board meeting were highlighted as: • Reduction in risk score for BAF6.1 (Estates) and BAF6.3 (Finance) • Thirteen actions were proposed for closure since the last meeting, reflecting the ongoing and sustained mitigation work undertaken across the organisation. • Attention was drawn to the close down report (p65 of the paper pack) which summarised the year end position. • Throughout 2025-26 the Trust held thirteen strategic risks with two originally shared with Northamptonshire Healthcare Foundation Trust. Over the course of the year, an additional four risks matured into Group level strategic risks, resulting in six Group-aligned risks by year end. • Three risks remained at a score of twenty, which was consistent with national trends with access, workforce and capital continuing to represent high scoring risks across many NHS organisations. • The risk score trajectory map, which demonstrated incremental changes over the year, would be reflected within the Annual Governance Statement. Josie Spencer queried the scoring presented for BAF3.2 (Patient Safety), noting that the risk was shown with a consequence score of five and a likelihood score of two, which would normally equate to a total score of ten rather than the fifteen recorded in the report. Kate Dyer confirmed this was a typographical error in the reporting of the likelihood score, which should correctly read three, resulting in the combined score of fifteen being accurate and undertook to ensure the correction was reflected. **Action:** Kate Dyer to correct the likelihood score for BAF3.2 (Patient Safety). **Resolved:** The Board approved the proposed changes and noted the 2025/26 close-down position.
TB/25-6/140	**Board Assurance Framework Refresh 2026-27 (Paper I)** Kate Dyer presented the refreshed Board Assurance Framework (BAF) for 2026-27, noting that approval of the action closures for 2025–26 would enable a clear list of any remaining actions to be mapped across to the new BAF or, where appropriate, de-escalated and managed separately. Introduced was the annual deep dive risk assessment, which formed the basis of the new BAF and Board was reminded that the assessment reviews the Trust's global, national, regional, system, group and internal risk profile against the THRIVE Strategy for the forthcoming year. Given the shared strategic framework

	with Northamptonshire Healthcare NHS Foundation Trust (NHFT) and the progress made during 2025-26 toward aligning risk management approaches, the move to a Group Board Assurance Framework represented a logical next step. Kate highlighted that the assessment paper, also considered by the NHFT Board the previous week, included a full mapping of risks from 2025-26 to 2026-27 (page 91 of the pack), enabling clear visibility of risks that had been closed, de-escalated, or transferred into the new Group risk register. It was noted that many mitigating actions reflected large, ongoing strategic programmes that would continue into the new year. The first full draft of the 2026-27 BAF was being prepared and would be reviewed by the Group Strategic Executive Board before being presented for formal approval. The proposed governance arrangements for the Group BAF were outlined and it was explained that this would differ slightly from existing oversight processes due to the strengthened Group level structures. The format remained consistent with the approach used within LPT and work was underway to ensure alignment of templates and processes across both organisations. The Chair offered thanks for the clarity of the report and commented that the Board could take a high level of assurance from the methodology, the maturity of the risk management approach, and the continued strengthening of the organisation's risk oversight processes. Melanie Hall welcomed the comprehensive approach set out and agreed with the Chair's comments regarding the maturity and breadth of the Trust's risk-management processes. Drawing on related discussions at the NHFT Board, she raised two areas for further consideration within the developing Group Board Assurance Framework. She highlighted the absence of explicit reference to social value and the Trust's role as an anchor institution, noting that social value was a strategic priority within the THRIVE Strategy and given the current economic and political volatility, suggested that risks linked to the organisation's anchor-institution responsibilities and wider social-value commitments should be clearly recognised within the strategic risk profile. She also sought clarification on the treatment of digital risks, observing that the current positioning appeared to focus primarily on cyber security. She expressed the view that digital transformation, a critical component of service improvement, staff efficiency and patient experience, might be insufficiently reflected, and queried whether it should be captured as a distinct strategic risk rather than solely as a mitigation against cyber threats. In response, Kate Dyer confirmed that the refreshed framework represented an initial draft, with further development underway across both organisations. She agreed that social value should be drawn out more explicitly and confirmed this would be incorporated into the ongoing refinement of the Group BAF. It was also explained that the maturing Group BAF model would rely more heavily on the corporate risk registers of each organisation to capture localised risks such as digital infrastructure, systems variation, and digital transformation challenges that underpin and inform the Group level strategic risks. It was noted that significant digital risks were currently being strengthened within the corporate risk registers of both Trusts, reflecting different digital estates and differing organisational needs. These developments would continue to inform decisions about whether

	additional digital related risks should be elevated to strategic level within the Group BAF. Angela Hillery welcomed the work undertaken to further mature the organisation's approach to risk management and the development of the new Group BAF and emphasised the importance of continued board development on risk. **Resolved:** The Board received this report and:- 1. Approved the approach to establishing a Group BAF for 2026/27, aligned with the THRIVE strategic ambition and agreed governance structure. 2. Approved the mapping of the NHFT, LPT and Group BAFs for 2025-26 into the revised 2026-27 Group BAF including the addition of one new strategic risk.
TB/25-6/141	**Audit and Risk Committee AAA Highlight Report: 6 March 202 (Paper J)** Hetal Parmar presented this report and drew attention to the following key points:- • A number of VAT related matters had emerged as part of the annual accounts exercise; the Finance Team was actively addressing these issues. • The Internal Audit Plan for 2026-27 had been approved following a constructive pre-meeting workshop. • The Committee also reviewed benchmarking information which demonstrated that LPT was not an outlier in any category assessed, providing additional assurance regarding organisational performance. • The number and value of Chief Executive waivers and awarded tenders continued to move in a positive direction, with eighteen fewer tenders year to date and a £1.5m reduction in value compared to the same period last year. • Work was progressing on a joint procurement related work plan with NHFT, supporting improved Group level efficiency; as part of this, a proposal was being considered to align the waivers process across both organisations. • Completion rate for all high and medium priority internal audit follow up actions was 100%. **Resolved:** The Board received this report for information and assurance.
TB/25-6/142	**Quality and Safety Committee AAA Highlight Report: 17 February 2026 (Paper K)** Josie Spencer introduced this report and highlighted the following key points:- • Ongoing alert regarding the sustained number of patients waiting over 52 weeks for treatment, predominantly within the neurodevelopmental pathways. The scale of the backlog meant that system wide support would be required to achieve meaningful improvement. Further detail on waiting numbers would be considered under the performance report later in the meeting. • Work was underway to strengthen the Freedom to Speak Up feedback loop into the Quality and Safety Committee (QSC) to improve the triangulation and reporting of information. • Attention was drawn to a concern previously raised regarding medical photography. A new risk had been added to the Risk Register, with mitigation

	initially expected by 1 April 2026, however, a post meeting update indicated that the revised and more realistic target date for completion was 1 May 2026, and assurance had been received that the Task and Finish Group was progressing the work as required. • QSC received the project closure report on the community nursing transformation and commended the significant improvement achieved • QSC received and approved the 2024-25 Service User Equality and Equity Annual Report and was scheduled for publication on the Trust's website. Jean Knight informed the Board that Freedom to Speak Up reports were now being received through the Accountability Framework Meeting (AFM) and confirmed this reporting route would provide improved visibility of concerns. Updates would be received by QSC and all Level 1 committees going forward. Angela Hillery drew attention to the ongoing alert regarding community waiting times, particularly in relation to neurodevelopmental pathways and noted that this issue also appeared in the performance report and had been a focus within planning discussions. It was suggested that the Board may wish to consider where further discussion would be most appropriate, to ensure clarity on actions being taken and support being provided to those waiting. The Chair confirmed this matter would be revisited under the Performance Report, linking it back to the alert raised through the AAA report. Melanie Hall highlighted a positive example within the celebrating success section of the report; the collaborative work between the police and LPT through the Youth Justice Prevention Panel pilot, and commended the initiative as an important piece of early intervention work supporting young people at a time of increasing pressures on their mental health. The Chair drew attention to the progress highlighted by QSC regarding the Public Sector Equality Duty and improved data completeness and noted that 90% of patients now had recorded ethnicity and demographic information, which was essential for addressing health inequalities and driving population health improvement. **Resolved:** The Board received this report for information and assurance.
TB/25-6/143	**Safe Staffing Monthly Report (Paper L)** Linda Chibuzor presented this report which provided a full overview of nursing safe staffing during the month of January 2026, including a summary and update of Allied Health Professional (AHP) and medical vacancies, key staffing areas to note, potential risks, and actions to mitigate, to ensure safety and care quality are maintained. This report triangulated inpatient nursing workforce metrics; fill rates, Care Hours Per Patient Day (CHPPD), Nurse Sensitive Indicators (NSIs) and patient experience feedback. The key points were highlighted as:- • Overall vacancy rate had improved since December and was now at 10%, meeting the Trust's target. • Notable improvements were seen within nursing and allied health professional staffing groups.

	• A Group wide sickness absence reduction programme was underway, recognising that sickness levels remained a national challenge and are influenced by seasonal winter pressures. • The monthly safe staffing scorecard continued to show compliance with expected standards across inpatient areas. • Instances of higher staffing levels related to increased patient acuity. • Appropriate mitigations for increased staffing demand were detailed within the report. Discussion followed where Melanie Hall raised a query regarding the significantly higher vacancy, sickness and turnover rates among healthcare support workers (HCSWs) and suggested this cohort should be considered as a future agenda item for the Joint People and Culture Committee (JPCC), to understand whether the issues reflected local or Group wide trends and to explore targeted interventions. Sam Leak highlighted that although overall vacancies had improved, the temporary workforce usage remained high and requested this issue also be reviewed in greater detail through the JPCC. Josie Spencer asked that, from a Quality and Safety perspective, the Committee receive clearer narrative on safe staffing improvements linked to ongoing programmes of work, to ensure alignment between workforce data and patient safety oversight. Sarah Willis clarified that the reference to a 'three year programme' related to the timescale for achieving the national 4.1% sickness absence target by 2029, not the duration of the programme itself. Liz Anderson sought assurance regarding staffing within the Crisis Resolution Team (CRT), given their critical role in urgent mental health care, and noted issues in the report relating to vacancies and the need to ensure safe staffing levels as the service approached April. Tanya Hibbert confirmed that recruitment into CRT had progressed, with some remaining vacancies and explained the service required Band 6 autonomous practitioners and operated a rigorous competency-based recruitment model due to the high-risk nature of the work. Skill mix changes had been introduced, including additional pharmacy posts. She also reported the successful reopening of Heather Ward following completion of anti-ligature works. Linda Chibuzor provided additional assurance across several areas. She noted that HCSW vacancies were monitored closely by NHS England and that some turnover reflected the success of the 'grow-our-own' programme, through with HCSWs progressed to student nurse associate and registered nurse roles. She also highlighted pressures related to the cost of living, particularly affecting community-based support workers. Linda further explained that sickness absence patterns partly reflected annual leave usage and seasonal illness which increased reliance on bank staff and confirmed ongoing work to reduce agency use, with an expected shift towards bank usage during the transition. It was acknowledged that safe staffing issues were routinely identified through patient safety reporting systems, including Ulysses, but reporting could be made even clearer to enhance transparency. The use of safety huddles, matron support,

	professional nurse advocate supervision and psychology input to maintain safety and resilience within the team during staffing pressures was also highlighted. In response to a query from Hetal Parmar, the meaning of the amber ratings was clarified as areas where active mitigations were in place and work was ongoing, rather than areas of unmanaged risk; the intention was to avoid prematurely presenting such areas as resolved while still demonstrating control and progress. The Chair thanked all for their contributions and confirmed that actions and areas for further exploration would flow through the JPCC and QSC as appropriate. **Resolved:** The Board received this report for information and assurance.
TB/25-6/144	**Patient Safety and Learning Assurance Report (Paper M)** Linda Chibuzor 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 continued to maintain a strong incident reporting culture with most reported incidents categorised as no-harm, demonstrating effective staff intervention and management of patient risk. • Work on falls prevention and management remained a priority. • Learning response and clinical investigation performance had improved, supported by a recovery plan overseen through AFM. • There had been a good uptake of patient safety training across the organisation. • Melanie Hall offered positive feedback from a recent service visit where she observed patient safety training and noted the enthusiasm and commitment demonstrated by staff. **Resolved:** The Board received this report for information and assurance.
TB/25-6/145	**Finance and Performance Committee AAA Highlight Report: 19 February 2026 (Paper N)** Melanie Hall presented this report and highlighted the following key points:- • One alert related to uncertainty around service development funding which was typical at this point in the financial year and greater clarity was expected at the next meeting in April. • The Committee reviewed capital where assurance discussions focused on improving tracking of purchase order pipelines and goods received timelines. A review of challenges experienced would inform learning for the next financial year.

	• FPC noted continued positive reduction in over 52-week waits despite ongoing challenges – the Committee recognised the significant work underway to reduce both long waits and overall waiting lists. • Assurance was received that solutions were progressing well and expected to be in place by the end of March regarding the Integrated Clinical Environment (ICE). • A small number of loss-making services were discussed – the Committee requested deeper analysis to ensure plans are in place to address cost pressures and improve service sustainability. • The AFM reviewed challenges with SNOMED rollout, and a further update was expected at a future meeting. • A digital plan update was received which demonstrated innovation and pilot activity supporting improved patient care, digital tools facilitating care at home and workforce efficiencies through reduced administrative burdens • Ongoing challenges were noted as backlog maintenance and strategic estates pressures and a deep dive into strategic estates was scheduled for April. • Celebratory items included the HSJ recognition for the Waterloo Programme and CAMHS Provider Collaborative, progress on the Digital Bookcase initiative, and patient support initiatives such as Body Rhymes and the enriched Dementia Care model. **Resolved:** The Board received this report for information and assurance.
TB/25-6/146	**Finance Report – Month 11 (Paper O)** Sharon Murphy presented this report which provided an update on the Trust financial position for the period ended 28 February 2026. Key points highlighted included:- • The Trust delivered a year to date deficit of £373k which was in line with the financial plan. • All operational areas reported positive movement through increased underspends, except for the Directorate of Mental Health (DMH) which reported a £95k adverse movement. • Corporate reserves had moved into an overspend position, reflecting under-delivery of some central planning assumptions. • The Cost Improvement Plan (CIP) continued to deliver in line with plan. All areas were forecasting full year-end delivery, although only 35% of CIP delivery was recurrent, which would increase pressure on the 2026-27 CIP requirement. • The forecast outturn range (worst to best case) had narrowed significantly from £3.2m in Month 10 to £1.2m in Month 11, demonstrating effective mitigation of identified financial risks. • Confidence remained high in delivering the planned break-even position, reflected in the reduced BAF risk score. • Performance against the Better Payment Practice Code (BPPC) showed two of the four targets achieving the 95% requirement, with the remaining two very close and expected to move above target for the 2026-27 financial year, due to improved performance in recent months. • The capital plan continued to evolve throughout the year, with further funding received. The plan now totalled £19m, with significant expenditure scheduled

	for Month 12 and mitigations in place to ensure funds were spent before year-end. A small, allowable underspend may remain and would be consistent with previous years. • The 2026-27 capital plan is similar in value to the current year, but several NHS England allocations remain awaiting approval - early approval is essential to avoid delays. • A break-even plan for 2026–27 and the following two years submitted to NHS England in February had been accepted. Continued strong CIP delivery will be essential to avoid additional controls or interventions. • The SDF element was confirmed as stable, with minimal movement of SDF funds between financial years. The contract with the ICB was due for sign-off today (31 March 2026). The Board expressed appreciation for the work of the finance team and operational services in delivering the Trust's financial position at year-end. **Resolved:** The Board received this report for information and assurance.
TB/25-6/147	**Performance Report – Month 11 (Paper P)** Sharon Murphy presented this report which provided an overview of the Trust's performance against Key Performance Indicators (KPIs) for February 2026. Key areas that were highlighted included:- **Operational Plan Metrics:** • Performance against the operational plan metrics was predominantly positive, with all indicators delivering as expected except for Length of Stay (LoS), where further work was still required within Community Health Services (CHS). **Access KPIs:** • In the Directorate of Mental Health, two of the four metrics had improved, with variation consistent with previous months. • Community Health Services showed improvement in both metrics. • Families, Young People and Children's Services showed mixed performance across the four metrics, though the issues were explored in detail at the Accountability Framework Meeting (AFM). **Over 52-week waits:** • In DMH, five of the seven metrics showed reduced waiting numbers, which reflected sustained work to bring waits down. The key exceptions remained ADHD and the Memory Clinic, which continued to be the main drivers of long waits. • In FYPC, six of ten areas showed improvement or stability. Community paediatrics continued to be the most significant concern, which was consistent with previous reporting. • The trajectory for 52-week waits in community services was currently being reworked, as the original plan submitted (approved by Board in February) was not compliant with plan. • In relation to the 2026–27 contract, the importance of joint work to be undertaken between the ICB and the Trust to address long waits in neurodevelopmental (ND) services was reiterated.

	• No further escalations emerged from the AFM. The Chair welcomed the positive movement reflected and expressed appreciation, on behalf of the Board, to all services and teams for their continued work and commitment in delivering improvements. Noting that neurodiversity waiting times and community waiting lists had been referenced in several parts of the meeting, the Chair acknowledged the significance of these areas, reiterated the importance of ensuring individuals are supported to 'wait well' while progress is made on reducing long waits, and requested confirmation of appropriate plans and actions in place. Sharon Murphy confirmed that the Trust had established clear plans, with ongoing oversight of actions to ensure individuals were waiting safely and appropriately and advised that regular updates on these areas were provided through the Access Delivery Group and the Quality and Safety Committee. Sam Leak then provided an update on the work underway to address long waiting times, particularly the organisation's approach to supporting people to 'wait well'. She confirmed the team remained fully assured regarding the processes in place to manage clinical risk and provide appropriate support to those on long waits and explained that the central objective now was to reduce all over 52-week waits to zero within the next three years, which aligned with the plan recently submitted to NHS England. Also reported was that the service had proactively engaged with other systems to learn from successful models. Portsmouth's service had recently achieved a reduction of their long waits to zero through significant redesign of their clinical pathway. It was reported that Portsmouth had achieved this by changing their clinical pathway and similar opportunities existed locally, but these would require genuine partnership working across the system, including primary care and the ICB. A proposal to adopt a model similar to that used in community nursing was described, working collaboratively with clinical teams to co-design and deliver sustainable change. While innovative and 'out-of-the-box' thinking would be required, along with potential short term front-loaded resource to address the backlog, the clinical teams were positive and motivated to explore new approaches. It was noted that one of the most significant changes implemented in Portsmouth had been a shift from a diagnostic only pathway to a treatment focused pathway, built around partnerships with schools and consistent engagement at every point of the children's journey; such a change locally would necessitate deeper collaboration with education settings and community partners. The Chair was encouraged to hear that the planned changes could deliver the necessary improvements, based on examples from other areas, but this required strong clinical engagement and system partnership working to address these. Angela Hillery stated it was helpful to hear the outline for new models of care both nationally and locally, recognising that developing more effective approaches to managing neurodevelopment and ADHD pathways would require significant redesign. Angela was encouraged to see the organisation proactively seek learning from other systems that had already made progress in this area but stressed the challenge was not one that could be addressed by LPT alone, as this was a system issue requiring a coordinated system response. Also highlighted was the importance of ensuring that discussions about 'waiting well',

	particularly within a public meeting context, were meaningful and understood and asked for further clarity on how the Trust was capturing and understanding people's lived experiences while they were waiting and how this informed the Trust's approach to supporting them. Bhanu Chadalavada advised that work was progressing collaboratively across LPT, NHFT, and the ICB and a joint working group was in place, bringing together primary care, secondary care, and system partners to review key elements of the pathway, including the proposed 'pop-up' model, referral thresholds, skill mix, staffing configurations and opportunities to use digital solutions to increase productivity. The overarching target of reducing long waits required multiple approaches and these included distinguishing between treatment pathways and self-help pathways, enabling early management options within primary care for those who may not require a diagnosis or medication. Primary care having a significant role in providing early advice and management strategies for individuals whose needs could be met without specialist intervention was emphasised. Turning to the concept of 'waiting well', it was clarified that this applied both to individuals waiting for their first assessment and to those awaiting treatment following an initial appointment. The resources available to support people during this period included self-help tools, guidance on when and how to seek further help if symptoms changed, and clearly signposted channels for accessing advice. Feedback from patients and voluntary sector partners had informed the development of these resources, including specific ADHD related materials, and this feedback continued to shape ongoing improvements. The importance of ensuring that patients and families had immediate, practical support while waiting, including tools for families to understand how best to support children and adults with neurodevelopmental needs across both educational and health settings was emphasised. These resources were recognised as a crucial element of the Trust's approach to supporting people during long waits. Josie Spencer welcomed the establishment of a group involving those who worked directly with patients as they held valuable insight into where processes worked well. Josie reflected on a previous service visit to the neurodevelopmental team and commented that staff spent significant time attempting to navigate pathways and secure support for individuals, but the challenges inherent in the system made this difficult; which in turn had implications for staff morale. Despite this, she described the team as highly dedicated, consistently looking for opportunities to improve and adopt different ways of working. Josie agreed with earlier comments about the importance of learning from other areas but cautioned that applying external learning required a careful balance between managing clinical risk, monitoring those on waiting lists, and ensuring appropriate clinical oversight, and stressed the accurate understanding of the needs of individuals who were waiting must inform any new approaches. With regard to partnership working, it was emphasised that system partners must work together collaboratively without any single organisation feeling that responsibilities were being passed on to them and while progress would undoubtedly be challenging, it was encouraging to see greater engagement from the ICB and the inclusion of joint working commitments in the contract for the forthcoming year.

	Tanya Hibbert provided a further update focusing on adult ADHD services and confirmed that a review had been undertaken to explore best practice and alternative national models. She explained that Dr Sam Hamer, Deputy Medical Director, had been leading extensive literature research into different models used across the UK. One area of particular interest involved developing improved ways of assessing impairment in adults, which could enable more effective clinical decision making. There had previously been a regional group dedicated to identifying best practice although it appeared unlikely to continue into the new financial year. However, a new Leicestershire, Northamptonshire and Rutland ICB group was being established, with its first meeting scheduled for April. Training packages were being designed to support GPs in managing some adults differently, with the aim of reducing pressure on specialist services while improving patient experience and outcomes. Also advised was that the external provider originally commissioned to deliver additional support to adults in the community had withdrawn from their contract before service commencement in January and work was underway to commission a new provider. The link to the 'Waiting Well' section on the Trust website which provides a comprehensive range of resources was provided:- **https://www.leicspart.nhs.uk/while-you-wait/** The Chair thanked colleagues for their contributions to the discussion, acknowledged the significant effort involved and expressed appreciation for the progress being made. **Resolved:** The Board received and approved this report.
TB/25-6/148	**Charitable Funds Committee AAA Highlight Report: 13 March 2026 (Paper Q)** Faisal Hussain, Chair of the Charitable Funds Committee, presented this report and drew attention to the charitable income generation being strong, with nearly £300,000 received from legacies and over £100,000 from NHS Charities Together. No questions or comments were received. **Resolved:** The Board received this report for information and assurance.
TB/25-6/149	**National Staff Survey Results (Paper R)** Sarah Willis presented the 2025 Staff Survey results and reported a highly positive outcome for the organisation, noting that LPT had performed strongly across the survey and achieved scores above the national average in all nine People Promise areas. This performance stood out in the context of a national picture where staff experience had declined in many parts of the NHS. It was confirmed that 4,000 staff members had completed the survey, representing a response rate of 56%. This strong level of engagement demonstrated the maturity and effectiveness of the Trust's staff engagement approach, and it had also been recognised externally, with LPT achieving HSJ Award finalist status and being featured in an NHS Employers publication as a good practice case study.

	LPT remained above average in staff perceptions of working at the Trust, receiving care, and feeling safe to raise concerns. The organisation was also approaching 'best in country' benchmarks in flexible working, line manager support, team effectiveness and confidence in speaking up. It was further noted that LPT's benchmark cohort ranking had improved significantly, moving from 9th to 5th place nationally. However, it was acknowledged there were areas where results had declined slightly compared to the previous year and these related to work pressures, wellbeing, and perceptions of equitable career progression. Although LPT remained above national averages in these categories, the downward shift indicated that continued attention was required. Progress in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) indicators was reported, though disparities remained when comparing the experiences of minority ethnic and disabled staff with those of white and non-disabled colleagues; work to address these gaps was continuing through established programmes, including the Together Against Racism strategy and Our Future, Our Way. These programmes would remain focused on equity, inclusion, staff wellbeing and meaningful staff involvement in change. It was confirmed that directorates were currently developing local action plans based on their individual results. A review of the staff survey findings was scheduled for the following month at the Joint People and Culture Committee where themes, risks and opportunities would be explored in greater depth. It was also noted that LPT was working closely with colleagues in Northamptonshire to align workstreams across the Group as the feedback was consistent within both trusts. Melanie Hall welcomed the results and emphasised that the organisation should take time to recognise the strength of the outcomes achieved as the results were impressive not only in terms of performance against national benchmarks but also in the year-on-year improvements seen across many areas. Whilst challenges remained in some aspects of staff experience, the overall direction of travel was testament to the sustained commitment to developing a positive organisational culture. The transparency with which the results had been shared, including the ease of accessing detailed breakdowns and national benchmarking information via the Trust's website was commended and colleagues were thanked for the sustained work that had contributed to such positive results. Tim Harrison also welcomed the strong staff survey results and commented that, while it was important for the organisation to avoid complacency, the achievements should be recognised. He emphasised that staff were working under exceptionally high and increasing levels of pressure, and yet the results demonstrated that they continued to do an excellent job. The fact that staff reported feeling happy at work was particularly powerful and a significant indicator of the organisation's culture. The Chair thanked colleagues for their contributions. **Resolved:** The Board received this report for information and assurance.

TB/25-6/150	**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/25-6/151	**Any Other Urgent Business** There was no other urgent business.
TB/25-6/152	**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, 26 May 2026 at 9.30am

C

Leicestershire Partnership NHS Trust

Public Trust Board 26 May 2026

Matters arising from the Public Trust Board meeting held 31 March 2026

Action sheet

Minute no.	Action/ issue	Lead	Due date	Status	Evidence
TB/25-6/137	**Friends and Family Test Results** Comparative Friends and Family Test benchmarking data from other trusts to be provided.	Jean Knight	18.05.26	Complete	Comparison for FFT to be included in the May MD report
TB/25-6/139	**Board Assurance Framework** Likelihood score for BAF 3.2 (Patient Safety) to be corrected.	Kate Dyer	18.05.26	Complete	

D

Leicestershire Partnership NHS Trust

LPT Trust Board Workplan 2026/27

		26- May-26	24-June-26	28-July-26	29-Sep-26	24-Nov-26	26-Jan-27	30-Mar-27
Item/Theme		DMH	EGM	FYPCLDA	Enabling (Medical)	CHS	DMH	FYPCLDA
Standing Items:	Frequency/Lead							
Service Presentation (to include patient/carer, staff/student and volunteer voice as applicable (40mins)	Every meeting	X		X	X	X	X	X
Questions from the Public	Every meeting	X		X	X	X	X	X
Declaration of Interests:- • Declarations of interest in respect of items on the agenda • Declarations of interest report • Annual Compliance Report	Every meeting	X Timing tbc		X Timing tbc	X Timing tbc	X Timing tbc	X Timing tbc	X Timing tbc
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	In months without a Group Board meeting	- *(Group Board)*		X	- *(Group Board)*	X	- *(Group Board)*	X
Managing Director's Report	Every meeting	X		X	X	X	X	X
Environmental Analysis	Every meeting	X		X	X	X	X	X

T H R I V E

		26- May-26	24-June-26	28-July-26	29-Sep-26	24-Nov-26	26-Jan-27	30-Mar-27
Item/Theme		DMH	EGM	FYPCLDA	Enabling (Medical)	CHS	DMH	FYPCLDA
Chief Executive's Verbal Update ***(Confidential Agenda)***	Every meeting CEO	X		X	X	X	X	X
Environmental Analysis ***(Confidential Agenda)***	Every meeting CEO/Managing Dir	X		X	X	X	X	X
Governance and Assurance:								
Audit and Risk Committee AAA Highlight Report	As required Chair, ARC	X (17.4.26)		X (12.06.26	X (11.09.25)		X (04.12.26)	X (05.03.26)
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			
Quality, Safety and Compliance:								
Quality and Safety Committee AAA Highlight Report *(Annual Reports to be appended following the June QSC)*	Every meeting Chair, QSC	X *(21.04.26)*		X *(19.05.26 & 16.06.26)*	X *(18.08.26)*	X *(20.10.25)*	X *(22.12.26)*	X *(16.02.27)*
Safe Staffing Monthly Report	Every meeting Group Chief Nurse	X		X	X	X	X	X
Patient Safety 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				
Emergency Preparedness, Resilience and Response (EPRR) Annual Report	Annual Managing Dir			X				

		26- May-26	24-June-26	28-July-26	29-Sep-26	24-Nov-26	26-Jan-27	30-Mar-27
Item/Theme		DMH	EGM	FYPCLDA	Enabling (Medical)	CHS	DMH	FYPCLDA
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 Highlight Report	Every meeting Chief Fin Officer	X *(23.04.26)*		X *(18.06.26)*	X *(20.08.26)*	X *(29.10.26)*	X *(21.12.26)*	X *(18.02.27)*
Finance Report	Every meeting Chief Fin Officer	X		X	X	X	X	X
Performance Report	Every meeting Chief Fin Officer	X		X	X	X	X	X
Charitable Funds Committee AAA Highlight Report	Quarterly Chair, CFC			X *(23.06.26)*		X *(23.09.26)*	X *(14.12.26)*	
Annual Operational Plan	Annual Group Exec Dir. Strat & Part							X
Risk Based Items When Required:								
Outline/Full Business Cases	As required							
CQC Inspection Reports	As required							
National/Local Reports	As Required							
Externally Commissioned Reports	As required							
System-wide Winter Planning	As required							
Award of legal contracts	As required							
Appointment of Senior Independent Director, Deputy Chair, Chairs of Committees	As required							

		26- May-26	24-June-26	28-July-26	29-Sep-26	24-Nov-26	26-Jan-27	30-Mar-27
Item/Theme		DMH	EGM	FYPCLDA	Enabling (Medical)	CHS	DMH	FYPCLDA
EGM Agenda								
Going Concern Assessment	Annual Chief Fin Officer		X					
Audited Financial Accounts	Annual Chief Fin Officer		X					
Letter of Representation	Annual Chief Fin Officer		X					
KPMG ISA 260 and Auditors Annual Report	Annual Chief Fin Officer		X					
Head of Internal Audit Opinion	Annual Dir Gov & Risk		X					
Annual Governance Statement	Annual Dir Gov & Risk		X					
LPT Quality Account 2025/26	Annual Group Chief Nurse		X					
LPT Annual Report 2025/26	Annual Group Chief People Officer		X					

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Leicestershire Partnership NHS Trust

Public Trust Board [26th May 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 April 26 – May 26. Activities relating to formal Committees of the Board are reported through custom reports.

Analysis of the Issue

This month has been a busy month getting out and about, I had the pleasure of joining our most recent cohort of Director of Nursing & AHPs Fellows to talk to them about my career journey and share an insight into how our Board operates.

It was also fantastic to see so many of our fantastic Nursing staff from across LPT and NHFT at our first ever joint Nursing Conference across the Group on 13th May and really inspirational to hear the variety in the nursing careers of our staff. Thank you to all involved in arranging and facilitating this event.

I have also met with the new NHSE Regional Chair, Russell Hardy, on a one-to-one basis to better understand his vision and priorities for the region, and to consider how we can best support him in taking this forward through our collective work.

NED Update

Following the appointment of a new NED and ANED earlier this year, and the subsequent review of committee chairing and membership arrangements, the review of committee structures has now been completed. The current arrangements to support the Trust's committee governance are set out in Appendix 1.

Joint Board Development Workshop

On 9 April 2026, Board colleagues came together for a Joint Board Development Workshop to continue strengthening collaboration across the Group and support alignment around key strategic and governance priorities. The workshop included discussion on cyber security and organisational preparedness, the development of the Group Board Assurance Framework, and consideration of

the Group's risk appetite. Time was also given to reviewing the wider operating environment, agreeing the THRIVE milestones for 2026/27 in advance of presentation to Board, and considering priorities for the Quality Account alongside wider quality governance arrangements. Collectively, these discussions provided a valuable opportunity for Board members to reflect on the Group's strategic direction, governance maturity and assurance requirements for the year ahead.

Midlands NHS Leadership Meeting

At the Midlands NHS Leadership Event on 21 April 2026, leaders from across the region came together to consider the national and regional context for 2026/27 and the implications for local organisations. Discussions focused on the national planning position, productivity and financial sustainability, and the scale of opportunity across the Midlands to reduce unwarranted variation and improve outcomes, quality and value. The event also provided an opportunity to hear reflections from regional and provider leaders on improvement, culture and delivery, alongside discussion on the transformational shifts required across community, acute and system working. These conversations offered a helpful regional perspective on the challenges ahead and reinforced the importance of collective leadership, partnership and a clear focus on improvement.

Mental Health Chairs Network

The Mental Health Chairs Network, April meeting, received a presentation on the CQC's draft sector-specific assessment framework for mental health, which represents a move away from a single, standardised model towards more tailored regulation. While the five domains of Safe, Effective, Caring, Responsive and Well-led remain, the framework introduces clearer "key lines of enquiry" with I statements and detailed rating characteristics, replacing numerical scoring to support more transparent, consistent and outcomes-focused judgements.
The proposed approach places greater emphasis on real-world impact, quality and people's experience of care, providing clearer expectations for providers and inspectors. The Mental Health Chairs Network then provided feedback and shared experience of CQC inspections to help further refine the assessment process. We await publication of the final version of the assessment framework.

Annual Health Service Journal top 50 NHS CEOs table

The Health Service Journal has published its annual top 50 ranking of NHS chief executives across the country, and I am delighted to share that our Chief Executive has been recognised in the top 5 of this year's table. This recognition reflects the exceptional leadership she continues to provide and is also a testament to the dedication, commitment and hard work of the outstanding teams across our organisation.

Working with Partners and Stakeholders

At a recent LNR health system Chairs and Chief Executives session, we met to discuss shared strategic priorities and the collective action needed to support delivery across the wider health system. The discussion focused on the alignment of organisational transformation priorities and time was also given to neighbourhood development and the continued shift towards more integrated, place-based models of care. The session provided a valuable forum for strategic reflection at Chair and Chief Executive level and reinforced the importance of close partnership working, clear governance and collective leadership in taking forward system priorities.

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

- NHS Confederation Mental Health Chairs Call
- System Chair & CEO Workshops
- System Chair Meetings
- NHSE Midlands NHS Leadership Meeting
- Joint strategic Freedom to Speak Meeting
- Joint NED Catch Ups

Public, Patient and Staff Engagement

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

- Joint Nursing Conference
- Service Visit: Neuro Psychology
- Service Visit: Employment Support Service
- Service Visit: Involvement Centre
- DAISY Award Celebration

All relevant meetings, events and visits for the period are detailed in Appendix 2.

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 May 2026
Paper sponsored by:	Faisal Hussain, Interim Group Chair
Paper authored by:	Sinead Ellis-Austin, Head of Chair/CEO Office
Date submitted:	18th May 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:	July 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	Yes

the safety of patients or the public:	
Equality considerations:	Incorporated in approach to recruitment and other activities.

Appendix 1

Name	CFC	ARC	QSC	Joint NRC	FPC	Joint PCC	Other
Faisal Hussain	Member (Chair)			Member (Chair)			Interim Group Chair
Hetal Parmar		Member (Chair)			Member		Security Lead
Josie Spencer		Member	Member (Chair)	Member (Deputy)			Interim Deputy Chair Consultant Interviews
Liz Anderson			Member			Member	University /Academic Research & Innovation
Melanie Hall			Member		Member (Chair)	Member (Deputy)	SID/FTSU and Disciplinary oversight
Chris Skelton (Associate NED)	Member	Member			Member		
Tim Harrison (Joint NED)				Member		Member (Chair)	Wellbeing Guardian across Group
***Natasha Fox (NHFT NED)**			Member				

Appendix 2

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Hetal Parmar	11/03/2026	SEND Alliance (Fay Bayliss and team)	I
Hetal Parmar	18/03/2026	GGI: Governance failings	E
Hetal Parmar	27/03/2026	Service Visit: Neuro Psychology	I
Josie Spencer	01/04/2026	Service visit with ICB QSC Chair	I
Faisal Hussain	01/04/2026	Associate Dean for Clinical Affairs, University of Leicester	E
Hetal Parmar	02/04/2026	360 Internal Audit catch-up	E
Josie Spencer	02/04/2026	Meeting with NHFT QSC Chair	I
Melanie Hall	02/04/2026	FPC Agenda setting meeting	
Faisal Hussain	08/04/2026	NHS Confederation MS Chairs Conference Call	E
Faisal Hussain	08/04/2026	Regional Chair, NHSE	E
Chris Skelton	08/04/2026	Service Visit - Adult Autism Assessment Service	I
Chris Skelton/Josie Spencer	09/04/2026	Buddy meeting with Deputy Chair	I
Faisal Hussain	10/04/2026	Chair, NHS Coventry and Warwickshire ICB and NHS Herefordshire and Worcestershire ICB	E

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Faisal Hussain	14/04/2026	LNR System Chair meeting	E
Melanie Hall	14/04/2026	FTSU Guardian Catch up meeting	
Tim Harrison	17/04/2026	CQC Mock Interview	I
Chair/Melanie Hall	20/04/2026	Joint Quarterly FTSU Meeting	I
Chair/NEDs	20/04/2026	Joint NED Catch up	I
Faisal Hussain	21/04/2026	NHSE Midlands Leadership Meeting	E
Faisal Hussain	22/04/2026	Chair, LNR ICB	E
Melanie Hall	22/04/2026	GGI AFT Webinar	E
Hetal Parmar	23/04/2026	LPT/NHFT ARC Chairs meeting	I
Faisal Hussain	28/04/2026	Chair, UHL/UHN	E
Faisal Hussain	29/04/2026	NHS Confederation MS Chairs Conference Call	E
Chris Skelton	29/04/2026	Mock CQC Interview	I
Tim Harrison	30/04/2026	Committee Chairs & Vice Chairs Mtg	I
Faisal Hussain	01/05/2026	NHSE, Appts Team Manager	E
Faisal Hussain	01/05/2026	LNR System Chair & CEO Meeting	E

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Josie Spencer	05/05/2026	Service Visit - Employment Support Service	I
Faisal Hussain	06/05/2026	Board agenda setting meeting	I
Josie Spencer	07/05/2026	Daisy Awards	I
Faisal Hussain	12/05/2026	LNR System Chair meeting	E
Faisal Hussain	12/05/2026	Chair/Deputy Chair Meeting	I
Melanie Hall	12/05/2026	FTSU Guardian meeting	I
Josie Spencer	13/05/2026	EMA QSC Chairs network	E
Faisal Hussain/ Josie Spencer	13/05/2026	Joint Nursing Conference 2026	I
Elizabeth Anderson	14/05/2026	Service Visit	I
Chair/NEDs	18/05/2026	*Joint NED Catch up	I
Faisal Hussain	19/05/2026	*Aspiring Chairs Engagement Session	E
Josie Spencer	20/05/2026	*Network with QSC Chair Provider Colleague	E
Melanie Hall	20/05/2026	*Involvement Centre Service Visit	I
Faisal Hussain	26/05/2026	*Shared Leadership Forum	E
Faisal Hussain	27/05/2026	*Chair, LNR ICB	E

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Faisal Hussain	27/05/2026	*NHS Alliance MH Chairs Conference Call	E
Tim Harrison/Melanie Hall	27/05/2026	*Joint PCC Agenda setting meeting	I
Melanie Hall	28/05/2026	*FPC Agenda setting meeting	I

*Planned at time of writing

Abbreviations:

AGM = Annual General Meeting

ANED = Associate Non-Executive Director

AHPs = Allied Health Professionals

ARC = Audit and Risk Committee

CEO = Chief Executive Officer

CFC = Charitable Funds Committee

FTSU = 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
LPT = Leicestershire Partnership NHS Trust
LNAHP = Leicestershire & Northamptonshire Academic Health Partners
MECC= Making Every Contact Count
NED = Non-Executive Director
NRC = Nomination and Remuneration Committee
PCC = People and Culture Committee
NHFT = Northamptonshire Healthcare NHS Foundation Trust
NHSE = NHS England
NHS CFA = NHS Counter Fraud Authority
QI = Quality Improvement
QSC = Quality and Safety Committee
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

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Leicestershire Partnership NHS Trust

Public Trust Board 26 May 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

Medium-term plan for 2026/27– 2028/29 and five-year Strategic Commissioning Plan
In October 2025, NHS England released the Medium-Term Planning Framework, marking the beginning of a new way of working in the NHS. This Framework set a clear expectation that organisations will work over multiple years, to restore constitutional standards, strengthen community-based care, and accelerate prevention and digital transformation. Planning over multiple years means that planning does not end with the agreement of the plan; the focus on delivery will also be accompanied by ongoing foundational work as we continue to work on understanding any changes in the demand and capacity of our services and population health needs.

LPT's submitted plan has been reviewed against the expectations set out in the national guidance and has been assessed as **Compliant with Conditions due to non-compliance in activity submissions.**

Care Quality Commission (CQC)
The Care Quality Commission (CQC) has published their reports following unannounced visits to our specialist community mental health services for children and young people in November 2025 and our community mental health services for adults in January 2026.

Both services received an overall rating of 'Good'.

Specialist community mental health services for children and young people: the CQC advised "the service consistently treated people with kindness, empathy and compassion, while respecting their privacy and dignity. They provided care to meet people's needs that was safe, supportive and enabled people to do the things that mattered to them."

Community mental health services for adults, the CQC assessed we had made significant improvements in patient waiting times (reduced by 62%) and consequently removed their previous warning notice.

This follows the ‘Good’ rating in March 2026 for our mental health crisis and health-based place of safety.

These results are huge credits to all involved and we couldn’t be prouder.

The full reports are available to read on the CQC website.

National Oversight Framework (NOF)
LPT received a Green rating for provider performance and remains in a good position at Segment 2 in the third quarterly NOF ratings for NHS providers across the country.

Meningitis vaccinations
Following national concern about the risks of meningitis among young adults, we have urged teenagers to take up the offer of vaccinations that may protect them. We are offering those aged 13-14-years-old the chance to boost their protection with the 3-in-1 teenage booster (tetanus, diphtheria and polio) and the meningitis ACWY vaccines. Young people over the age of 14, in older year groups, and who still need the immunisations will also have the chance to be vaccinated.

Digital Maturity Index score
LPT has scored 2.6 out of 5 in the NHS’s Digital Maturity Index for 2025. That represents an increase from the previous year, when the score was 2.3. The index is based on 160 questions and aims to provide a comprehensive view of how NHS organisations are progressing on their digital transformation journeys, helping to identify areas of strength and where further support is needed.

Praise from Healthwatch
Our community hospital wards demonstrated consistently high standards during a recent inspection from Leicester and Leicestershire Healthwatch.

The inspectors visited one ward each at Loughborough Hospital and Coalville Community Hospital, and two wards at the Evington Centre. Healthwatch recognised our staff’s hard work and high standards at all these community hospital wards.

We are particularly pleased that 100 per cent of patients they spoke to were either ‘happy’ or ‘very happy’ with the care they received.

Triangle of Care Award
Leicestershire Partnership NHS Trust (LPT) has been recognised for its sustained commitment to supporting unpaid carers after achieving the Triangle of Care Star 2 Award, while also maintaining its existing Star 1 accreditation.

The Triangle of Care, run by Carers Trust, sets clear national standards that encourage services to make sure carers are recognised early, listened to, supported and involved in care where appropriate and with consent.

For local carers, this means better recognition, clearer information, stronger support and a more consistent approach to involving them as partners in care, whether their loved one is being supported in the community, in hospital, or during a crisis.

LPT signed up to the Triangle of Care programme in September 2023, working alongside local carers and staff to strengthen partnership working. Achieving Star 2 confirms that these standards are now embedded across community mental health and learning disability services, building on earlier progress in inpatient and crisis care.

Resident Doctors industrial action strike 7am 7 April to 6.59am 13 April
Our Trust's overriding statutory obligation was, as always, to provide high quality and safe services to patients. During any periods of industrial action Trust management implemented contingency plans to ensure our services continued to run safely and efficiently. Our contingency plans helped to minimise disruption, meaning LPTs services remained robust and effective throughout the strike.

NHS Forest
Staff at LPT have planted 60 trees as part of the NHS Forest.

The saplings will grow at Coalville Community Hospital, on land which is unsuitable for future development. They will help absorb carbon dioxide from the atmosphere and improve the view for some of the hospital's inpatients.

The hospital is on the site of a former orchard and includes a number of mature apple trees.
The NHS Forest is an alliance of health sites working to transform their green space to realise its full potential for health, wellbeing and biodiversity, and to encourage engagement with nature. It is run by the Centre for Sustainable Healthcare, an independent UK charity, as part of its Green Space for Health programme.

Downing Street reception
Kartar Singh Bring, LPT and UHL's head of chaplaincy, joined Sikh leaders from across public life at the Prime Minister's Vaisakhi reception.

Kartar said: "It was a privilege to represent both the NHS and the communities we serve across Leicester, Leicestershire, and Rutland. As Sikhs across Leicester and around the world mark Vaisakhi, it is an opportunity to recommit to service, to stand for equality, and to continue building environments where every person feels seen, respected, and cared for."

Vans go green
LPT has recently taken ownership of two electric vans, as part of the NHS's drive towards net zero.

The vans are used for a number of purposes, including collecting blood samples from our various community hospitals and delivering them to the labs, and delivering patient medication.

Electric power is expected to be around £400 cheaper per van than diesel, representing a saving on running costs as well as reducing carbon emissions. Charging equipment has been installed thanks to a government grant.

NHS reforms and financial sustainability
Announced by NHS England in May 2025, NHS reforms asks all providers to focus on productivity and delivering value. In 2025/26 we have met the efficiency target we were set of £28.4million within our final accounts; an excellent achievement.

Like all NHS trusts, in 2026/27 we are again required to deliver national efficiency targets while continuing to provide safe, responsive care. For 2026/27, this means delivering £27.6m of efficiency savings as part of our medium-term financial plan and it is important that we deliver these savings on an ongoing basis to improve our underlying deficit position of £13m. These challenging requirements are essential to maintaining our financial sustainability as we commit to continuing to offer and invest in our services for our population and our future.

Major overhaul to assessing and managing patient safety and risk
Staff are being given an early preview into new ways of assessing patient risk and safety. Our teams have been working on a new policy which will reduce administration and make it clearer what a patient's potential for harm is. There would also be changes to terminology, which in other trusts had helped staff to look at understanding potential harm more positively and collaboratively.

Celebrating doctoral training success for our nursing workforce
Congratulations to two of our nursing colleagues in securing highly competitive doctoral fellowship awards through the Wellcome Trust PhD programmes. The fellowships are fully funded and include tuition fees for the full three-year PhD, a research training and support grant, and a full-time salaried studentship.

These fellowships will help develop future research leaders, strengthen our ability to generate and apply evidence, and ultimately improve outcomes for the patients, services and communities we serve.

Dial 9 for clinicians – improving urgent clinician to clinician contact
To help clinicians at our Trust speak to each other more quickly when it really matters, the Integrated Care Board (ICB) and Local Medical Committee (LMC) are promoting the "Dial 9 for clinicians" approach across general practice and UHL. This is a simple way for clinicians to bypass the patient phone queue when calling a GP practice or UHL switchboard for urgent clinical reasons.

Used appropriately, "Dial 9 for clinicians" helps ensure urgent clinical conversations happen at the right time, with less delay.

Health and Wellbeing Boards
In April LPT presented to the LLR Joint Health Scrutiny Committee on our speech and language therapy (SLT) service. Our report provided the Committee with an update on Early Language Support for Every Child (ELSEC), LPT's SLT provision, our system plans for the future and also set out the central role that this collaborative arrangement across LLR will play in responding to the SEND Reforms that will be set out in Schools White Paper published on 23 February 2026.

Our report is available to read on both Leicester City Council and Leicester County Council's websites.

In May, Rutland Health and Wellbeing Board held an extraordinary meeting to discuss/approve the draft Better Care Fund plan prior to its submission on the 19 May 2026. Further information can be found on their website.

Also in May, as part of our regular formal interaction with Leicester and Leicestershire Healthwatch, LPT gave an update on the Trust Research and Innovation programmes and improvement work and waiting times in CAMHS and adult and children's ND services (assessment and treatment). We also discussed the integration of LPT pathways with other external mental health service providers and mental health support in Rutland.

In May 2026 the Leicestershire Health and wellbeing Board manager attended the Executive Management Board at LPT along with the Director of Public Health to present the Revised Joint Health and Wellbeing Strategy for Leicestershire. This was a helpful session and enabled reflection on the importance of aligning priorities across the Health and wellbeing boards and NHS services.

Health & Wellbeing Board and the Revised Joint Local Health & Wellbeing Strategy
Leicestershire Health and Wellbeing Board was invited to attend LPTs Executive Management Board in May to provide an update of the review, how LPT has been involved and the impact the changes have had on Leicestershire's Health & Wellbeing Board including membership and governance. This included an; update on the revised Joint Local Health & Wellbeing Strategy (JLHWS) and Delivery Plans; how LPTs current strategic priorities link to the JLHWS and; an outline of next steps for the JLHWS including implementation, delivery and governance.

Staff Voice

Celebrating excellence awards
We have received around 280 nominations for our annual Celebrating Excellence Awards. These fully sponsored awards are an opportunity for us to recognise and celebrate the outstanding achievements of our staff and volunteers. The process of shortlisting and judging will now begin, and the award winners will be announced in October. All those not shortlisted will receive a thank you letter from our Chief Executive.

Service visits
The Board undertook 29 service visits in March and April across a wide-ranging range of operational and enabling services and sites, including community and mental health inpatient settings, community nursing teams, our Estates and Facilities services and our mental health crisis support and referrals teams. Visits continue to be undertaken both within and outside of 'normal working hours'.

At a school in Loughborough, three nurses empathetically delivered vaccinations to anxious students whilst staff at a CAMHS inpatient Unit enthusiastically expressed the enjoyment they got from working with their patients and witnessing the impact the delivery of their care had on the young people. Teams are always given the opportunity to raise any concerns during the visits which the Board member will try to resolve whilst on site or discuss with the appropriate Board lead following the visit. It is evident from the visits, despite growing demands on many of our services there is a strong sense of teamwork across the estate.

The Big Pitch Innovation Fund
Recognising that every day across our Trust, ideas take root in conversations, corridors, clinics, community visits and team huddles we have launched an initiative for teams to grow those ideas by pitching them in a 'Dragons Den' style forum. The Innovation Panel will offer guidance and support to all pitched ideas with those ideas able to demonstrate delivering a measurable efficient and effective being considered for funding to enable their idea to take root and flourish.

International Nurses Day
We celebrated International Nurses Day as a Group on 13 May to amplify the voices of nurses working in unique or highly specialised areas that may not always be visible due to their team size or niche expertise. It was a fantastic day and enabled further opportunities for shared learning and connections across the Group.

Mental health Awareness Week
We promoted various support and advice during Mental Health Awareness Week (11-17 May) for the public. This included the launch of a men's mental health booklet, codesigned with local men's mental health groups, and launched a new While you Wait area on our website (https://lptnhs.com/WhileYouWait) to support those waiting for mental health care, with practical advice and information to manage their wellbeing. We also promoted maternal mental health week with videos from our team throughout the week, sharing tips and advice on social media. We also asked staff to pause, check in with themselves and think about the small things that support wellbeing, especially during a time of change and pressure; highlighting practical support to look after mental health.

Freedom To Speak Up staff reporting tool launched
This reporting tool enables us to progress further with our aim of driving an environment where everyone feels safe to Speak Up and therefore speaking up becomes business as usual. We will be able to produce 'live' data to support more effective triangulation, data reporting and National Guardian's Office compliance; allowing us to be fully able to identify emerging themes and to be proactive in addressing areas requiring focus. This ultimately, reinforces the safety and wellness of both our staff and service users.

Staff Support Networks (SSNs)
SSNs provide a channel for communication between management and staff; maximising contribution and fulfilling the commitment to the Equality, Diversity and Inclusion agenda. The groups help support local, regional and national initiatives and discuss any impact they will have on local activity. SSNs are spaces where staff can feel safe, seek support and learn as well as raising the profiles of development opportunities, be kept informed of latest legislation updates and to seek advice from peers. In April the Armed Forces Network welcomed a new Chair.

Reverse Mentoring for Inclusion - cohort 7 launched
Reverse mentoring is a professional development practice where junior or younger employees' mentor senior leaders, reversing the traditional hierarchy to facilitate knowledge transfer. LPT has engaged in this practice for several years successfully.

Cohort 7 training in April for Mentors and Mentees commenced as a system-wide project across NHS/LA/Health and Social Care system partner organisations; Matching people with lived experience of being disadvantaged or marginalised in terms of gender, race/ethnicity, disability, and/or being part of the LGBTQ+ community, with mentees of a different background.

Group Talent Matters programme launch
We have launched our Group Talent Matters (Developing Diverse Leaders) programme this month - a powerful opportunity designed to support, inspire, and empower colleagues to step confidently into their leadership potential. This cohort specially focuses on developing our ethnic and cultural minority staff (ECM) with a focus on nurturing their career ambitions, grow their confidence, strengthen their voice, and unlock their potential. This is a key part of our Together Against Racism commitment, to improve career development for ECM colleagues that can be under-represented at leadership levels.

Active Together – Menopause support
Staff told us they would value more guidance on staying active during perimenopause and menopause. To support this, Active Together (an organisation hosted by Leicestershire County Council who work with local system partners to lead the strategic direction and delivery of physical activity) shared a short blog offering practical advice on how physical activity can help during this stage of life.

Monthly Feedback into Action
The staff newsletter was launched as a regular space to encourage feedback to understand staff experience of working at LPT. The e-newsletter outlines how that feedback has been put into action. May's edition featured:

- Thank you to colleagues for completing People Pulse.
- Our Future Our Way - a message from our Change Leaders 2026.
- NHS Staff Survey 2025: The results.
- NEW! FTSU speak up tool.

The Our Future Our Way programme is our culture improvement programme led by change leaders from across the Trust. Focusing on areas we want to continue to improve staff experience from our staff survey results, they are prioritising co-designing actions to address experiences of racism and discrimination and ensure equitable career development for all. This follows an extensive engagement period by them as part of the Discover, Design, Deliver methodology being followed.

Working in partnership
- At the Blaby and Lutterworth Annual Health Event, a dedicated mental health space was created to bring together a wide range of local support services for the community. This included NMH Leads, community MH colleagues, system partners and VCS partners.

- Across Oadby, Wigston and Harborough, bipolar awareness sessions were delivered to both community members and professionals, with strong attendance and overwhelmingly positive feedback.
- Healthy Together-Department of Education requested Leicester Family Hub and Leicestershire Partnership NHS Trust submit a case study regarding the setting up of the Frenotomy Service. This has subsequently been chosen to showcase best practice under the Healthy Babies enhanced support offer. Published and launched as part of the new national Best Start Family Hubs and Healthy Babies Guidance for local authorities for the next 3 years.
- Teams supported the wider Autism Acceptance Month with a series of in-person drop in events.
- Championed Maternal Mental Health awareness week (4-10 May) raising the awareness of mental health struggles before, during and after pregnancy; highlighting support available in-house to staff.

Patient Voice

People's Council
The People's Council is an independent advisory body for the Trust made up of individuals with a lived experience of receiving healthcare services from Leicestershire Partnership NHS Trust (LPT).

The Trust's Lived experience leadership framework continues to deliver meaningful co production and lived experience influence, including service design (e.g. CAMHS toolkit and youth led improvements), patient information development via the Reader Panel, and carer involvement embedded through the Triangle of Care programme. Patient and Carer voice continues to grow through our level 3 and 2 Trust governance structures and workforce development through training and development.

Lived experience partners are increasingly shaping education, recruitment and quality improvement, alongside groups such as the Youth Advisory Board and People's Council ensure diverse voices are heard. The Trust continues to grow its culture where patient and carer voice is systematically captured and increasingly embedded in decision making, with continued focus required on improving feedback uptake, addressing variation across services and sustaining timely complaint resolution.

Friends and Family Test (FFT)
FFT posters are displayed in all LPT service areas as LPT encourages patients, friends and families to all have their say in the service they receive. Through this all voices can be heard, improvements made and positives celebrated. In March and April 2026, our Trust received a total of 3,573 Friends and Family Test (FFT) feedback responses from our patients (overall 16% response rate).

NHS
Leicestershire Partnership
NHS Trust

March 2026 Friends and Family Test

WeAreLPT
compassion respect
integrity trust

Total feedback figure: 1802	Response rate: 15%	Positive score: 90.51%	Negative score: 4.77%

Falls Programme
"Very happy and enjoyable even when it was a struggle to do. Everybody was ready to help and encourage us to do what we were capable to do"

"Everyone was very friendly and helpful."

Heart Failure Service
"From start to finish we were looked after. We were given the information and helped with any questions we had and we were kept in the loop as to what was happening, we were very satisfied thank you."

TSPPD
"Felt very listened to. Felt like I was thought about and not dismissed. Very therapeutic and was validated. The best I've ever been treated in any therapeutic place My name was respected, I was treated very kindly. My worker adapted and tailored their sessions to me. Found the whole process incredibly kind wasn't just another client."

Perinatal Service
"My team are brilliant, always helpful advice, support and kindness."

CAMHS Young peoples team
"Understanding and helpful."

"The practitioner listened, was reassuring, demonstrated knowledge, was supportive and gave sound advice/tips.."

Health Visiting
"The health visitor was absolutely amazing and so helpful. She gave me lots of reassurance and answered all my questions. I walked away from the appointment feeling very happy with how it went."

What our patients said in March

April 2026 Friends and Family Test

WeAreLPT
compassion respect
integrity trust

Total feedback figure: 1771	Response rate: 15%	Positive score: 92.43%	Negative score: 3.16%

Respiratory Specialist Service
"The treatment we got from the consultants down to the people who provided refreshments were amazing. Everyone involved in my treatment were both caring and informative and nothing was too much trouble never once did i feel alone there was always someone to reassure me more so because i am partially sighted."

Rutland ward
"Professional, caring, ethical going over and above the call of duty. All staff whether clinical or administrative are a credit to the NHS. We could not praise each and every member of staff enough. Thank you for your love, devotion and selfless commitment."

Tongue tied service
"Both ladies were really compassionate & caring - all info was provided in a clear & concise manner - we struggled with TT diagnosis with our son so really appreciated this opportunity - procedure was done quickly and we as parents were provided support & guidance."

MHSOP Gwendolen
"We were always treated with respect and care, being updated regards changes and events in my care. I as his wife and carer was included in decision making."

Ashby ward
"The staff are all fabulous, caring and professional. The psychiatric care was excellent. Very good, clean facilities and catering."

Community LD - SALT
"The SALT was excellent. She was very thorough, knowledgeable, and communicated clearly. She listened carefully to everything I said and was very professional throughout the appointment. She kept us up to date with what was going on and was particularly good when talking to my son.

What our patients said in April

T H R I V E

FFT Benchmarking
Benchmarking against peer organisations using Model Hospital data indicates that, based on available information to February 2026, LPT performs at or above the level of comparable trusts and the national median.
% of people who would recommend LPT for Mental Health Services
LPT Value – 92.7%
Peer Median – 84.9%
Provider Median – 86.6%

Enormous thanks to all staff and partners who are taking such an active role in achieving our vision of 'Together we thrive, building compassionate care and wellbeing for all'.

Relevant external meetings attended since last Trust Board meeting

April 2026	**May 2026**
Joint CQC Workshop	The Apology Tightrope Webinar
Joint People Committee in Common	Mental Health in Urgent & Emergency Care
Group Board Development Workshop	Healthwatch/LPT
Wait list sharing engagement meeting (Birmingham Community Healthcare NHS FT)	*Joint meeting with London CEO Group
Group Strategic Executive Board	*Regional Performance & Delivery Group (Midlands NHSE)
National CEO meeting: New Approach to Mental Health (NHSE)	*LLR Sync
Provider Review Meeting (NHSE Midlands & NHFT)	*LLR Local Health Resilience Partnerships
LLR ICB & NICB Boards in common (Public & Private)	*Monthly COO/MD/DoN call
LNR Health Partners' Executive	*Group Trust Board
Freedom to speak up leads and Executive leads session (LLR & Northamptonshire)	
Local Resilience Forum Executive Board	
LLR Urgent & Emergency Care System Winter Review	
Joint Governance & Risk Leadership Group	

*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:	Sam Beaty, Business Manager
Date submitted:	14.05.26
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:	July 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

Alert, Advise and Assure Highlight Report

Audit and Risk Committee (extraordinary) – 17 April 2026

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
			No issues to highlight to Board	

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
Draft Annual Financial Accounts 2025/26	ARC/26/025	Chief Finance Officer	As part of the ARC review of key judgements and estimates, it was noted that there were a number of material transactions, including two related to HMRC - a £1.6m provision for a potential VAT liability in respect of local authority income and an expected VAT recovery on locum payments. The timing of the receipts and payment was not known and would be dealt with in year following normal accounting processes.	BAF10 BAF 11

ASSURE: Inform the Board where positive assurance has been received

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
2025/26 Interim Head of Internal Audit Opinion	ARC/26/023	Director, 360 Assurance	An interim opinion of significant assurance was given confirming there was a generally sound framework of governance, risk management and control to meet the organisation's objectives. The final HoIAO would be presented to the next meeting in June once the accounts had been signed off.	N/A
Draft Annual Governance Statement	ARC/26/024	Director of Governance and Risk	The committee received assurance that no significant internal control issues had been identified. LPT had a generally sound system of internal control that supported the achievement of its policies, aims and objectives and minimised exposure to risk.	All
Draft Annual Financial Accounts 2025/26	ARC/26/025	Chief Finance Officer	The annual accounts for the year ended 31 March 2026 were presented, the committee carried out an in-depth review of the key financial statements, key judgements and estimates made when preparing the accounts. ARC was assured that good financial arrangements were in place for the preparation of the 2025/26 annual accounts. The draft accounts showed that the Trust had delivered its statutory duties and a £313k surplus in line with plan. The accounts were reported subject to audit.	BAF10 BAF11
Losses and Special Payments Policy - **Approval**	ARC/26/026	Chief Finance Officer	ARC approved the policy which had been reviewed ahead of its scheduled review date to address some recent claims for special payments that were not fully covered in the previous version.	BAF10 BAF11

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

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
2025/26 Interim Head of Internal Audit Opinion	ARC/26/023	Director, 360 Assurance	ARC noted the Trust had a robust process and proactive culture on the completion of internal audit actions and was reporting the first follow up action for high and medium risks at 100%, the implementation rate overall was also 100%.	N/A

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Leicestershire Partnership NHS Trust

Alert, Advise and Assure Highlight Report

Quality and Safety Committee 21st April 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
Accountability Framework Meetings Triple A	QSC/26/007	Jean Knight	The Committee noted ongoing concern regarding patients waiting over 52 weeks, particularly in neurodevelopmental pathways. It was noted that a national solution to waits over 52 weeks in neurodevelopmental pathways is being sought but the Committee agreed to continue to escalate as an alert to Trust Board at this stage. There was a discussion about the new Plymouth model of care based on best practice. It was advised that work is underway to explore this further and an update the Committee will be provided at the August 2026 meeting. **Post meeting note: As assurance re the new model of care will be sought across a number of governance routes it has been agreed that an update on the work will be an agenda item for a Board Development session.**	4

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
Staying Safe from Suicide Guidance	QSC/26/009	Dr Bhanu Chadalavada	The Committee received an update on actions taken in LPT to implement the NHS England Staying Safe from Suicide guidance, including the move away from risk stratification to formulation-based safety planning, the steps being taken to expand training and processes to embed co-produced safety plans. The Committee welcomed the progress being made, which is being overseen by the Suicide Prevention group and supported by the Trust Suicide Prevention Lead. It was agreed that the Committee would receive an assurance report demonstrating how the actions had been embedded and their effectiveness in six months.	5
Level 2 Mental Health Assurance Group Triple A report	QSC/26/014	Dr Bhanu Chadalavada	A self-assessment was undertaken in relation to the new Mental Health Act Bill and alongside a review of findings from the previous Mental Health Act inspection and this highlighted the need for LPT to strengthen the Section 132 process. Work is progressing in Directorates to develop a consistent template and clearer guidance for staff	5
Patient Experience and Involvement Report Quarter 3 2025-26	QSC/26/015	Linda Chibuzor	The Committee received an update on progress against the Complaints Improvement Plan. It was noted that there had been a long-standing ambition to achieve 90% compliance with complaint response times by the end of March 2026, however this has not yet been fully achieved. It was acknowledged that significant improvement has been made overall, with an increase of approximately 23% and some areas demonstrating sustained performance at or around the 90% target. It was highlighted that a dedicated improvement plan within the Families, Young People, Children and Learning Disabilities (FYPCLDA) directorate had contributed to a steady upward trajectory, despite the complexity of complaints in that area.	5
Level 2 Health and Safety Committee AAA Report	QSC/26/020	Jean Knight	The Committee noted a staff safety concern regarding the use of personal safety alarms provided to staff. It has been identified that in some areas these alarms are not being actively used and the barriers to use are being explored via a Task and Finish group. The committee will receive feedback on the outcomes of this work at a future meeting.	N/A

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/26/005	Linda Chibuzor	The committee received an update was on development of a Group Quality Framework and including a working draft for information. . The Trust is already working to the accountability framework and the Quality Framework will clarify quality governance, roles, responsibilities and use of data. An initial draft has been shared and feedback received, and further development is underway, with a fuller version expected in June 2026.	5
Level 2 Quality Forum AAA report	QSC/26/011	Emma Wallis	The forum provided assurance that all previous alerts from the Quality Forum have been closed. This information is now included as part of a pilot of a new Triple A report designed to provide clearer feedback on previous alerts. The staff annual flu vaccination programme has concluded. The Trust achieved and improved the uptake position compared with the previous year; 45.67% and narrowly missed the 5% stretch uptake target (47%). Planning for the next flu season is already under way.	5
Quality Improvement report	QSC/26/013	Emma Wallis	The Committee received the report which provides an update on progress against the four key deliverables within the Quality Improvement Programme. Following a request at the February Committee meeting, the narrative places a stronger emphasis on demonstrating the impact of the work undertaken rather than solely reporting activity. For each of the quality improvement projects, progress and outcomes were outlined within the paper. The report also included the outturn position for the Trust's Quality Improvement Programme for 2025–26. The Committee concluded that there was significant level of detail contained within the paper to support assurance and understanding of performance across the programme	5
Patient Safety Incident Response Plan	QSC/26/016	Linda Chibuzor	The Committee received and approved the Patient Safety Incident response plan.	5
Audiology update	QSC/26/017	Dr Bhanu Chadalavada	The Committee received an update on the audiology improvement work which has been an ongoing programme for approximately 18 months. It	5

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
			was noted that while there have been some specific local issues, the work has been influenced by a national programme. The Committee was assured that the vast majority of the immediate and short-term actions outlined in the plan have now been completed and progress on the longer-term strategic actions continues, particularly in relation to developing the student pipeline, collaboration with the university, and exploring further workforce opportunities. Work is also underway to evaluate the impact and effectiveness of the improvement plan to ensure sustained improvement. The Committee was assured of the current position and agreed to onward monitoring being managed through business-as-usual governance within the Directorate, with the option to escalate any future concerns should they arise.	
Level 2 Safety Forum AAA Report	QSC/26/018	Dr Bhanu Chadalavada	Following on from the previous advisory in February 2026 the Committee was updated on safeguarding photography practices within community paediatrics. Previously, photographs had been stored on a shared drive, which raised accessibility and information governance concerns. Following multidisciplinary discussions involving medical teams, safeguarding leads, and data privacy colleagues, it has been agreed that safeguarding photographs will be stored within SystmOne and from 5th May 2026 new photographs will be uploaded directly. Work is ongoing to review and transfer existing images where appropriate, recognising that not all historical photographs will need to be migrated due to the age of some cases.	5
Level 2 Safeguarding Committee AAA Report	QSC/26/021	Linda Chibuzor	The Committee received a combined Triple A report for the meetings held in February and March 2026, which provided confirmation of the closure of the Safeguarding Improvement plan previously agreed with the Integrated Care Board (ICB). Remaining actions have been consolidated into a single internal action plan and are being progressed via business-as-usual arrangements.	5

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

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Accountability Framework Meetings Triple A	QSC/26/006	Jean Knight	The pharmacy team has supported DMH with the launch of a new point-of-care testing (POCT) service for Clozapine patients under the City East team. This service enables patients to attend a clinic at the Maidstone Centre where they can receive both essential blood monitoring and a review of their treatment in a single visit. Further clinic development is underway CAMHS Intensive Community Support Team data reflects 79% reduction in admissions for CYP in three-year period	5
Quality Assurance Report	QSC/26/007	Linda Chibuzor	It was reported that the final Care Quality Commission (CQC) inspection report for Children and Adolescent Mental Health Services has been published with an overall rating of Good. It was emphasised that these services support some of the most vulnerable children and young people within local communities, and that this outcome represented a very positive result for the organisation. Members were also informed that the long-anticipated inspection report for the Crisis and Health Based Place of Safety had been received in the previous month. This service had likewise achieved an overall rating of Good, providing further assurance regarding the quality and safety of care delivered. In it was also highlighted that the Integrated Crisis Response Service, which is hosted by local authority with input from LPT has achieved an outstanding rating from the CQC. The Chair formally acknowledged and thanked staff for their continued hard work and commitment. It was emphasised that the organisation's approach to regulatory compliance is not undertaken purely to satisfy regulatory requirements, but is driven by the organisation's vision and values, with a clear focus on delivering outstanding, high-quality care, ensuring patient safety, and achieving positive outcomes for those using services.	5

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Leicestershire Partnership NHS Trust

Trust Board 26 May 2026

Safe Staffing March 2026

Purpose of the Report

This report provides a full overview of nursing safe staffing during the month of March 2026, including a summary/update of Allied Health Professional (AHP) and medical vacancies.

Key staffing areas to note, potential risks, and actions to mitigate to ensure that safety and care quality are maintained as presented 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 report safe staffing to board monthly and 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 and Developing Workforce Safeguard 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.

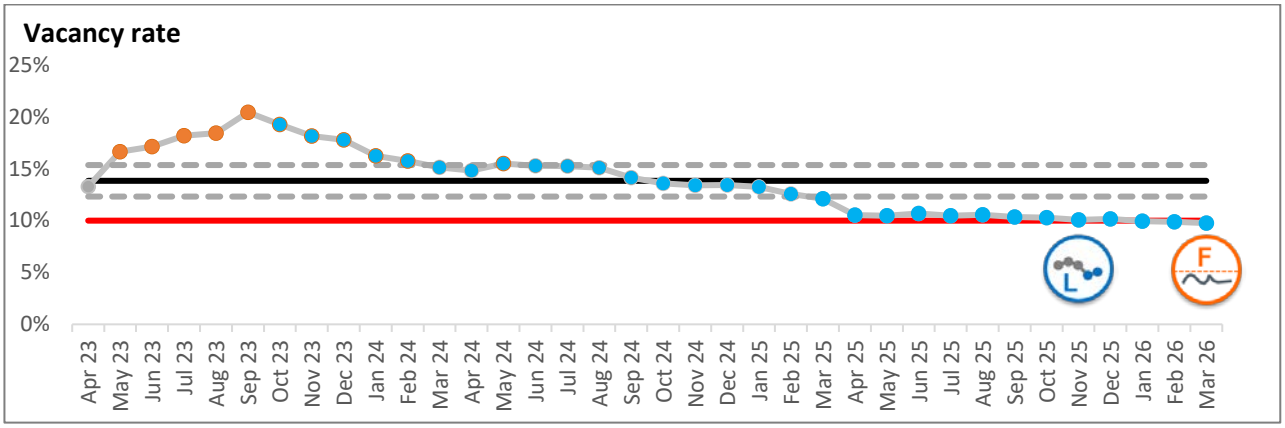
The Trust demonstrates its position regarding mandatory submission of fill rates required by the Department of Health via UNIFY and paying attention to any variance below 80% and above 110%. The upload of these figures to UNIFY occurs on the 15th of each month following review and sign off by the Group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

Analysis of the issue

Right Staff

Trust overall vacancy rate

In March 2026, the overall Trust vacancy rate was 9.8% which is slightly below the Trust target of 10%.



Registered Nurses

- Vacancy position is at 225.6 Whole Time Equivalent (WTE) with a 11.2% vacancy rate, no change since February 2026.
- Turnover for nurses is at 6.0% which is below the Trust target of 10%.
- Sickness reported at 6.9 % an increase of 0.1% since February 2026.
- A total of 8.6 WTE nursing staff (bands 5 to 8a) were appointed in March 2026.

HCSW

- Vacancy position is at 154.8 WTE with a 14.6% vacancy rate, a decrease of 0.5% since February 2026.
- Turnover rate is at 8.4%. which is below our internal target of no more than 10%.
- Sickness reported at 6.6% which is a decrease of 1.4% since February 2026.
- A total of 16.6 WTE HCSW were appointed in March 2026.

Allied Health Professionals (AHPs)

- Vacancy position is at 63.8 WTE with a 6.9% vacancy rate, a decrease of 0.5% since February 2026.
- Turnover rate is at 8.7%, which is below our internal target of no more that 10 % turnover.
- Sickness reported at 4.1%, which is a slight decrease from 4.2% reported in February 2026.
- A total of 7.4WTE AHP were appointed in March 2026.

Medical

- Vacancy position is at 12.4 WTE with a 7.7 % vacancy rate with an increase of 0.7% since February 2026.
- Turnover rate is at 9.3%, an increase of 0.2 % since February 2026.
- Sickness reported at 0.9% which is a decrease of 0.6% since January 2026.
- No medical staff were appointed in March 2026.

Temporary workforce

- Temporary worker utilisation rate reduced slightly this month by 1.18 % reported at 26.76% overall, of this, Trust wide agency usage decreased this month by 0.32% to 2.40% overall.

Group Sickness Absence Reduction Project

In line with the national medium term workforce planning guidance LPT are working together with its Group partner Northamptonshire Healthcare Foundation Trust (NHFT) on achieving a reduction in sickness absence rates. A detailed project and workplan is being progressed.

Right Skills

- Across the Trust on average core and Clinical mandatory training compliance is currently compliant (green).
- Across the Trust, on average appraisal rates and clinical supervision remain consistently compliant (green).

Right Place

- In March 2026, the total Trust Care Hours Per Patient Per Day (CHPPD average), including ward based AHPs, is calculated at 11.2 CHPPD (national average 10.8) consistent with February 2026.

March 2026 staffing scorecard is presented in accessible format in **Appendix 1.**

Table 1 below identifies key areas to note for March 2026 from a safe staffing, quality, patient safety, and experience review, including high temporary workforce utilisation and fill rate with actions and mitigation. Following this triangulation Table 1 reports exceptions to planned staffing of a moderate or higher risk.

The table is presented, and RAG rated using the thresholds and tipping points as described in the Trust Safe staffing policy:

Level of Risk	**RAG rating**
Low	GREEN
Moderate	AMBER
High	RED
Unmitigated	BLACK

Table 1 – Key Areas to Note

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
CHS In-patients	Temporary workforce utilisation higher for: Grace Dieu (72.2%), due to an additional 18 beds opened from 5 January to 12 March 2026 to support winter pressures across the system. Ward 1 & Ward 3 St Lukes and Swithland 25% temporary workforce due to vacancies and sickness. Dalgleish and Rutland over 25.0% of which 8.2 – 8.5% was agency. Daily staffing reviews, and staff movement to ensure substantive Registered Nurse (RN) cover in each area, or regular bank and agency staff for continuity to mitigate the risks. All Nurse sensitive indicators (except complaints) increased this month on Snibston ward. This will be monitored next month to assess any actions as needed.	**Green**
CHS In-patients	**Fill rate** Fill rate below 80% for RN Day shifts on East ward and Grace Dieu. Reduced fill rate on East Ward was mitigated by having a registered nursing associate as the fourth registered staff member. Reduced fill rate on Grace Dieu was due to bed capacity reduction and planned staffing adjusted accordingly with closure of the ward on the 12 March 2026. Fill rate above 110% of HCSW day shifts on ward 1 St Lukes, ward 3 St Lukes, East ward and Snibston is due to patient acuity and dependency, increased Enhanced Therapeutic Observations of Care (ETOC) following transfer from acute providers requiring additional staff to meet the patient care needs.	**Green**
CHS In-patients	**Nurse Sensitive Indicators (NSIs)**	**Green**

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
	Falls No significant change in falls since last month **Medication incidents** Medication incidents increased from 12 in February to 19 in March 2026. Of the nineteen medication incidents reported, 15 resulted in no harm and 4 as low harm. The main theme was medication unavailability; none related to staffing. **Pressure Ulcers** The number of category 2 pressure ulcers developed or deteriorated in our care has decreased from 11 in February to 6 in March 2026. The Moisture Associated Skin Damage (MASD) quality account priority work continues. Continence link nurse education training days were hosted during March 2026. **Staffing Related Incidents** The number of safe staffing related incidents has decreased from 18 in February to 11 in March 2026 across seven wards. Incidents reported were relating to a reduction in staffing due to sickness, high acuity and patients requiring Enhanced Therapeutic Observations Care (ETOC), shifts unfilled and temporary staff not attending booked shifts. All staffing related incidents reported as no harm.	
DMH In-patients	**Staffing:** High percentage of temporary workforce to meet planned staffing for Belvoir at 56.9%, Heather and Watermead over 40.0 % temporary workforce. 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, resulting in 2 staff related Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), hospital escorts, patients requiring 2 to 1 continuous observation, sickness and moving staff to support Thornton ward. Thornton ward reopened four beds on the 20 February until 23 March 2026. (Supporting patients from Beaumont and Ashby wards whilst maintenance work conducted). Registered nursing staff were moved from other wards supported by HCSW temporary workforce, due to the short-term opening of Thornton. This is not identified separately on the March 2026 scorecard.	**Green**

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
	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. **Allied Health Professional (AHP) Staffing:** Reduction in Technical Instructor (TI) posts in Mental Health Services for Older People (MHSOP) due to vacancies. Long term sickness in Occupational Therapy (OT) in Acute, Forensic, Psychiatric Intensive Care Unit (PICU), rehabilitation, and MHSOP physiotherapy. Therapy Instructor (TI) recruited into MHSOP with temporary workforce and staff movement in place for physiotherapy. Currently sourcing temporary workforce for OT in Rehabilitation.	
DMH In-patients	**Fill rate:** Fill rate RN night shift above 110% on Bosworth. Safe staffing levels maintained, staffing reviews in place and closely managed. Increased RN fill rate night shift (on Bosworth) due to a senior RN being allocated as Clinical Duty Manager and backfilling three vacant HCSW shifts required to support periods of increased therapeutic observations. Fill rate HCSW on day shifts above 110% on Ashby, Belvoir, Bosworth, Heather, Watermead, Kirby and Langley. Fill rate HCSW night shifts above 110% on Beaumont, Belvoir, Watermead, Coleman, Gwendolen, Kirby, and Mill Lodge. HCSW fill rate above 110% was due to increased patient acuity and dependency requiring increased therapeutic observations to manage increased incidences of violence, physical aggression and behavioural distress, management of falls and deterioration in mental and physical health needs, patient escorts, and urgent transfers to acute hospital.	**Green**
DMH In-patients	**Nurse Sensitive Indicators:** **<u>Falls</u>** An increase in the number of falls incidents from 72 in February to 76 in March 2026. All falls were reported as low or no harm and staffing was not identified in initial review as a contributory factor. Falls huddles are in place	**Green**

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
	and physiotherapy reviews for patients with sustained falls and increased risk of falling, where themes and trends in falls are being discussed to share, learn and support safe care. **<u>Medication Incidents</u>** The number of medication incidents increased from 11 in February to 25 in March 2026. All incidents were reported as no, or low harm and staffing was not a contributory factor. **<u>Pressure Ulcers</u>** The number of category 2 pressure ulcers developed or deteriorated in our care decreased from 3 in February to 2 in March 2026. The pressure ulcers developed in our care attributed to high-risk physical and mental health patient factors. All incidents reported as low harm and patient care being managed with tissue viability support and guidance It is noted that all Nurse sensitive indicators (except complaints) increased this month on Heather and Kirby wards. This will be monitored next month to assess any actions as needed.	
FYPC.LDA in- patient	**Staffing:** 42.3% temporary workforce at Beacon to ensure continuity of care to meet safe planned staffing due to high levels of acuity/complex needs and increased therapeutic observations to maintain patient safety Agnes Unit at 37.9%. One patient requiring six staff to deliver safe and effective care. Safe staffing is reviewed daily due to increased patient acuity and complexity with staffing levels adjusted accordingly. Beacon and Agnes Unit continue with reliance on high temporary workforce usage with advance booking of staff. Mitigation remains in place; potential risks being closely monitored.	**Green**
FYPC.LDA in- patient	**Fill Rate:** Below 80% for RNs on day shifts and night shifts at the Grange and below 80% for HCSWs on day shifts at the Gillivers	**Green**

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
	Above 110% for RN on days at the Agnes unit and Gillivers and above 110% for HCSWs on day shifts at the Beacon and day and night shifts on Welford ED. The Grange & Gillivers offer planned respite care, the staffing model is dependent on individual patient need, presentation, and associated risks. As a result, this fluctuates the fill rate for RNs and HCSWs on days and nights for the month in both services. Mitigation was provided with cross cover for significant reduced RN fill rate on the day and nights shifts at the Grange during March 2026. Work is in progress to align the Gillivers and the Grange fill rate analysis, to potentially enable joint reporting as short breaks going forward. Staffing levels reviewed and adjusted accordingly at the Agnes unit. Increased RN fill rate due to high patient acuity and support required on Pod 1. Beacon unit continue with high levels of acuity and patient complexity. Welford ED continues with high patient acuity, a number of patients requiring additional staff to provide increased therapeutic observations, supervision at mealtimes and Naso-Gastric feeding.	
FYPC.LDA in- patient	**Nurse Sensitive Indicators:** **Falls** The number of falls incidents increased from 2 in February to 5 in March 2026. **Medication Incidents** The number of medication related incidents decreased from 7 in February to 4 in March 2026.	**Green**
CHS Community	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. Ongoing quality improvement work focusing on pressure ulcer and insulin continues and community nursing transformation programme including the review of senior nurse role. Community Nursing Safer Staffing Tool II (CNSST II) implementation continues across the service.	**Green**
DMH Community	The next phase of the Community Mental Health Team (CMHT) transformation continues.	**Green**

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
	Key areas to note - Mental Health Urgent Care Hub (MHUCH) for registered clinicians, nurses and HCSW's. Sickness impacting the Crisis team. Working to OPEL level 3. City West has significant pressure due to high referral rates requiring longer management time in daily huddles and high sickness in MHSOP community teams. South Leicestershire and City East continue to review patient tracker list, case management and waiting times for Community Psychiatric Nurse (CPN) input. Psychosis Intervention Early Recovery (PIER) caseloads remain high, overall reducing. 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. PIER caseloads are monitored on a weekly basis and overall are starting to reduce. The team has additional bank and agency staff to support. Crisis Resolution Home team (CRHT) staffing model fluctuates in response to case load and clinical risk. OPEL level 3 enacted team leads continue stepping into planned staffing to support safe staffing. Four new Mental Health practitioners recruited into Crisis team pending onboarding. Challenges continue in MHUCH, Place of Safety Assessment Unit (PSAU) and Mental Health Response Vehicle service with Mental Health Practitioner (MHP) vacancies being backfilled with additional temporary workforce. Active on-going recruitment although progressing remains challenging. West Leicestershire CMHT staffing shortages due to long term sickness mitigation includes support with RN temporary workforce. City West CMHT has high sickness and managing currently. Charnwood has high sickness and new team manager in post **AHP Community** Reduction in Occupational Therapy posts in Adult Mental services in City West, City East, Charnwood, East Leicestershire, Forensics and Mental Health Services for Older People in South Leicestershire, Melton, Rutland and Harborough and Charnwood due to vacancies, Sickness, and maternity leave.	

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
	New ways of working to support workflow and reduction in waiting times in progress. Registered staff currently being aligned to new neighbourhoods. Attendance at referral huddles by OTs identified increase in referral rates. MHSOP community OT team cross covering across LLR to support waiting list management.	
FYPC.LDA Community	Learning Disability (LD) city and county nursing, LD access and LD Crisis Response Intensive Support Team (CRIST) are areas to note due to maternity leave and sickness. Mental Health Support Teams (MHST) in schools, a number of City and County Healthy Together teams and LD physiotherapy experiencing significant increase in referrals. 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. Child Adolescent Mental Health Service Eating Disorder Team (CAMHS EDT) staffing significantly reduced due to sickness/maternity leave now listed as a fragile service. Mitigation continues in place with potential risks being closely monitored within Directorate. Safer staffing plans/models reviewed including teams operating in a service prioritisation basis.	**Green**

Summary

- Considering the triangulated review of workforce metrics, nurse sensitive indicators, patient feedback, and outcomes in March 2026, staffing challenges continue with clear actions in place to mitigate the risks and as such are rated overall as (Green) low risk.
- The key areas to note are identified and discussed at daily safe staffing huddles within directorate and actions put in place to manage any immediate risks.
- Key areas to note and mitigations are escalated monthly to Directorate Management Team meetings.
- Table 1 demonstrates mitigations and actions to safely manage the staffing risks and planned longer term improvements related to workforce and nurse sensitive indicators.

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 26.5.2026
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:	8 May 2026
Name and date of other committee / forum at which this report / issue was considered:	Executive Management Board 5.5.2026
Level of assurance gained if considered elsewhere	☒Assured ☐ Partially assured. ☐ Not assured
Date of next report:	Bi-Monthly
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 04 Timely Access BAF 05 Patient Safety BAF 07 Culture BAF 08 Workforce resourcing strategies
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

There are 2 tables, the first contains the main report data and the 2nd contains further descriptors of what the values contained in the main report data mean.

Ward Name	Average Beds	Average Occupied Beds	% Fill Rate Registered Nursing Day	% Fill Rate Unqualified Nursing Day	% Fill Rate Registered Nursing Night	% Fill Rate Unqualified Nursing Night	% Fill Rate Allied Healthcare Professional Registered Day	% Fill Rate Allied Healthcare Professional Unregistered Day	Temporary Workers % (Nursing)	Bank % (Nursing)	Agency % (Nursing)	Overall Care Hours Per Patient Day	Medication Errors (and monthly movement)	Falls (and monthly movement)	Complaints (and monthly movement)	Pressure Ulcers Category 2 (and monthly movement)	Pressure Ulcers Category 4 (and monthly movement)
Beechwood Ward - BC03	23	22	99.8% Green	106.5% Green	100.0% Green	108.0% Green	100.0%	100.0%	18.4% Green	18.0% Green	0.4% Green	10	2 Up	1 Down	0 No Change	0 No Change	0 No Change
Clarendon Ward - CW01	21	19	102.9% Green	107.0% Green	100.0% Green	98.7% Green	100.0%	100.0%	7.3% Green	7.3% Green	0.0% Green	10	1 Up	2 Down	0 No Change	0 No Change	0 No Change
Dalgleish Ward - MMDW	17	16	99.6% Green	100.2% Green	100.1% Green	102.2% Green	100.0%	100.0%	26.2% Amber	17.9% Green	8.2% Red	9	1 Up	2 No Change	0 No Change	1 Up	0 No Change
Rutland Ward - RURW	18	17	98.6% Green	104.1% Green	100.0% Green	149.5% Blue	100.0%	100.0%	33.1% Amber	24.7% Amber	8.5% Red	9	0 Down	2 Up	0 No Change	0 No Change	0 No Change
Ward 1 - SL1	21	20	95.4% Green	111.7% Blue	100.0% Green	115.2% Blue	100.0%	100.0%	29.8% Amber	26.2% Amber	3.5% Green	11	0 Down	4 Up	0 No Change	0 No Change	0 No Change
Ward 3 - SL3	14	13	102.3% Green	127.3% Blue	100.0% Green	127.4% Blue	100.0%	100.0%	27.4% Amber	23.8% Amber	3.6% Green	11	1 No Change	2 Up	0 No Change	0 No Change	0 No Change
Charnwood Ward - LBCW	19	17	95.9% Green	98.7% Green	100.0% Green	101.1% Green	100.0%	100.0%	15.9% Green	14.7% Green	1.2% Green	10	1 Up	2 Down	0 No Change	0 No Change	0 No Change
East Ward - HSEW	28	26	76.3% Red	120.3% Blue	100.0% Green	121.8% Blue	100.0%	100.0%	21.2% Amber	19.1% Green	2.2% Green	10	1 No Change	5 Up	0 No Change	1 No Change	0 No Change
Ellistown Ward - CVEL	19	17	97.3% Green	109.5% Green	100.0% Green	131.1% Blue	100.0%	100.0%	21.4% Amber	20.4% Amber	1.0% Green	11	2 Up	2 Up	1 Up	2 Up	0 No Change
Grace Dieu - LBGR	3	7	35.0% Red	22.5% Red	36.9% Red	28.0% Red	100.0%		72.2% Red	67.5% Red	4.8% Green	15	0 No Change	0 Down	0 No Change	0 Down	0 No Change
North Ward - HSNW	19	18	103.4% Green	103.0% Green	100.2% Green	120.1% Blue	100.0%	100.0%	20.4% Amber	19.4% Green	1.0% Green	10	1 No Change	2 Down	0 No Change	0 No Change	0 No Change
Snibston Ward - CVSN	20	18	100.0% Green	115.1% Blue	100.1% Green	129.1% Blue	100.0%	100.0%	23.0% Amber	21.3% Amber	1.7% Green	11	4 Up	8 Up	0 No Change	2 Up	0 No Change
Swithland Ward - LBSW	21	19	85.0% Green	104.1% Green	108.1% Green	110.8% Blue	100.0%	100.0%	29.2% Amber	25.6% Amber	3.6% Green	9	2 No Change	4 Down	0 No Change	0 Down	0 No Change
Ward 4 - CVW4	15	13	102.8% Green	108.5% Green	100.0% Green	122.6% Blue	100.0%	100.0%	15.0% Green	14.9% Green	0.2% Green	12	3 Up	3 Up	0 No Change	0 Down	0 No Change
Ashby	13	13	93.2% Green	116.4% Blue	95.2% Green	104.8% Green		100.0%	23.7% Amber	19.8% Green	3.9% Green	9	1 Up	6 Up	0 No Change	0 No Change	0 No Change
Aston	17	16	106.5% Green	97.0% Green	100.0% Green	101.1% Green		100.0%	21.3% Amber	21.0% Amber	0.3% Green	7	2 No Change	0 No Change	0 Down	0 No Change	0 No Change
Beaumont	21	20	87.3% Green	105.6% Green	92.3% Green	117.3% Blue		100.0%	30.0% Amber	29.4% Amber	0.7% Green	8	2 No Change	2 Down	0 No Change	0 No Change	0 No Change
Belvoir Unit	10	9	104.5% Green	139.6% Blue	96.8% Green	170.3% Blue		100.0%	56.9% Red	54.7% Red	2.2% Green	25	1 Up	2 Up	0 No Change	0 No Change	0 No Change
Bosworth	14	14	95.0% Green	114.2% Blue	110.1% Blue	105.0% Green		100.0%	26.1% Amber	26.1% Amber	0.0% Green	8	2 Down	0 No Change	1 Up	0 No Change	0 No Change
Griffin - Herschel Prins	6	6	102.7% Green	92.1% Green	100.5% Green	99.9% Green		100.0%	32.0% Amber	32.0% Amber	0.0% Green	23	0 No Change	3 Up	0 No Change	0 No Change	0 No Change
Heather	18	17	92.3% Green	121.1% Blue	102.4% Green	120.5% Blue		100.0%	42.2% Amber	38.1% Amber	4.2% Green	9	4 Up	14 Up	0 No Change	1 Up	0 No Change
Watermead	20	20	95.2% Green	123.4% Blue	97.3% Green	114.1% Blue		100.0%	40.1% Amber	38.9% Amber	1.2% Green	7	3 Up	4 Down	0 Down	0 No Change	0 No Change
Coleman	19	17	96.8% Green	107.5% Green	100.0% Green	124.5% Blue	100.0%	100.0%	20.2% Amber	20.0% Amber	0.2% Green	15	1 Up	6 Down	0 No Change	0 Down	0 No Change
Gwendolen	19	15	85.7% Green	96.4% Green	100.2% Green	117.9% Blue		100.0%	29.2% Amber	28.7% Amber	0.5% Green	14	1 Up	10 Up	0 No Change	1 Down	0 No Change
Kirby	24	23	98.8% Green	132.8% Blue	88.1% Green	165.8% Blue	100.0%	100.0%	32.9% Amber	32.9% Amber	0.0% Green	9	1 Up	21 Up	0 No Change	1 up	0 No Change
Langley (MHSOP)	20	18	95.5% Green	120.1% Blue	99.9% Green	108.5% Green			21.1% Amber	21.1% Amber	0.0% Green	7	0 No Change	4 Down	0 No Change	0 No Change	0 No Change
Mill Lodge	14	9	97.3% Green	94.2% Green	98.1% Green	134.3% Blue		100.0%	24.4% Amber	23.9% Amber	0.4% Green	19	3 Up	1 Down	0 No Change	0 No Change	0 No Change
Phoenix - Herschel Prins	12	12	89.0% Green	87.6% Green	100.0% Green	100.0% Green		100.0%	12.5% Green	12.5% Green	0.0% Green	10	0 Down	1 No Change	0 No Change	0 No Change	0 No Change
Skye Wing - Stewart House	30	30	85.8% Green	109.8% Green	100.0% Green	100.1% Green		100.0%	17.1% Green	17.1% Green	0.0% Green	5	3 Up	1 Up	0 No Change	0 No Change	0 No Change
Willows	9	8	92.5% Green	107.1% Green	99.0% Green	105.5% Green		100.0%	30.2% Amber	29.5% Amber	0.7% Green	12	1 Up	1 No Change	0 No Change	0 No Change	0 No Change
CAMHS Beacon Ward - Inpatient Adolescent	17	5	101.4% Green	111.3% Blue	99.9% Green	86.8% Green			42.3% Amber	40.1% Amber	2.2% Green	35	2 Up	3 Up	0 No Change	0 No Change	0 No Change
Welford (ED)	15	14	99.2% Green	170.1% Blue	100.0% Green	113.1% Blue	100.0%	100.0%	18.4% Green	17.7% Green	0.7% Green	12	2 No Change	0 No Change	0 No Change	0 No Change	0 No Change
1 The Grange	1	1	76.9% Red	91.3% Green	26.3% Red	88.3% Green			4.2% Green	4.2% Green	0.0% Green	63	0 No Change	0 No Change	0 No Change	0 No Change	0 No Change
Agnes Unit	1	1	110.3% Blue	82.9% Green	104.2% Green	85.4% Green			37.9% Amber	23.4% Amber	14.5% Red	103	0 Down	2 No Change	0 No Change	0 No Change	0 No Change
Gillivers	3	3	115.5% Blue	59.3% Red	108.6% Green	104.4% Green			2.6% Green	2.6% Green	0.0% Green	32	0 No Change	0 No Change	0 No Change	0 No Change	0 No Change

Metric	Average Fill Rate Thresholds Registered Nursing, Unqualified Nursing Days and Nights			Temporary Workers % Nursing (Total and Bank)			Agency	
Threshold	Below <=80%	Above >80%	Above >110%	Below < 20%	Between 20% - 50%	Above >50%	Below <=6%	Above > 6%
Rag Rating	Red	Green	Blue	Green	Amber	Red	Green	Red
Fill rate will show in excess of 110% where shifts have utilised more staff than planned or due to increased patient acuity requiring extra staff. Highlighted for trust wide monitoring purpose only.				Please see table (in main report) for high level exception reporting highlighting reduced fill rate below 80% threshold and key areas to note due to high bank and agency utilisation.				

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Leicestershire Partnership NHS Trust

Public Trust Board – 26th May 2026

Patient Safety & Learning Assurance Report for March/April 2026

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 March/April 2026, there were 3635 patient safety incidents reported that were classified as "incidents attributable to LPT" and "Incidents affecting patients". The top five reported incidents account for 63.96% of all patient incidents reported during this period and are explored in order and in more detail below. This equates to an average of 1817.5 incidents per month during March/April 2026.

Top 5 reported patient safety incidents March and April 2026

Category	Number of incidents	Directorate with highest % of the total reported
1. Tissue Viability	830	CHS (98.93%)
2. Self-Harm	585	DMH (68.38%)
3. Care/Treatment Under Restraint	340	DMH (61.47%)
4. Violence/Assault	301	DMH (83.39%)
5. Clinical Condition	260	CHS (51.54%)

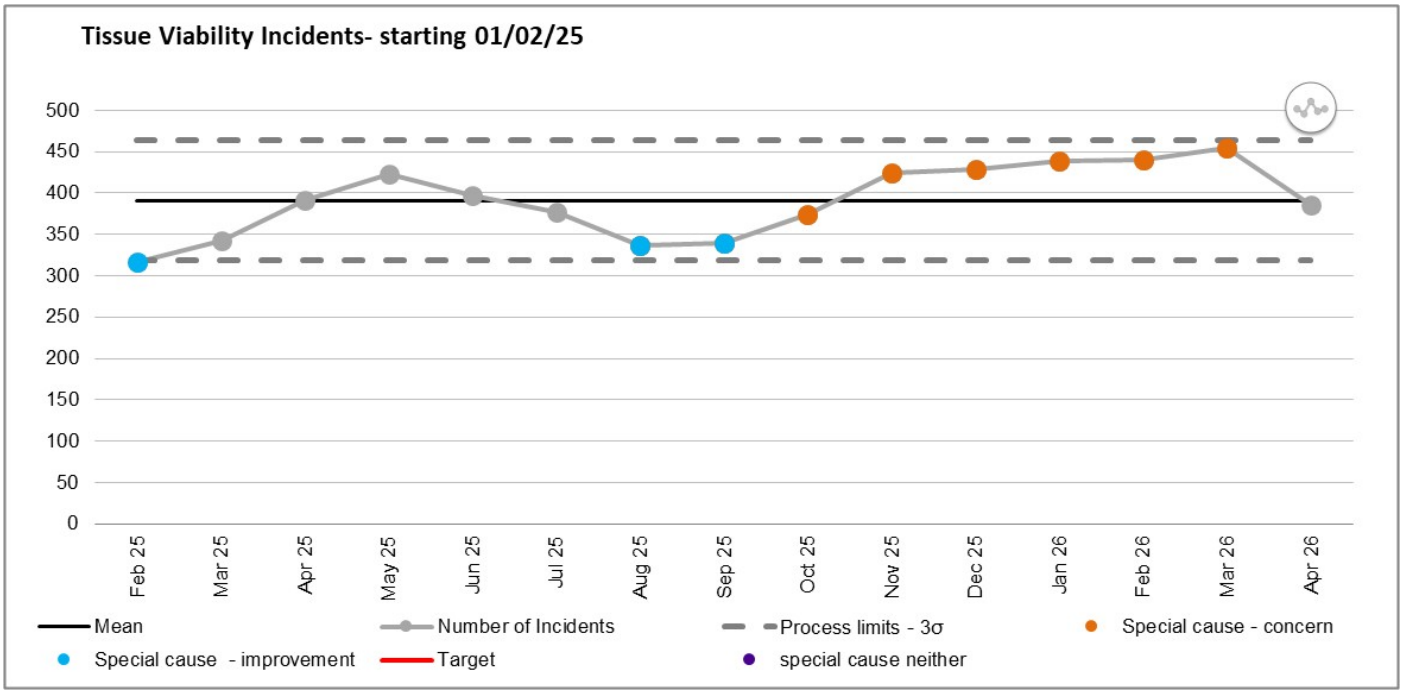
Degree of harm recorded for all patient safety incidents for March and April 2026

Reported degree of harm	Number	% of total incidents reported
No Harm	2015*	55.43%
Minor/Low Harm	1562	42.97%
Moderate Harm	31	0.85%
Severe Harm	2	0.06%
Death	23	0.63%
Blank	2*	0.06%

*those left blank are an anomaly as the incident was part reported and then 'saved for later' by the reporter as they were unable to complete.

NB: these incidents were reported in March and April 2026 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 as well as the harm as a result of an incident. 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



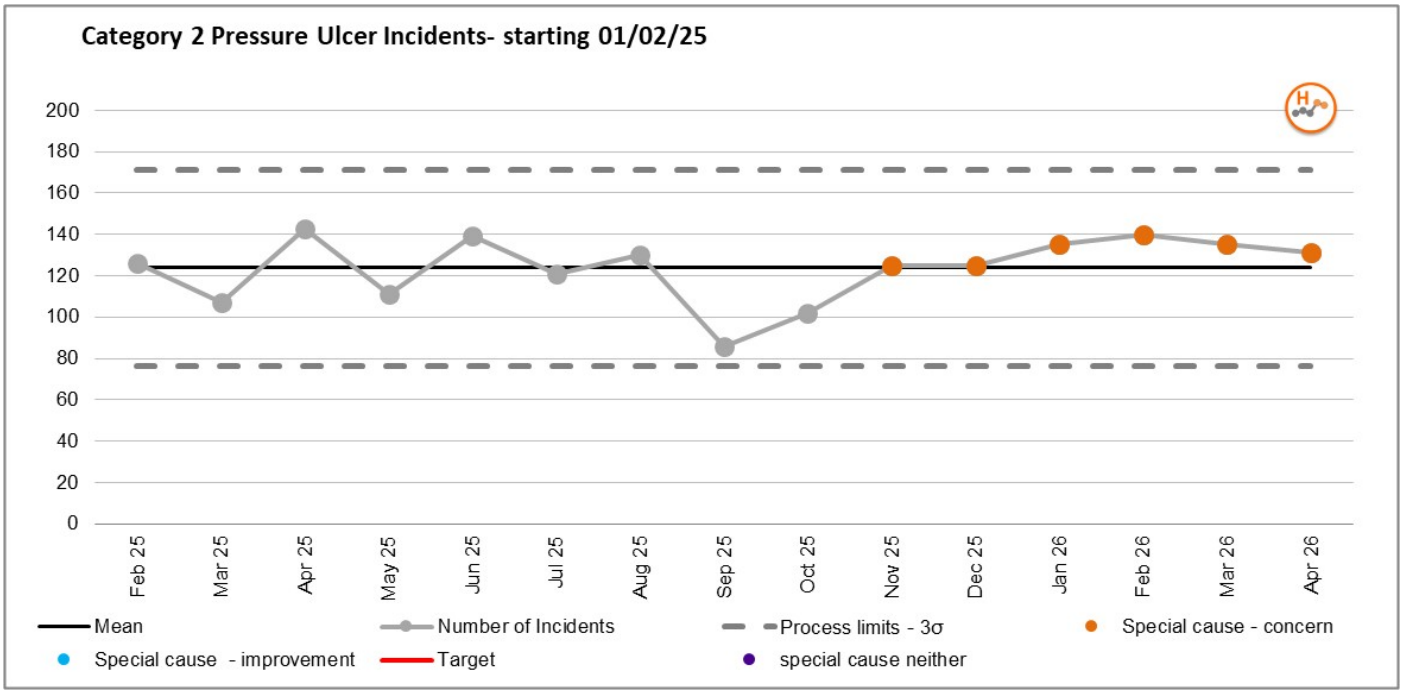
23.08% of all patient safety incidents reported relate to 'Tissue Viability' during March and April 2026; this equates to 839 incidents. This category includes pressure ulcers on admission, developed or deteriorated in our care, skin tears, scalds, wounds, and moisture associated skin damage. As Pressure ulcers (category 2,3,4 and unstageable) represent 67.22% of these, we will focus on this aspect of patient harm.

In March and April 2026, there were 564 reported incidents where patients had been affected by category 2,3,4 and unstageable pressure ulcers reported to have developed or deteriorated in LPT care. This is a 0.18% decrease in pressure ulcers reported in comparison to the previous 2 months reporting.

During this period, 543 (96.28%) were reported in Community Hospital Services (CHS) Community Nursing Services and 16 (2.84%) were reported in Community Hospitals (Inpatients).

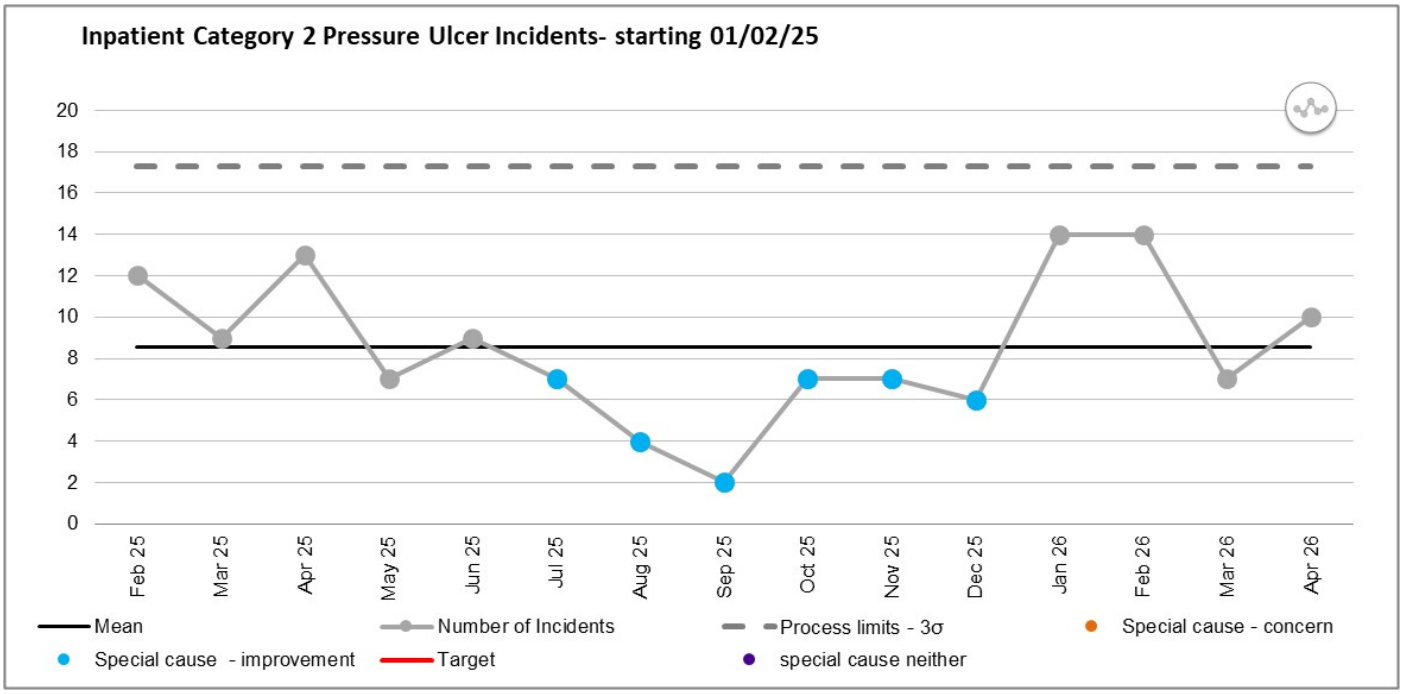
Of the remaining 5 incidents (0.89%), 4 were reported in the Directorate of Mental Health (DMH), all of which were Category 2 Pressure Ulcers –2 reported by Gwendolen Ward, 1 reported by Langley Ward, and 1 reported by Heather Ward. 1 Pressure Ulcer was reported in Families Young People, Children/ Learning Disability and Autism (FYPC/LDA), a Category 2 Pressure Ulcer reported by the Children's Physiotherapy Team.

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



The SPC chart shows special cause concern for Category 2 pressure ulcers developed or deteriorated in LPT care, it is noted there is six consecutive points increasing (trend up), however close to the mean number of incidents, this will continue to be monitored by the pressure ulcer group to understand if there are any themes.

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

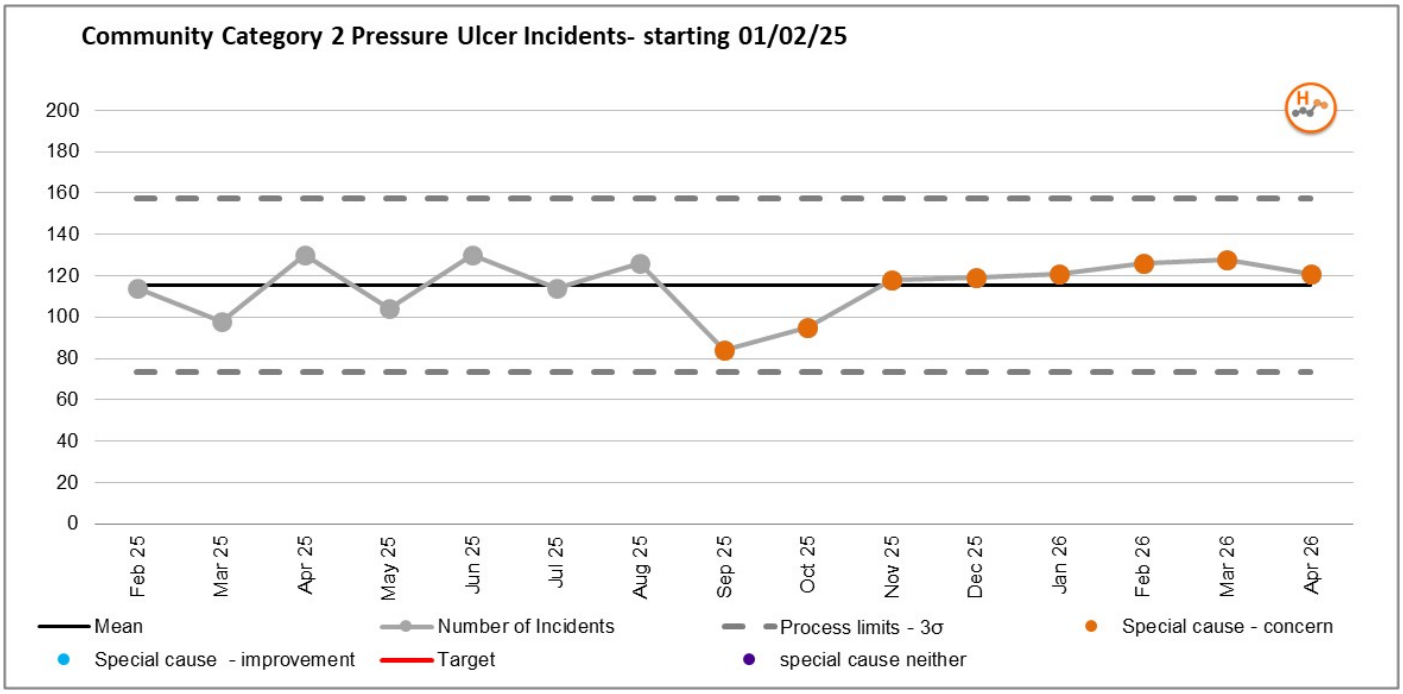


The above SPC chart shows normal variation which is disappointing after a six-point special cause improvement seeing an increase in January and February coming down in March and April 2026 of category 2 pressure ulcers developed in Community Hospitals. It was noted there has been a slight increase in the number of patients admitted with Moisture Associated Skin Damage (MASD)

that can increase the risk of developing a pressure ulcer. CHS community hospital pressure ulcer prevention work continues with a quality improvement focus on Moisture Associated Skin Damage (MASD). There is a pressure ulcer validation and learning meeting held weekly led by the senior nursing team focussing on category 2 pressure ulcers developed in care led by a Matron, to learn and share from incidents and ensure an evidence-based review process for hospital acquired pressure ulcers.

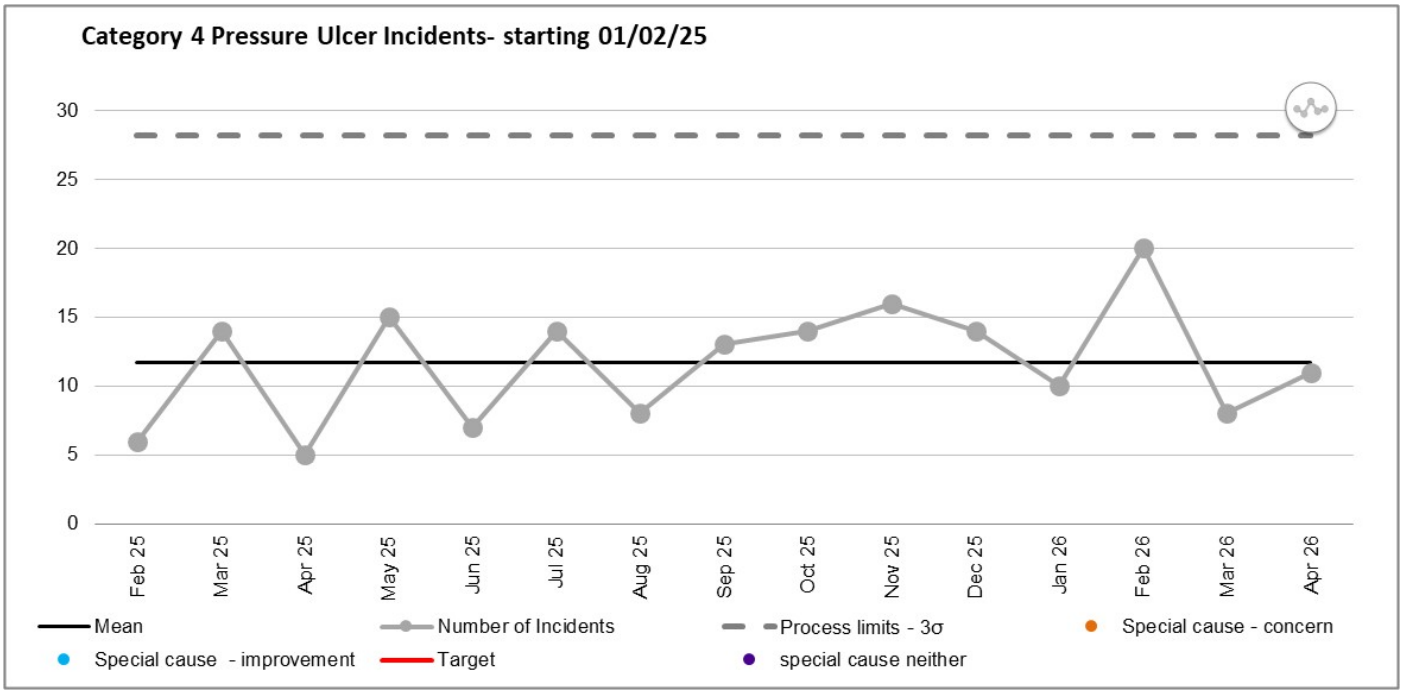
To note there have been zero Cat 3 pressure ulcers developed or deteriorated in our community hospitals since May 2025 (special cause improvement for one year) and one Category 4 pressure ulcer developed in our care since April 2024.

Community Category 2 pressure ulcers developed in our care.



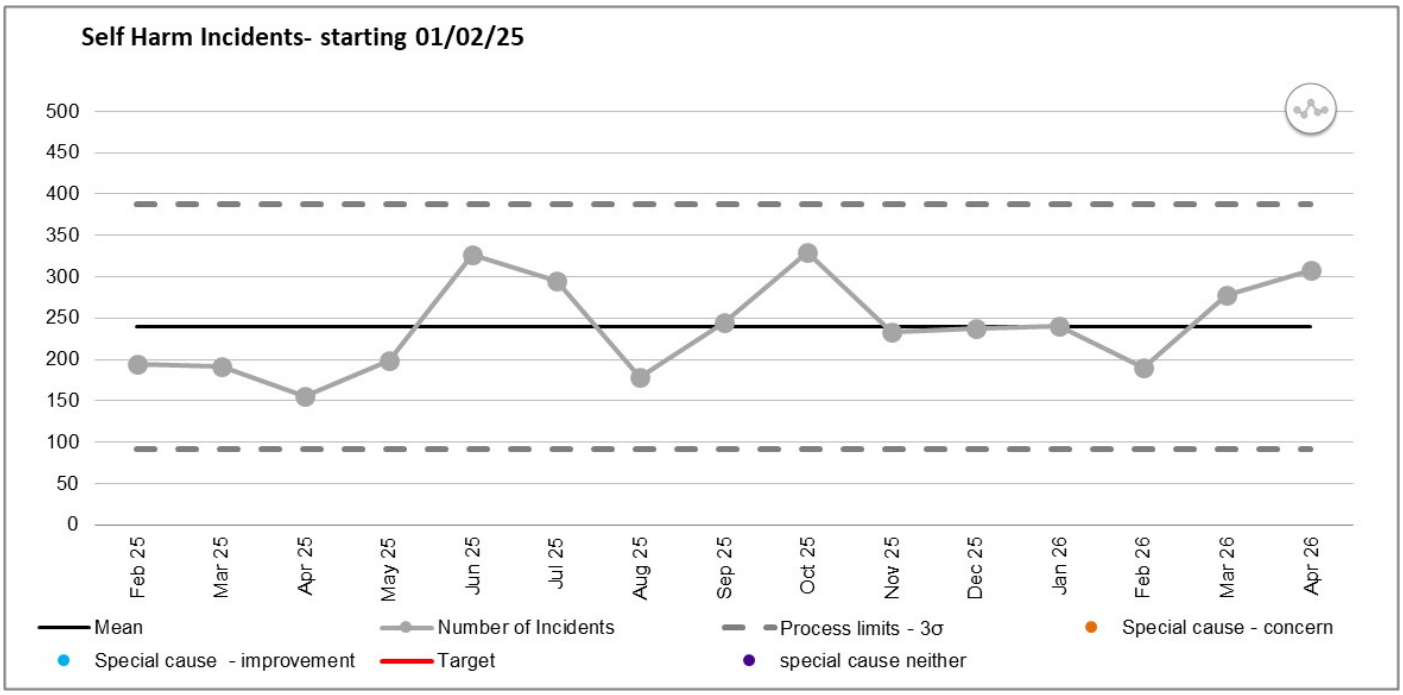
The chart above details the number of patients who have developed a Category 2 pressure ulcer in LPT community services. It is noted there is a special cause concern of eight consecutive points increasing (trend up), however close the mean. For context it is noted out of 6,688 patients on our community nursing caseload the percentage of pressure ulcers developed or deteriorated in our care, by caseload overall, is 1.79%. A review of these incidents by Community Hubs has identified that Charnwood and East North are the highest reporting hubs. Quality improvement interventions to support actions and themes from incident reviews are in place to facilitate improvements in pressure ulcer prevention and treatment.

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

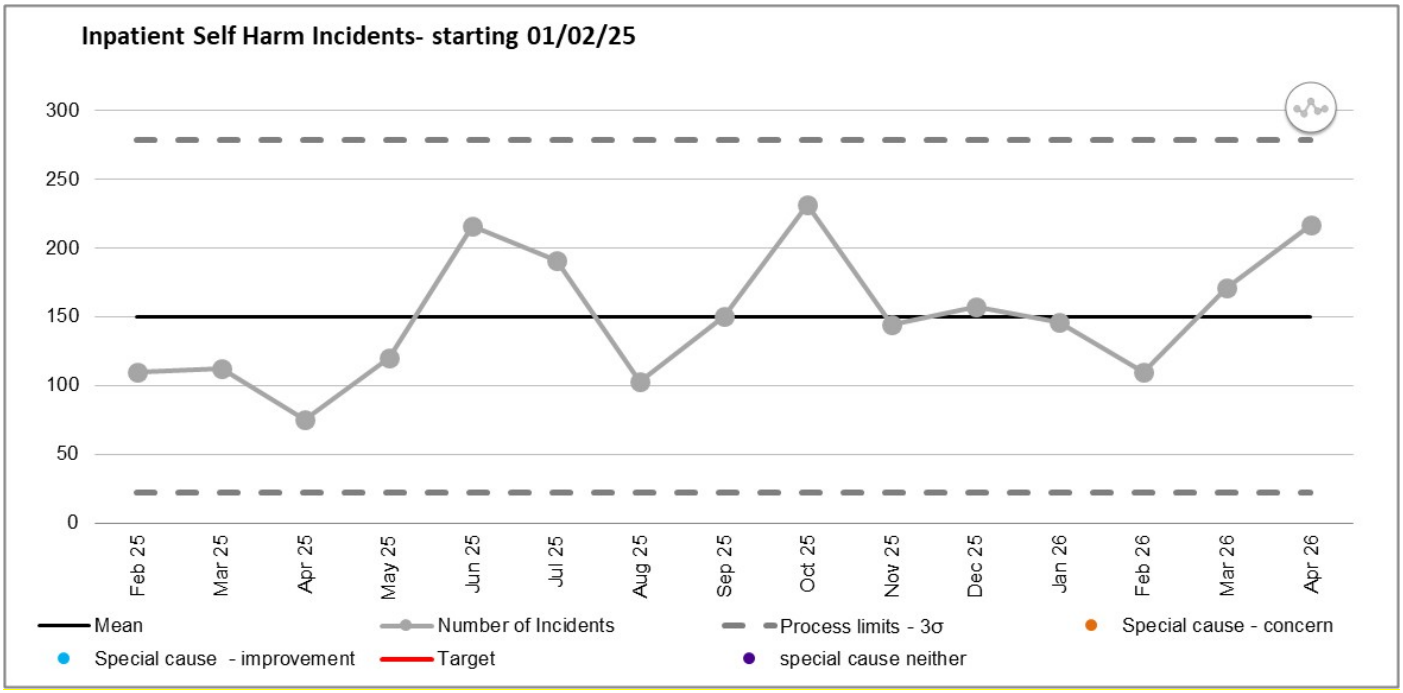


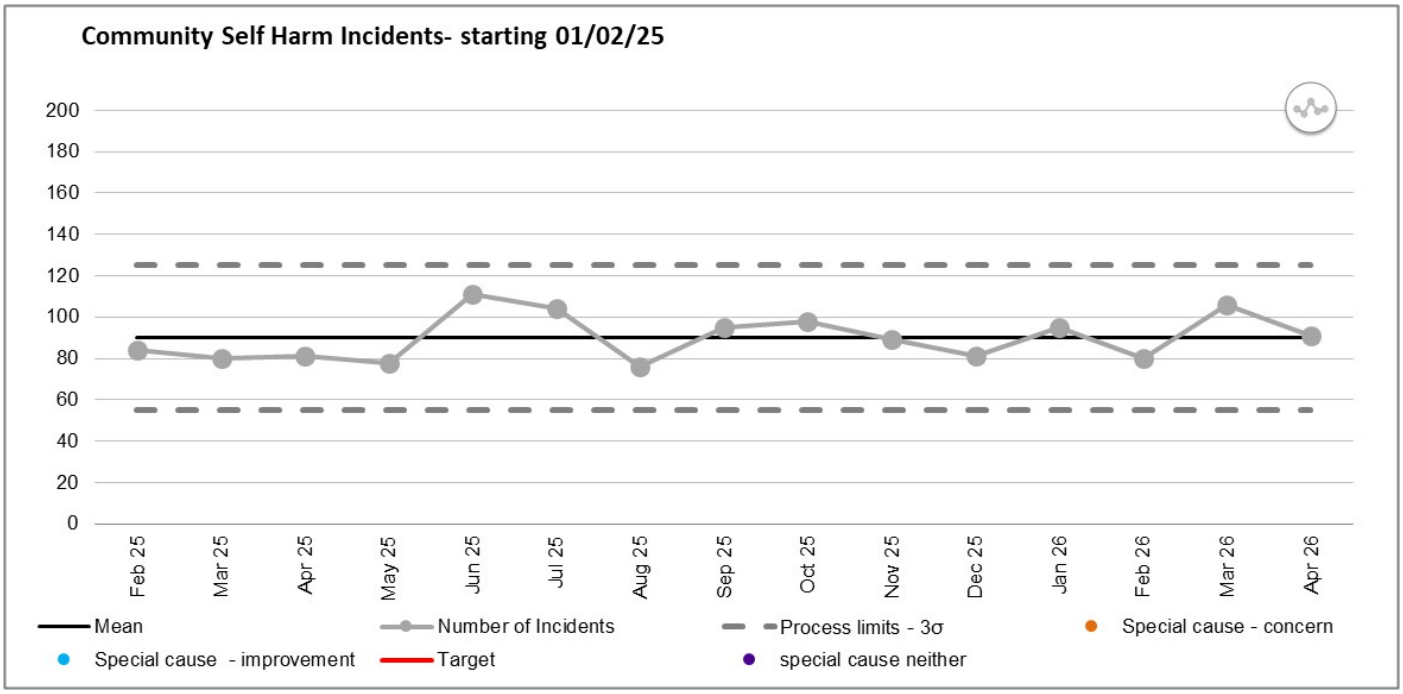
The SPC chart shows normal variation for Category 4 pressure ulcers developed or deteriorated in our care. The CHS pressure ulcer delivery group continue to implement improvement work around moisture associated skin damage, repositioning, exploring the use of handheld devices for recording repositioning in care home settings, pressure ulcer prevention at end of life, pressure relieving equipment and patient choice.

2. Self-Harm – inpatient and community



T H R I V E





There were 585 patient self-harm incidents reported during March and April 2026, this equates to 16.09% of all reported patient safety incidents during this period. Of the 585 incidents reported as patient self-harm, 388 were inpatient incidents and 197 were community incidents.

During the previous reporting period, there were 429 self-harm incidents reported across both inpatient and community settings, this shows an increase of 36.36% during the current reporting period. This increase is primarily within inpatient incidents, which saw a 133 incident (52.16%) increase, while community incidents saw a 23 incident (13.22%) increase, as measured against the previous reporting period.

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 (585) of such incidents reported:

- CAMHS Beacon – 135 incidents (23.08%) This figure involves 7 patients; this is an increase from 62 total incidents reported in the previous reporting period.

- Beaumont Ward – 66 incidents (11.28%) This figure involves 28 patients; this is a decrease from 85 total incidents reported in the previous reporting period.
- Ashby Ward – 60 incidents (10.26%) This figure involves 27 patients; this is an increase from 15 total incidents reported in the previous reporting period.

The Self- Harm and Suicide Prevention Lead has now commenced in post is meeting with the ward leaders to review this data look at some of the drivers for the increase and to consider what actions can be implemented to reduce incidents.

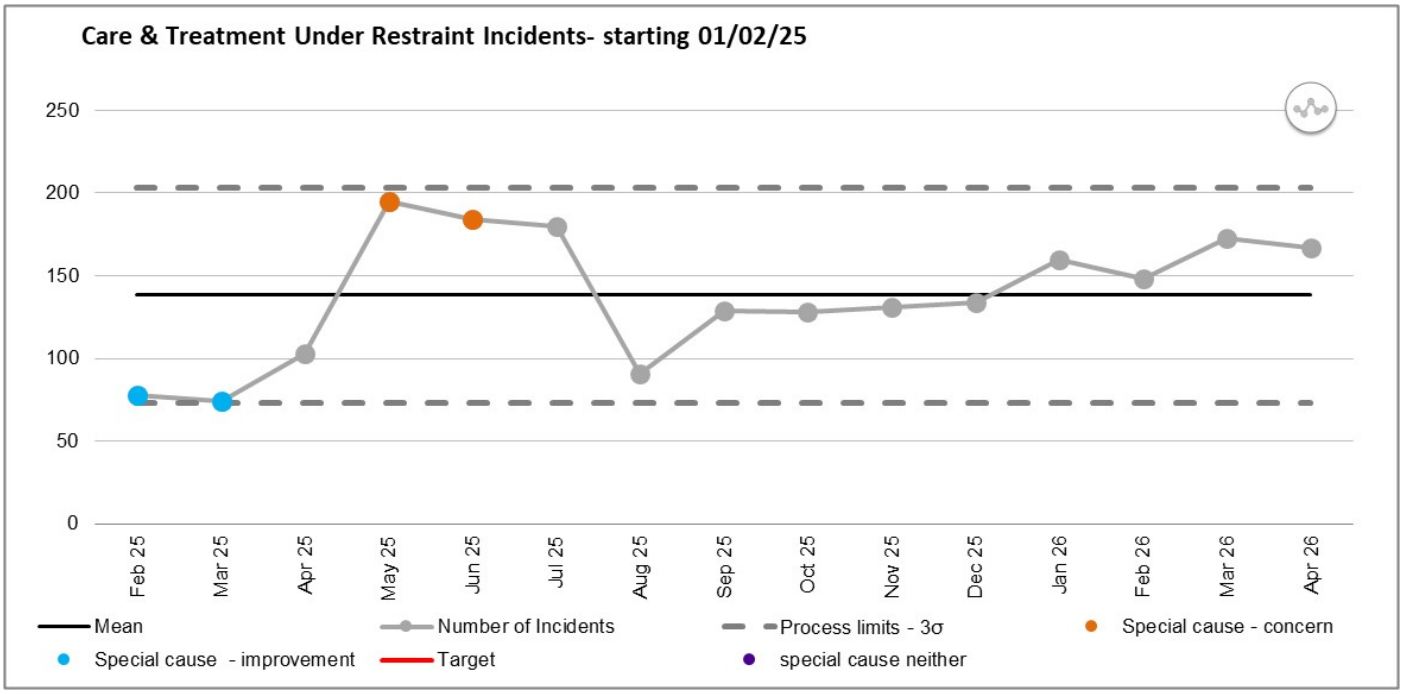
Harm Levels
Within the 3 areas of CAMHS Beacon, Beaumont Ward, and Asby Ward there were no incidents reported as moderate harm or above. Of the 135 incidents reported by CAMHS Beacon, 56 (41.48%) were recorded as minor/low harm, with the remaining 79 (58.52%) being reported as no harm. Of the 66 incidents reported by Beaumont Ward, 37 (56.06%) were recorded as minor/low harm, with the remaining 29 (43.94%) being recorded as no harm. Of the 60 incidents reported by Ashby Ward, 40 (66.67%) were recorded as minor/low harm, with the remaining 20 (33.33%) being recorded as no harm.

Overall, of the 585 total reported self-harm incidents, 1 (0.17%) was recorded as major harm and since regraded to no harm, 6 (1.03%) have been recorded as moderate harm of these 2 are a duplicate, 2 will be reviewed at IRLM in May and 2 will likely be regraded on review.
284 (48.55%) have been recorded as minor/low harm, 293 (50.09%) have been recorded as no harm, and 1 (0.17%) does not have an indicated harm level (refer to the additional text on page 2 for explanation).

Self-harm and management of self-harm is currently captured in the risk assessment and risk management training in LPT.

Self-harm management training (from another Trust in the region) has been forwarded to the Learning and development team to build some training for staff specifically in reducing and managing self-harm.

3. Care & Treatment Under Restraint



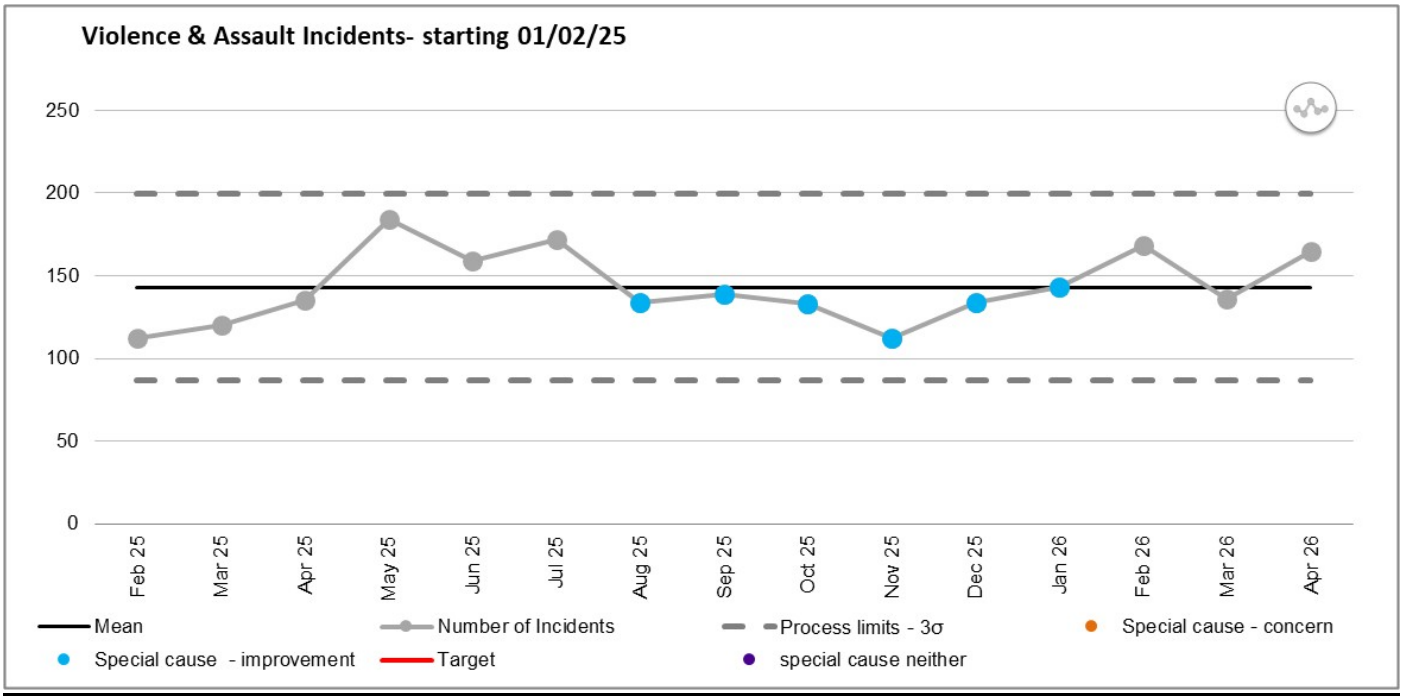
There were 340 incidents where restraint holds were used to support care delivery during March and April 2026, representing 9.35% of all reported patient safety incidents during this period. During the previous reporting period, there were 306 incidents reported where restraint was utilised, therefore this shows an increase of 11.18% 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 has scoped additional training options for 'clinical holding' to support these care activities. A training day took place March 2026 to discuss additional training and trial different holds using practical scenarios. The group are now looking at changes to the existing training programme and the Safety Intervention training requirements for staff in services where clinical holding is required.

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 (340) incidents. 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. There were 161 (43.35%) incidents, compared to 117 during the last reporting period, due to other patients now requiring holding during personal care. The restraint incidents at the CAMH's Beacon Unit are part of the young people's care and treatment, balancing least restrictive practice with the need to keep them safe from self-harm and includes feeding regimes. There were 125 (36.76%) incidents, an increase on the 115 reported during the last reporting period.

Overall, of the 340 incidents reported where restraint was utilised, 73 (21.47%) were reported as minor/low harm, and 267 (78.53%) were reported as no harm.

4. Violence & Assault



There were 301 incidents of violence and assault reported during March and April 2026. These incidents are reported under the categories patient violence towards other patients, people not

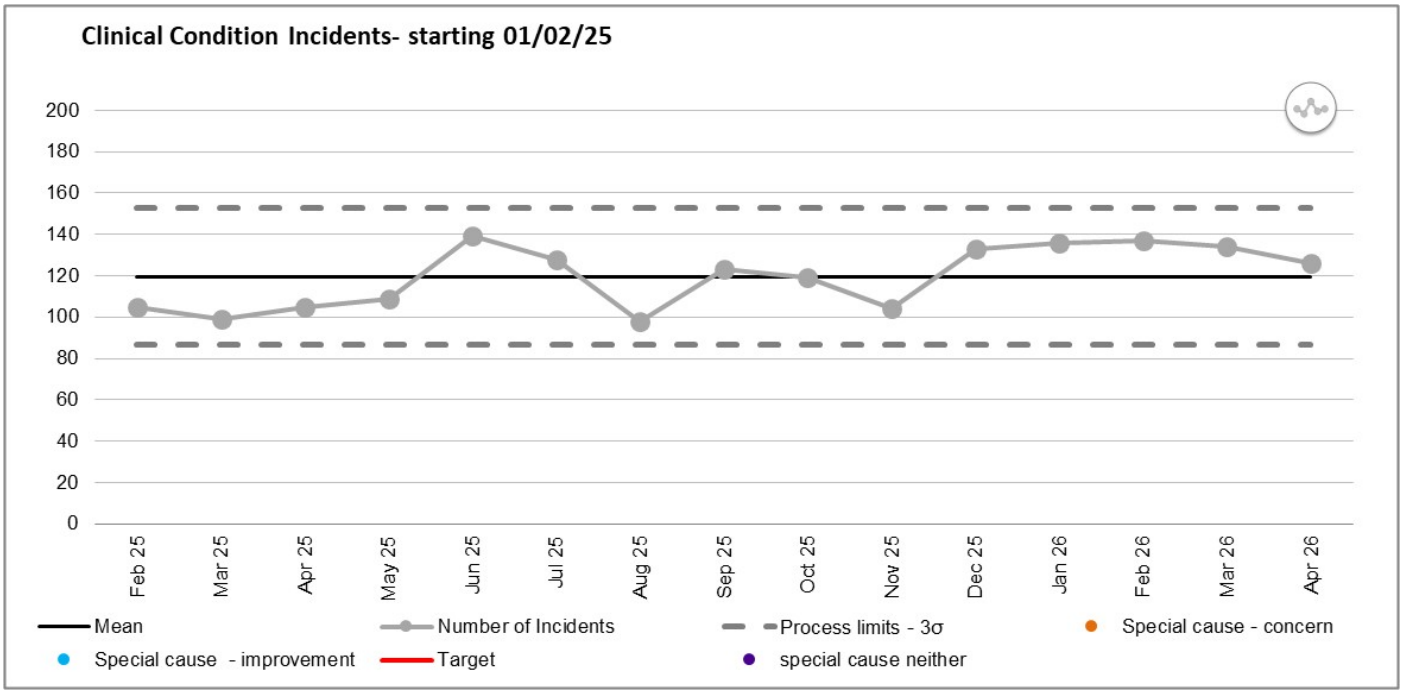
employed by the trust and incidents of disruptive behaviour towards others. This represents 8.28% of all reported patient safety incidents. During the previous reporting period, there were 307 violence and assault incidents reported, this shows a decrease of 1.95% during the current reporting period.

The number of violence and assault incidents has been analysed and over the reporting period, there are four areas with the highest number of incidents reported relative to the total number (301) of violence and assault incidents, Belvoir Ward with 41 (13.62%) incidents, Griffin Ward with 25 (8.31%) incidents, Bosworth Ward with 23 (7.64%) incidents, and Mill Lodge with 22 (7.31%) incidents. Of these 301 incidents, 160 (53.16%) were reported as physical disruptive behaviour. Belvoir Ward has a group of patients requiring more complex treatment approaches to support recovery and this has increased resulted in increased incidents of violence and aggression requiring the use of physical restraint and medication. Beaumont Ward also had a complex group of patients, some with autism spectrum disorder requiring community placements and exhibiting behaviour when anxious and frustrated and one requiring safe holds related to medication administration and self-harm prevention. In FYPC/LDA there has been an increase in use of safe holds related predominantly to safe holding for NG feeds, intervention to prevent self-harming, ligatures, headbanging and aggression towards staff.

Of the 301 incidents reported as Violence and Assault, 2 (0.66%) were recorded as moderate harm, both will be reviewed to agree further action. 89 (29.57%) were recorded as minor/low harm, and 210 (69.77%) 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.

5. Clinical Condition



There were 260 clinical condition incidents during March and April representing 7.15% of all reported patient safety incidents. During the previous reporting period there were 269 clinical condition incidents reported, this shows a decrease of 3.35% during the current reporting period.

The number of clinical condition incidents have been analysed and over the reporting period, out of the 260 reported clinical condition incidents, the top 4 areas were Bosworth Ward at the Bradgate Unit who reported 18 (6.92%) incidents, Belvoir Ward at the Bradgate Unit who reported 17 (6.54%) incidents, Dalgleish Ward at Melton Mowbray Hospital who reported 17 (6.54%) incidents, and East Ward at Hinckley & Bosworth Community Hospital who reported 16 (6.15%) incidents.

Of the 260 reported clinical condition incidents, 3 (1.15%) incidents were recorded as moderate harm, these have all been reviewed and the harm not felt to require further review. 76 (29.23%) incidents were recorded as minor/low harm, and 181 (69.62%) incidents were recorded as no harm.

Falls

The next Falls Steering Group is on 13/5/26 where April's data will be reviewed. Hence this update will focus on March 2026 data.

DMH

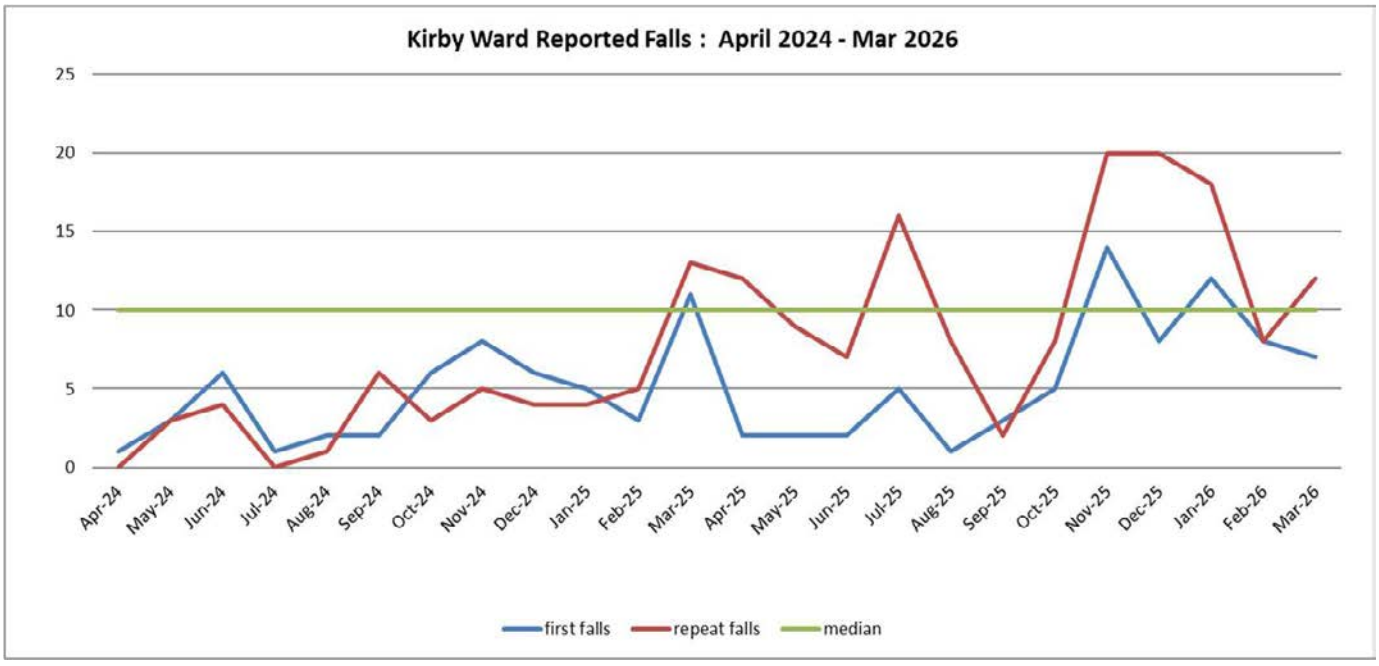
MHSOP

42 falls incidents were reported in March 2026. (50 falls incidents in February). Kirby remains the highest reporter of falls with repeat falls in a small number of patients.

Kirby Ward – 21 falls incidents reported: 7 first falls, 12 repeat falls and 2 placed themselves on the floor.

- 1 patient had repeat falls x 6.
- 1 patient had repeat falls x 3.
- 1 patient had repeat falls x 2.
- 1 patient had repeat fall x 1.

The patient that had the majority of no-harm falls over the past 6 months on Kirby is managed through an MDT approach and total number has reduced peaking with 17 falls in November and reducing to 11 in December.



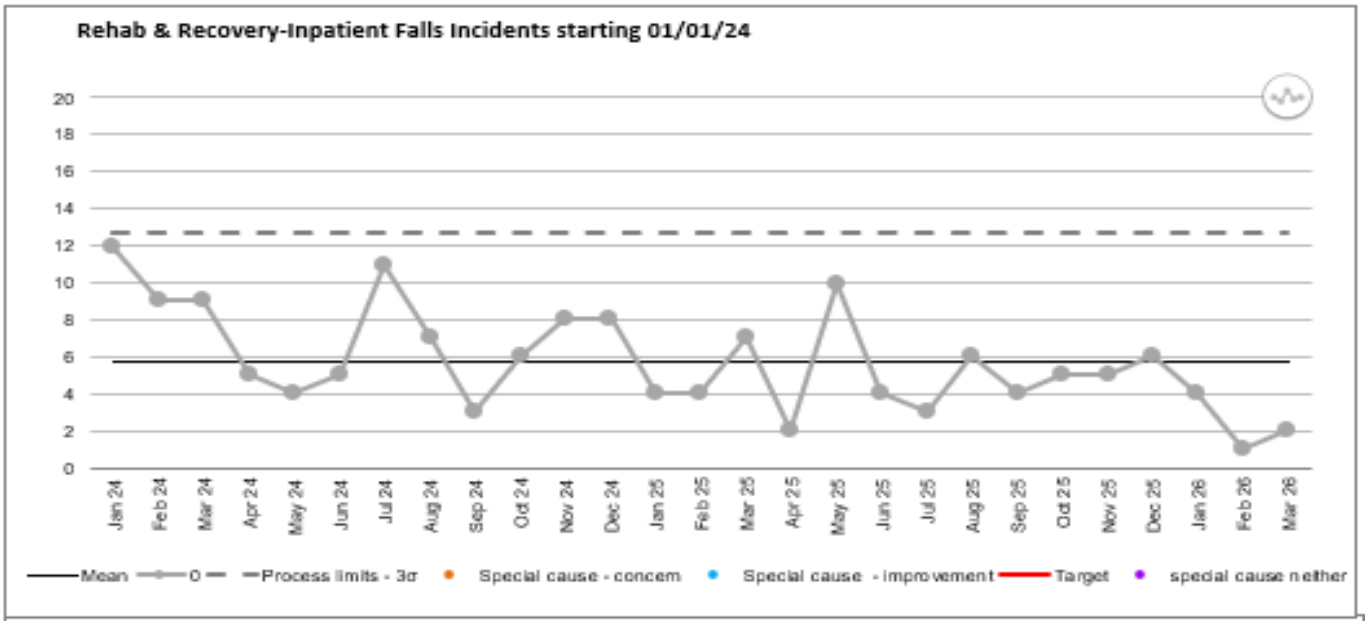
Bradgate Unit

There was a rise in numbers of falls over the Bradgate Unit. 31 falls incidents with no moderate or severe harm incidents This was related to a rise on Heather ward with 14 falls, 9 of which were repeat falls by 3 patients. The DMH team are undertaking a review of these cases.

Heather ward	Oct 25	Nov 25	Dec 25	January 26	February 26	March 26
No of Falls	4	3	1	4	2	14

Rehab wards.

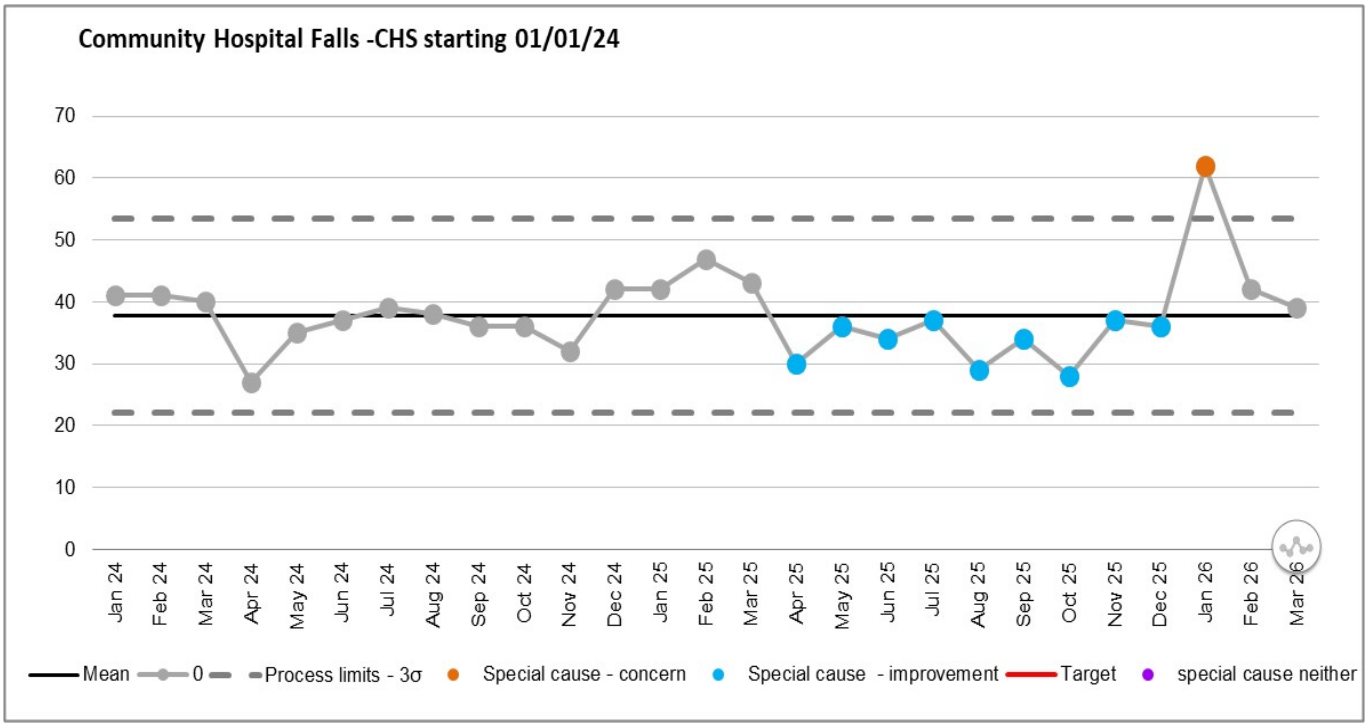
Numbers of falls have significantly reduced over the past few months. Only 2 falls incidents reported in March 2026 with no moderate of severe incidents.



The pilot to evaluate the use of assistive technology in prevention of falls continues with a trial of the Wellbeing Sensor on some Mental Health Services for Older People (MHSOP) wards any learning will be shared across the directorates.

CHS

The number of falls in February and March 2026 have fallen in comparison to an exceptional peak in January 2026 (67 incidents reported) with 42 and 39 falls incidents reported respectively. The falls were spread across all 12 wards with a slight rise in numbers on ward 1 at Coalville Hospital.



A CHS deep dive at the March 2026 Meeting raised the following points from review of Falls incidents.

- January peak in falls linked to winter pressures and surge ward activity.
    - Staff movement, sickness, and reliance on bank/agency staff during winter increases risk.
    - High patient acuity and increased one-to-one supervision place additional strain on wards.
    - Need for proactive winter planning, particularly ahead of January, aligned with surge ward planning.
- Clear correlation between increased falls and pressure ulcers, likely driven by patient deconditioning. Reduced mobilisation leads to deconditioning, contributing to both falls and skin damage.
- Post-fall head-to-toe assessments not consistently documented, raising concerns about quality and assurance.
- Audit evidence shows a gap between reported practice and recorded evidence.
- Strong ward-level analysis and feedback loops help translate themes into meaningful actions.

FYPC/LDA

Continue to report low numbers of falls across both inpatient and community areas. Falls mainly related to clinical presentations (e.g. epilepsy) and engagement in physical activity. They are working on improving falls risk assessment process to reduce risk as far as possible.

Risk of falls from Commodes

Working with the Moving and Handling Lead, wards have undertaken a scoping exercise of commodes in CHS and MHSOP following discussions identified the risk of falling for small patients not being able to reach the floor when sitting on a regular commode. The team are working to ensure access to smaller static commodes to be available for these cohort of patients to reduce the risk of falling.

Review of Falls Documentation

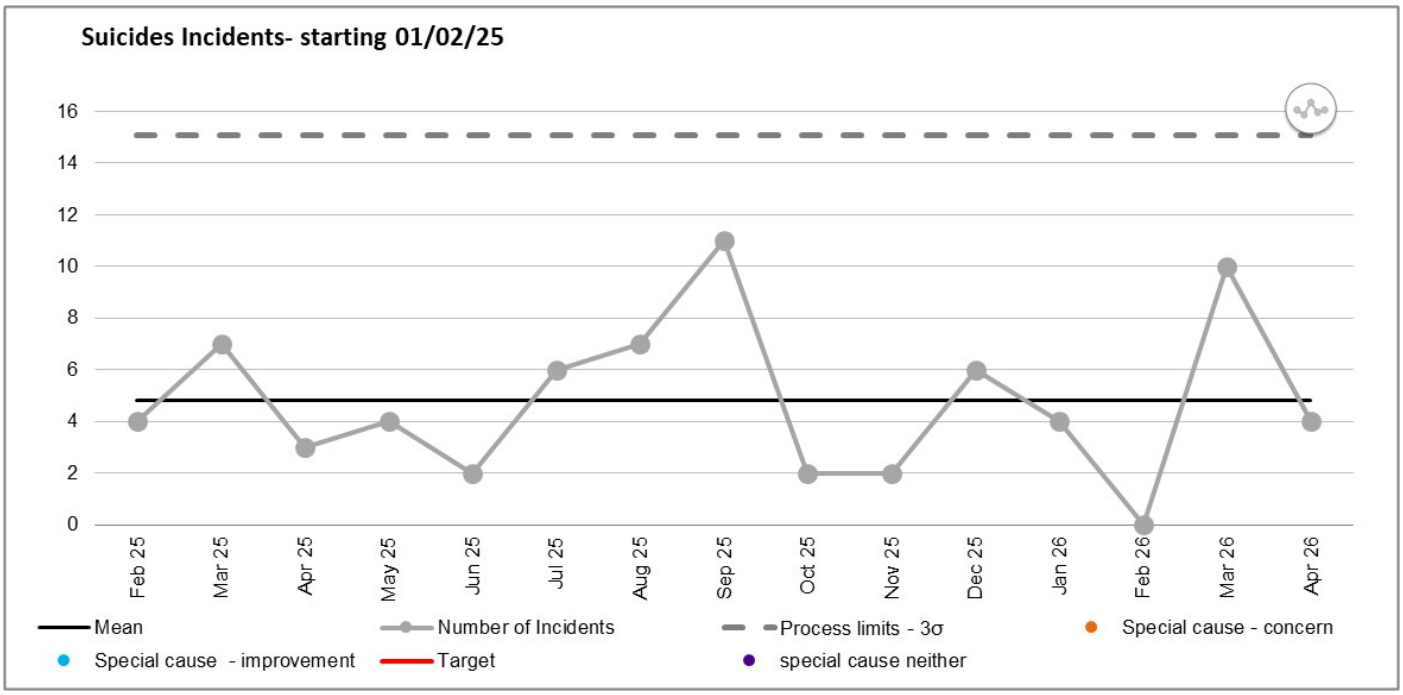
The Falls Steering group have recognised that whilst audits show relatively good compliance with process, incident investigations show that the quality of falls risk assessments and care planning could be improved. Staff feedback describes the falls risk assessment process long and cumbersome and there are poor links from the risk assessments into care planning and lack of personalisation.

The Steering group have set up a task and finish group to review the falls risk assessment process and documentation, in line with falls standards and aim to streamline and improve the quality of assessment and care planning.

This work will be in line with the current initiatives around care planning.

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)



Between March and April 2026, there were 14 deaths by suicide within Leicester and Leicestershire involving individuals who were known to, or had contact at some point with, Leicestershire Partnership NHS Trust (LPT) services.

The LPT Suicide Prevention Lead meets weekly with the Suicide Audit and Prevention Group to review each death by suicide. These meetings aim to identify emerging themes, shared learning, and potential actions, including consideration of any high-risk locations.

Each death by suicide is also discussed at the LPT Rapid Review Meeting, which is attended by multiple professionals. This forum focuses on identifying any immediate learning. Where issues or risks are identified, actions are promptly escalated and addressed to mitigate further risk and better understand how repetition may be prevented.

Incidents are additionally escalated to the Incident Review and Learning Meeting (IRLM), where each case is explored in more detail. This ensures that appropriate contact has been made with the family and that any learning is identified. Where required, matters are escalated further for formal investigation.

LPT have been rolling out a medicines amnesty for the last 2 years, this runs throughout March and did so this year.

This amnesty is in conjunction with partner agencies, police, public health, pharmacies. The aim of the amnesty is to try to reduce the availability of unnecessary medicines in people's homes to reduce the availability and therefore the opportunity for people to take overdoses to end their lives or self-harm. It is recognised that those with social factors and serious physical illness are at increased risk of suicide and will often have access to medications most often cited in deaths by suicide. The amnesty will be evaluated, and we hope to be repeated each year.

Staying safe from suicide guidance has been discussed and shared in both directorate and trust wide suicide prevention meetings. The suicide prevention lead has started conversations within the LPT learning and development team to put the staying safe from suicide training onto Ulearn, so this can be rolled out and staff encouraged to compete the training.

Sexual Safety for Patients

Throughout 2025/26 the Trust has been reviewing the approach to supporting patients and staff feel sexually safe whilst working or receiving care in services. Members of the Trust Sexual Safety Group have worked with patients, their families, and staff to develop Ward Charters regarding appropriate/ inappropriate behaviour and how to seek support from staff to discuss any concerns. A poster and leaflet, including an easy read version are currently being shared with all areas for implementation in May and June 2026.

Learning from Deaths

The Learning from Deaths Clinical Lead has now been appointed and will commence in post in June 2026. Work is underway with the Medical Examiner's Office to establish a process that will enable LPT to receive the confirmed cause of death for all patients under our care, and the new lead will continue to drive this forward.

The team has already begun reviewing patients' protected characteristics to identify any themes that may indicate potential health inequalities. They are also developing the dataset so that, once cause-of-death information is available for all patient deaths, a more robust thematic review can be undertaken. This will support improved triangulation of data and strengthen our ability to identify and address 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 6 notifications made by LPT staff to LeDeR related to patients with a known learning disability or autism and who have died for March (3) 2026 and April (3) 2026.
- For City and Countywide reviews, there were 12 patient death notifications in March 2026 and 7 patient death notifications in April 2026.
- Of the total 19 notifications,6 are focused and 13 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.

NATPSA Alerts

National Patient Safety Alerts remain a critical mechanism for safeguarding patients and strengthening organisational reliability. They provide a clear, standardised framework for identifying, escalating, and mitigating risks, with the alert triangle serving as a strong visual cue that reinforces the urgency and priority of required actions.

Effective management of these alerts—through timely assessment, robust governance oversight, and demonstrable implementation—ensures that learning is rapidly translated into safer clinical practice. For the Board, continued scrutiny of alert compliance is essential not only to meet statutory obligations but to gain assurance that the organisation is proactively addressing system vulnerabilities and embedding a culture of continuous safety improvement.

LPT current position

Alerts received in the last two months or that are ongoing or open past their closure date

Alert	Detail	Due for closure	Notes
NATPSA/2023/010/MHRA	Bed rails and Levers and their safe use and ongoing assessment of risk	1st March 2024 (overdue closure)	This alert remains open past its closure date due to the need to develop a process for patients who are in their own homes with levers or bedrails who are no longer on our

Alert	Detail	Due for closure	Notes
			caseload to be offered a risk assessment. The process has now been agreed along with an implementation plan commencing in quarter 2; when this is confirmed this alert can be closed
NATPSA/2025/006/NHSPS	The incorrect recording of Penicillin Allergy as Penicillamine	20th November 2026	This alert is being led by LLRICB and involves all system partners -LPT have all possible actions in place and have provided this assurance to the LLR group. This alert is on track for closure on time.
NATPSA/2025/008/NHSPS	risk associated with adult breathing circuits lacking a patent exhalation route	12th June	Actions are in place and this alert has been recommended for closure
NatPSA/2026/003/DHSC	Shortage Of Dinoprostone 3mg Vaginal Tablets And 1mg/2.5ml, 2mg/2.5ml Vaginal Gel	Issued 8th April 2026 Closed 20th April 2026	Confirmed by Pharmacy -The Trust does not carry this dose of medication.

LPT Outstanding patient safety reviews: (As of 20th April 2026)

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	0	0	0
Awaiting specialist review	0	1	0	1

SMART Action Planning	0	0	1	0
Directorate Sign off Stages	0	4	1	4
Right to Reply Family	2	1	0	0
Right to Reply Staff	0	1	0	3
Submission to CPST	0	0	0	0
Exec Review	0	0	1	0
With ICB	0	0	0	0
Directorate Post Exec Review	0	0	0	0
Total Learning Responses Overdue	**2**	**7**	**3**	**8**

Current Position

- As of 20th April 2026, there were 55 open investigations. 17 DMH, 18 Corporate, 9 CHS and 9 FYPC/LDA.
- Of these 20 are overdue and of these 3 are in right to reply with patient or family
- 7 DMH (41.18%) are overdue.
- 8 Corporate (44.44%) are overdue all are within the various phases of sign off.
- 2 CHS (22.22 %) are overdue.
- 3 FYPC/LDA (33.33 %) are overdue

Those reports that are overdue are all in the final stages of the review and patients and or their families have been kept fully informed of progress.

Duty of Candour

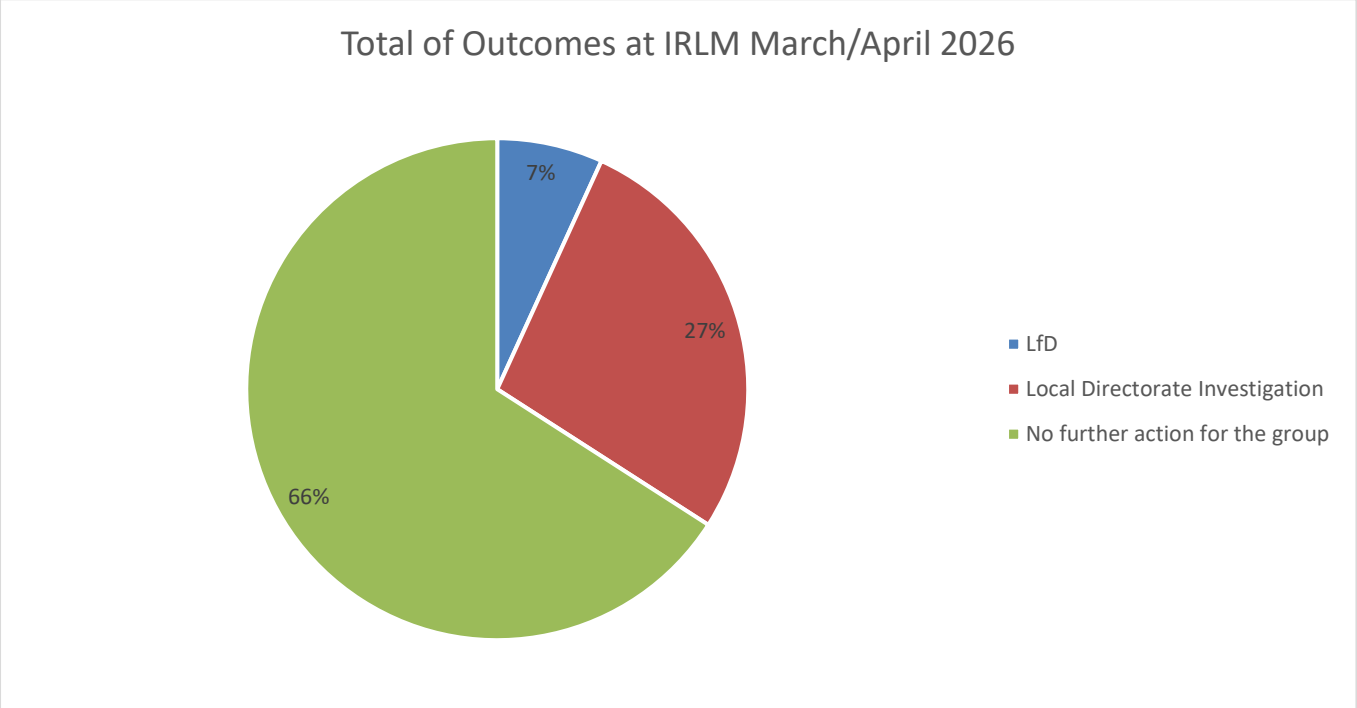
There was no statutory duty of candour breaches during this period. We continue to follow 'being open' which is inbuilt in PSIRF principles of compassionate and positive engagement with patients/families.

Never Events

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

Incident Review & Learning Meeting (IRLM)

44 cases were reviewed at IRLM during March and April 2026. 0 (0%) Patient Safety Incident Investigations (PSII) were declared during this reporting period. 29 (66%) were identified as having already identified any learning and actions put in place. There were 12 (27%) Local Directorate reviews requested to explore appropriate actions, 3 (7 %) 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.
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 currently October/November 2025.

Patient Safety Strategy

Training: SEIPS approach to investigation training.

During March 2026, 21 staff had been trained bringing the total so far to 362 members of staff. There will be 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 2025/2026**
DMH	109
CHS	54
FYPC/LDA	73
Enabling	6
TOTAL	**242**

The CPST have extended the offer to support training to NHFT colleagues and two dates have been arranged one in June and one in July.
The patient safety 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.
One of these reviews has been presented at the system Transferring Care Safely group (TCS) to share both the benefit of the model and the learning identified.

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
Jan – Feb 2026	96	6	102
March – April 2026	134	5	139
Total	7946	201	8079

Decision Required

Briefing – no decision required.

Governance Table

For Board and Board Committees:	Trust Board
Paper sponsored by:	Linda Chibuzor, Group Chief Nurse/ Executive Director of Nursing, Allied Health Professionals (AHPs) and Quality
Paper authored by:	Tracy Ward, Head of Patient Safety, Patient Safety Specialist
Date submitted:	15/05/2026
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:	July 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:	
False or Misleading Information (FOMI) considerations:	
Positive confirmation that the content does not risk the safety of patients or the public:	
Equality considerations:	

K

Leicestershire Partnership NHS Trust

Thriving Through Transformation 2025/26

Gemma Barfoot Head of PMO | April 2026

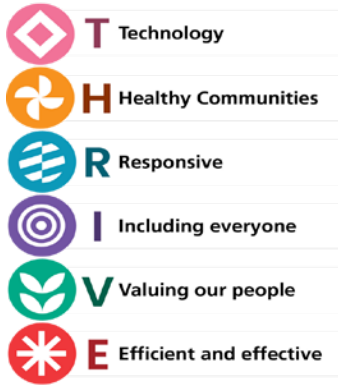
Our group strategy

- T Technology
- H Healthy Communities
- R Responsive
- I Including everyone
- V Valuing our people
- E Efficient and effective

Executive Summary

Over 2025/26 LPT delivered a broad and ambitious programme of transformation focused on improving access, equity, quality and productivity, strongly aligned to the Trust's THRIVE strategy and national priorities set out in the NHS Oversight Framework and Mental Health Long Term Plan.

Activity spanned neighbourhood-based service redesign, significant waiting-list reductions, strengthened Central Access Point performance, targeted health inequality interventions and accelerated digital adoption.



Collectively, this work advanced **Technology** through scaled use of shared records and patient and clinician digital tools; supported **Healthy Communities** and **Including Everyone** via expanded neighbourhood mental health offers, VCS partnerships and culturally informed engagement; enhanced **Responsiveness** through improved access routes and reduced backlogs; strengthened **Valuing Everyone** through workforce development, peer support and inclusive leadership programmes; and delivered **Effective and Efficient** care through improved flow, reduced length of stay and demonstrable productivity gains.

This activity directly supports national expectations around access standards, neighbourhood integration, digital maturity, co-production and reducing unwarranted health inequalities.

The PMO played a critical enabling role in translating ambition into delivery across the Directorate. Through clear prioritisation, disciplined governance and consistent performance oversight, the PMO provided structure, pace and assurance while allowing clinical and operational teams to retain ownership of solutions. This approach has enabled teams to focus on improvement at the frontline, ensured benefits were realised and evidenced, and established a stronger foundation for delivery in 2026/27 as the Directorate continues to progress its THRIVE ambitions.

THRIVE Key Achievements and Impact – 2025/26

T – Technology

Using technology to improve care, productivity and experience

- **LLR Care Record**: 100% of frontline staff trained, embedding real-time access to shared records and enabling improved clinical decision-making and care coordination.
- **Airmid (patient-facing app)**: Rolled out across multiple services with improved appointment management, reduced patient calls and postage, and increased access to information.
- **Brigid (clinician-facing app)**: Piloted and expanded in community services (e.g. phlebotomy), reducing documentation time, improving staff morale and reducing risk of lost paperwork.
- **ServiceNow ITSM**: Group-wide implementation initiated to modernise IT support, streamline processes and improve user experience.
- **Microsoft Copilot Chat**: Enabled for all staff, supporting administrative efficiency and productivity.
- **Ambient Scribe**: Procurement and regional collaboration commenced, with deployment planned for 2026/27.

H – Healthy Communities

Empowering people to live well and reducing inequalities

- Expansion of **Neighbourhood Mental Health Cafés**, Getting Help in Neighbourhoods (GHiN) and JOY social prescribing, increasing reach and access to community-based support.
- **£925k secured** to develop a Neighbourhood Mental Health Centre at **Fearon Hall, Loughborough**.
- Targeted **health inequalities initiatives** using the Thinking AHEAD app, with registered users increasing from 2 to 38.
- Increased awareness and access for people living with **serious mental illness (SMI)**, including cancer screening and respiratory pathway improvements.

R – Responsive

Delivering timely access and flexible services

- **Central Access Point (CAP)**: Significant improvement in call handling, triage and responsiveness through workforce expansion, NHS 111 Option 2 and 24/7 Chat MH.
- Routine referral backlog cleared and redirected to neighbourhood MDTs for daily review.
- **Perinatal mental health** access improved to **9.9%** by February 2026 following workforce and leadership redesign.
- Outpatient pathway redesign for clozapine and depot clinics, supported by additional nursing capacity.

THRIVE Key Achievements and Impact – 2025/26

I – Including Everyone

Improving access, experience and outcomes for all

- Deepened co-production and engagement through the **African Heritage Alliance**, including focus groups and a community-led manifesto for culturally informed mental health care.
- Live Well Programme community insight work with Bangladeshi communities, CYP in Coalville and autistic people.
- Increased uptake and use of culturally adapted resources in CAMHS and community services.
- Lived Experience Partners embedded across PCREF and Culture of Care programmes.

V – Valuing Everyone

Supporting our workforce, leadership and culture

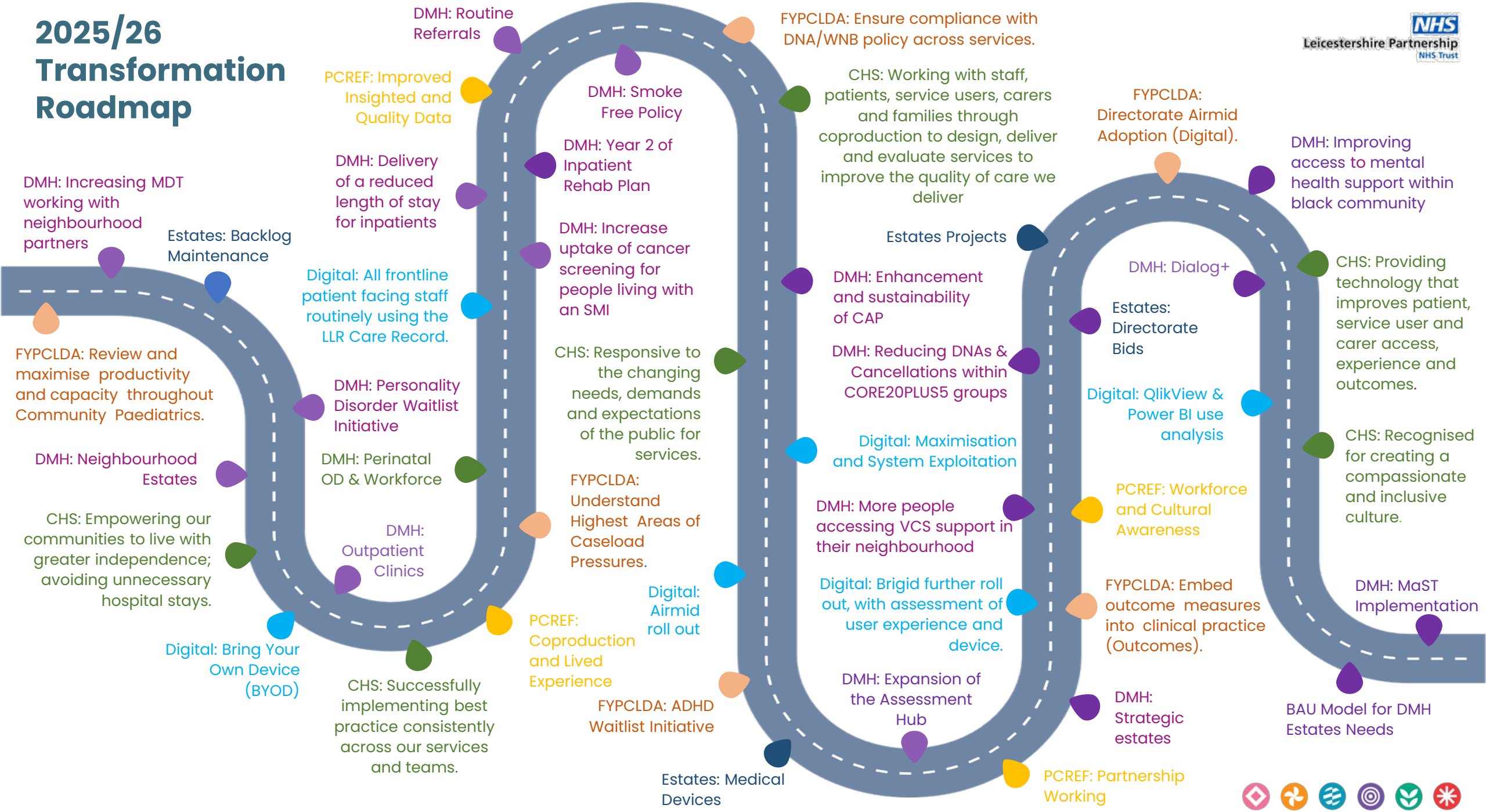
- **Reverse Mentoring Programme (Cohort 6)** delivered, with strong feedback and evidenced improvements in cultural competence and leadership awareness.
- Rollout of the **Active Bystander Programme** across the system.
- Expansion of the **Peer Support Worker workforce** to 32 roles, underpinned by ImROC training and strengthened governance.
- Culture of Care ward-based quality improvement delivered in partnership with patients and staff.

E – Effective and Efficient

Delivering value, productivity and sustainability

- **52% reduction** in the Personality Disorder treatment waitlist within five months, reduced further to **82 patients by January 2026**.
- Reduction in inpatient length of stay through improved flow, discharge planning and rehab pathways.
- Establishment of Integrated Neighbourhood Teams and clearer service offers.
- Development of PCREF dashboards and neighbourhood risk profiles to support data-driven decision-making.

2025/26 Transformation Roadmap



WeArePMO
Programme Management Office

Good News Stories

25/26 Top Good News Stories: PCREF

Making a difference, together

For use in eNews, the outstanding practice section of the AAA report and to celebrate success/share learning

Live Well Programme

Work with the Bangladeshi community has progressed significantly, supported by strong collaboration, culturally aligned engagement, and the involvement of respected community leaders, this work aligns to core Live Well values and PCREF priorities. Key Achievements:

- 4 workshops delivered to Imams, Healthwatch, NHS Staff and learned women, building early trust and enthusiasm for wider community involvement.
- Development of Ashar Alo, a culturally tailored guide to support future community insight workshop delivery.
- Workshop has been expanded to include short mental health awareness sessions
- Co facilitators identified from the Bangladeshi community in Leicester to support the delivery of insight workshops during April 2026 respected community members who strengthen the approach and its credibility.
- Partnership now includes: Equality Action, Healthwatch, GSC Friendship Group, LPT, Jamila's Legacy, Dara Salaam Masjid, and the Bangladeshi Action Resource Centre.

Live Well Programme

The CYP strand of work is developing well across rural Leicestershire, where young people face unique challenges around transport, spaces, belonging, and access to support. The emerging work reflects Live Well values possibility thinking, co production and relational trust and aligns closely with PCREF addressing structural barriers.

A key milestone was a workshop with 54 primary school children (9–11 years) exploring Your Town, Your Voice, delivered with Coalville CAN. This created a safe, creative space for children to share what helps them feel hopeful and what gets in the way of belonging. Working in partnership with local groups such as Regul8, Go-Getta, Coalville CAN, Loughborough college, Leicestershire county council and others we are ensuring we are connected with organisations who have long standing trust with local young people. These organisations work closely with children facing adversity, exclusion, or limited opportunity, ensuring the work is rooted in local need and trusted spaces

Culture of Care Programme

Welford Ward – an inpatient – eating disorders ward, developed several change ideas through the programme. Here are two of them:

- Redeveloping the garden to support trauma-informed and autism-informed care principles.
- Increasing access to meaningful activities, aligned to the Therapeutic Care Standard.

Patients asked for

- Bright murals on the walls
- Moveable, less clinical furniture
- A comfortable place to meet friends, family and carers
- A calm space to relax and connect with different senses

Patients also said that they wanted more to do on the ward, so we asked for suggestions and held a vote. We now additional activities such as movie nights and cultural celebration events. We have also:
Removed blanket restrictions, including the requirement to eat only in the dining room
Created a sensory room
Added sensory adaptations, such as ear defenders
All of this supports more personalised, needs-based care.

Coproduction and engagement with Black and African Caribbean Communities

The African Heritage Alliance delivered a summer of Appreciative Inquiry Workshops into "What does it look and feel like when Black people are truly safe, respected, and thriving in mental health services?"

Engaging with Black communities across Leicester who have or don't have lived experience of mental health; Sessions – Young People, Faith Groups, Long term health conditions, all genders and sexualities and Care Leavers .

The resulting Manifesto for Black Safety, Healing and Belonging in Mental Health. The Manifesto sets out the collective vision from those who took part in the workshops:

- Holistic – seeing the whole person and their world.
- Culturally relevant – reflecting lived experience and heritage.
- Informative – empowering people with knowledge and agency.
- Therapeutic – offering consistent, compassionate, culturally sensitive care.

25/26 Top Good News Stories: CHS

Making a difference, together

For use in eNews, the outstanding practice section of the AAA report and to celebrate success/share learning

Brigid community inputting

Pilot – in City Phlebotomy caseload

Aim: staff being able to input directly into SystmOne using the Brigid app

Benefit: GP able to see INR result on the record immediately to prescribe patient medication

Evaluation: Refreshed training based on service feedback
Roll out to remining caseloads, team by team

Now fully rolled out across the service

Health Inequalities

Across CHS we have carried out a suite of thematic reviews using the insight data within LPTs DNA/WNB app – Thinking AHEAD. This data has enabled our teams to understand where potential health inequalities exist within our services related to patient DNA's to form a plan of intervention and change – to reduce health inequalities within DNAs and improve access.

Project to continue for 2026/27 to:
Embed Thinking Ahead app within CHS services
In depth DNA analysis within CHS services
Reaching out to communities (to understand challenges attending apts)

Self care pilot – East South community nursing hub

Pilot – to improve patient experience, reduced nursing visits, and empowered wound care self-management with clinical oversight. Remote monitoring via digital tools allowed asynchronous wound image submissions, reducing face-to-face visits safely.
The pilot avoided 147 nursing visits, enhanced patient independence, and received positive staff feedback and satisfaction.
The pilot enrolled 21 patients, surpassing the initial target of 10, indicating strong uptake and feasibility.
Next steps – roll out across community nursing

Community currency ICSPC pilot

Pilot – to test the process for Last Year of Life community currency

Review with service to determine primary interventions and treatment options
SNOMED codes added to S1 unit prior to working with the service on how to capture the information
Once codes adding – training with service prior to testing.

Now business as usual within the service

25/26 Top Good News Stories: Digital

Making a difference, together

For use in eNews, the outstanding practice section of the AAA report and to celebrate success/share learning

IT Service Management System

An example of a Group-wide initiative that marks a significant step in modernising our digital service infrastructure, streamlining support processes and enhancing user experience across the organisation.

Group ServiceNow provider partner selection process completed.

Group project initiated.

Airmid/Brigid

Trust-wide pilots of a patient-facing app (Airmid), and a clinician-facing app (Brigid) in non-inpatient settings.

Airmid benefits include positive patient experience, reduction in patient calls, reduction in postage and increase in availability of patient information. Alongside the rollout of communications annexe functionality to send out questionnaires to patients, there was a 500% increase reported for patient details information in Perinatal service.

Brigid benefits include reduction in time taken to complete recordkeeping, improved staff morale, reduced risk of lost paperwork.
Multiple organisations have contacted LHIS to learn about our experiences.

LHIS Space Utilisation

£124k delivered as part of Cost Improvement Programme (CIP) by reducing the amount of office and storage space at Gwendolen House.

A detailed review of how space was being used was undertaken with opportunities identified to reorganise office layout, consolidating storage and operating from a smaller footprint.

The freed-up space was then allocated to Diana service. The service's relocation into Trust owned estate meant the organisation was able to serve notice enabling the Trust to eliminate costly external rental requirements.

Celebrating Excellence

Two initiatives recognised at LPT Celebrating Excellence Awards:

1. SystmOne ePrescribing Project Team – enabling clinicians to issue prescriptions from within the electronic patient record, delivering efficiencies for staff, reducing time taken to process prescriptions by 50%, allowing clinicians to work more agilely, postage saving and patient experience.
2. Community phlebotomy service blood labels – solution to print all bottle labels with service reporting a significant improvement in quality and productivity, together with patient care.

25/26 Top Good News Stories: DMH

Making a difference, together

For use in eNews, the outstanding practice section of the AAA report and to celebrate success/share learning

Clozapine and Depot Clinic Pathways

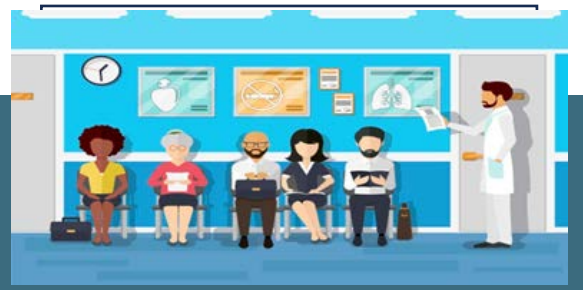
As part of our outpatient waiting times work in the Neighbourhoods, a Task and Finish Group was established to review cohorts of patients in OPD lists who were on depots / clozapine. Patient pathways were mapped and demand and capacity exercise completed. Additional resource and clinics have been established in City East.

Waiting lists and KPis

CAP routine backlog was cleared by the NH teams.
The MHF Team have continued through 2025/ 2026 to deliver above the agreed target for the 6 physical health checks.
TSPDD have significantly reduced the treatment waiting list during 2025/2026. As of January 2026 the treatment wait list is at 82.
Perinatal Access target as of end of February 2026 has reached 9.9%.

Perinatal Team Access Improvements

Establishment of the Perinatal and MMH Senior Leadership Team has helped drive a culture of improvement across the service with work to improve the governance in the service through define roles & responsibilities, setting leadership and management expectations, confirmation and sustaining BAU process



Waiting Well

Identification of charitable funds to support the purchase of a licence for a digital bookcase and enabled Information to be available on LPT Website about ADHD and Mental Health
https://www.leicspart.nhs.uk/while-you-wait/adhd/adhd-and-mental-health/
https://www.leicspart.nhs.uk/while-you-wait/mental-health/

25/26 Top Good News Stories: DMH

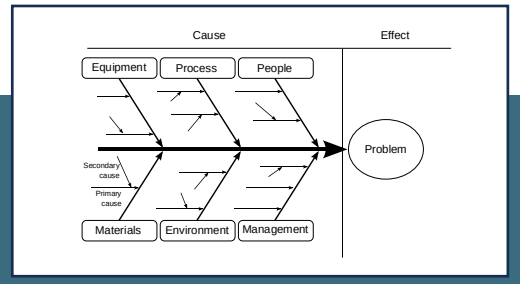
Making a difference, together

For use in eNews, the outstanding practice section of the AAA report and to celebrate success/share learning

Urgent Care

Improvement in pathway performance for Central Access Point ;

- Call handling compliance improved
- Triage improvement
- Routines moved to planned care
- Chat MH
- Improved Environment
- Warm Handovers



Therapeutic Inpatients

Improved Environments;

- Male PICU upgrade
- Ward Redecorations
- 1st phase of En-suite anti-ligature works

Commenced PiPA roll out on two wards

Reduced length of stay

Rehab Pathway

Expanded CERT

Successfully discharged 29 patients from out of area rehab settings

Commenced final design stage of Level 2 female Rehab Ward

Data Quality

Implemented the Urgent Care Data Quality Improvement plan across CAP, Liaison, Hub and Crisis.

Notable improvements in quality of clinical and performance data.

25/26 Top Good News Stories: DMH

Making a difference, together

For use in eNews, the outstanding practice section of the AAA report and to celebrate success/share learning

Successful Neighbourhood Mental Health Centre bid

We were successful in securing £925k of mental health capital investment to develop a **neighbourhood mental health centre at Fearon Hall in Loughborough**. This approach will enhance the building to be more accessible and provide a venue to deliver care and support from in an area of high need.

Community Response Framework developed

Neighbourhood Leads, Samaritans, LLR Local Resilience Forum and Leicestershire Police collaborated to create a framework and guidance to support development of trauma informed **community response plans** to support individuals post incident.

Improving signposting to the right support

A range of tools have been developed to help professionals quickly identify the most appropriate commissioned support for individuals. This includes the new **'At a Glance' tool**, which brings together information on all commissioned services in a clear, concise format to improve accessibility and decision-making**.**

Understanding barriers to psychological support in diverse communities

As part of our **health equity approach**, x3 VCS organisations were funded and have worked with City East CMHT and Neighbourhood Leads to engage with local people through focus groups to inform how access, experience and outcomes to mental health could be improved for diverse communities.

25/26 Top Good News Stories: DMH

Making a difference, together

For use in eNews, the outstanding practice section of the AAA report and to celebrate success/share learning

BAU for DMH Estates Needs

The creation of a model that enables teams to identify the amount and type of space needed to meet their needs has directly led to City East being able to utilise the space at St Peters without the need for capital works and also the identification of a new base for City West in partnership with Estates.

Dialog+

Pilot of Dialog+ has been extended across 7 teams including 3 NHMT's, and 1 MHSOP team. This has generated significant learning both in terms of SystmOne and also the quality of care plans. Service user feedback has been extremely positive

MaST

Capital funding prioritised for 26/27 with implementation of MaST due to commence from April 2026.

25/26 Top Good News Stories: FYPCLDA

Making a difference, together

For use in eNews, the outstanding practice section of the AAA report and to celebrate success/share learning

Community Paediatrics

Whilst you wait digital communication shared with Children and Young people who have been waiting longest.

Roll-out of digital ADHD Medication reviews to commence from end of March 2026.

North-West Leicestershire – successful pilot for consecutive ADHD medication reviews via PCN.

Digital/Outcome measures

Digital

Members of the digital team and specialist autism team delivered a spotlight talk on the use of their Guidance package for delivering workshops and the impact of this on their waiting list. The introduction of the digital workshops reduced the wait from over a year to 1 week within the SAT team.

Outcome Measures

Care Plan Visualisations- the CAMHS care plans have been reviewed and updated with outcome measures embedded in the care plan. A visualisations dashboard has been built in the EPR to improve user interface and reduce the admin burden on staff completing the care plans. Staff feedback has been positive, and the service are closely monitoring the impact.

Adapted Goal Based Outcome Measure (GBO)- The leads have worked directly with Professor Duncan law who is the author of the GBO to adapt this tool to make it more user friendly and accessible in the EPR. Further work is continuing to produce a toolkit to improve accessibility for people with a learning disability and/or autism.

Reducing Health Equalities

Rollout of Thinking AHEAD app across the Directorate via group training sessions and a Change Network session .

Training delivered via:-

- LDA THRIVE meeting.
- Group 1 Extended Leadership - Performance & Workforce meeting.
- Group 2- Thursday 9am call.
- Change Network on 6th August to 17 members of FYPCLDA.

Safer Caseloads

Process devised to identify service users waiting over 40 weeks.

While you're waiting CAMHS booklet available to support children and young people via the LPT website and Health for Teens website.

25/26 Good News Stories: Estates

Making a difference, together

For use in eNews, the outstanding practice section of the AAA report and to celebrate success/share learning

Installation of Solar Panels

PV (Solar) panels have been installed across the Estate at Herschel Prinz; Gwendolen House, The Evington Centre and Coalville Community Hospital.
This will contribute to lower energy bills and our reduction in CO_2 emissions

NHS Forest

60 tree saplings have been planted at Coalville Community Hospital as part of the NHS Forest initiative. The trees were provided to the Trust free of Charge.

Electric Vehicles

The Trust is beginning to transform its vehicle fleet – moving over to Electric Vehicles.
The Trust Transport and Logistics Team have 2 EV Ford Transits and Charging infrastructure based at Meridian

PLACE

PLACE results for 25/26 indicated that that LPT had scored well compared to its peers. We are in first place, scoring 100% for Cleanliness and 3rd place for Food at 95.22%

WeArePMO
Programme Management Office

Spotlight Reports

Caseload Review 2025-2026 plan

Leicestershire Partnership NHS Trust

Output Summary

- **Caseload reviews**: Focus on outpatient teams with high workloads due to short-term locums.
- **Initial scope**: Start with the Melton team, then review North West Leicestershire, City West, and City East.
- **Objectives**: Identify patients suitable for discharge and optimise discharge planning.
- **Referral backlog**: Address routine referrals from the Central Access Point (CAP) through dedicated triage review sessions.
- **Dual approach**: Reduce existing caseloads while managing ongoing high referral volumes.
- **Governance**: Oversight by a multidisciplinary team (consultants, nurses, operational leads, Lived Experience Partner, admin staff, Neighbourhood Lead).

Why we are proud

- Established a Governance Group (Apr 2024) with clinical leaders, managers, lived experience partners, and nurses - ensuring reviews are clinically safe and strategically prioritised.
- Demonstrated cross-team collaboration, with City Central, City East, City West, and NW teams all engaged in discussions about process and learning.
- Embedded patient-centred practices (lived experience partners contributing to FAQs, letters, and discharge processes).
- Overall reduction in caseloads, improving manageability for staff and ensuring safer, more focused care for patients
- Overall achievements per team progress map slide.

How we plan do it

1. Streamline current caseload review template focusing on discharge needs
2. Allocate medical staff for paper-based reviews at Melton OP
3. Identify medical workforce for Melton discharge clinics.
4. Assess need for additional clinical nursing support at Melton discharge clinics
5. Allocate administrative resources to manage patient bookings and
6. Build template in S1 to carry out reviews and track outcomes
7. Repeat Steps 2 to 5 for additional teams

Outcomes and Impact

- **Significant caseload reductions** achieved:
- South Leics: **–470 cases** since Aug 2022.
- Charnwood: **–203 cases** since Apr 2024.
- City Central: Consultant caseload **–50 cases**.
- **Discharge decisions supported by evidence**:
- South Leics (2023): **39% possible discharge**.
- City Central (2024): **39.8% identified for discharge**.
- Melton (2025): **47.6% of reviewed cases for discharge**.

Staff and Patient Feedback

- Discharge FAQ and discharge letter co-produced with lived experience partner. This was well received by patients who felt assured on discharge, particularly regarding their future care and benefits.
- Themes from reviews shared with Neighbourhood leads to ensure support offered if relevant and available locally.
- Feedback from staff suggested our FAQ along with our discharge letter was helpful and a request was made to use this for all discharges, not just discharges as part of caseload review.

Next steps

- Identification of a number of patients for Nurse led discharge
- Identification of patients needing urgent care
- Overall net Reduction in caseloads.
- Reduction in backlog of routine referrals for triage
- Tailored Discharge letters and FAQ's for each team carrying out reviews.
- Continue to measure outputs

PEER SUPPORT WORKER Spotlight Report

Leicestershire Partnership NHS Trust

Output Summary

Leicestershire Partnership NHS Trust (LPT) recruit people with lived experience of mental health as dedicated Peer Support Worker.

The Peer Support Workers use their personal experiences of mental health challenges in local services to bring hope to current service users. Peer Support Workers empower individuals to take control of their own recovery journey and taking steps to towards building the life they want.

"Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing symptoms or problems" (Laurie Davidson, Recovery Devon)

A Peer Support Worker is someone who has their own experience of mental health challenges and who usually has received support from secondary mental health services. Peer Support Workers bring their own unique perspectives on recovery, and what it takes to live with mental health challenges.

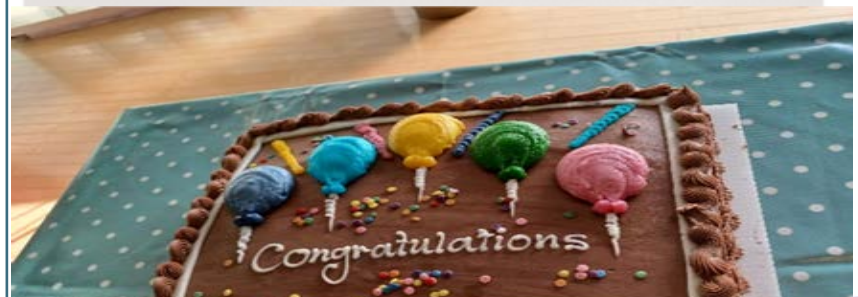
This personal experience can help others on their recovery journey, through promoting hope, providing support based on similar experiences and mutual learning.

Peer Workers are recruited because of their journey, experiences and their passion to support others.

A PEER SUPPORT WORKER IS:

- ❑ A person with lived experience of mental health challenges
- ❑ Someone who is employed specifically as a result based of skills and knowledge gained through their lived experience
- ❑ An individual who is passionate about motivating, inspiring and encouraging others to believe in their own potential and their own strengths
- ❑ Someone who is a valuable part of the multi-disciplinary team, committed to supporting people to improve their health and wellbeing
- ❑ Someone who works collaboratively allowing the individual to take control of their own recovery journey
- ❑ Someone who does not judge or make assumptions about a person

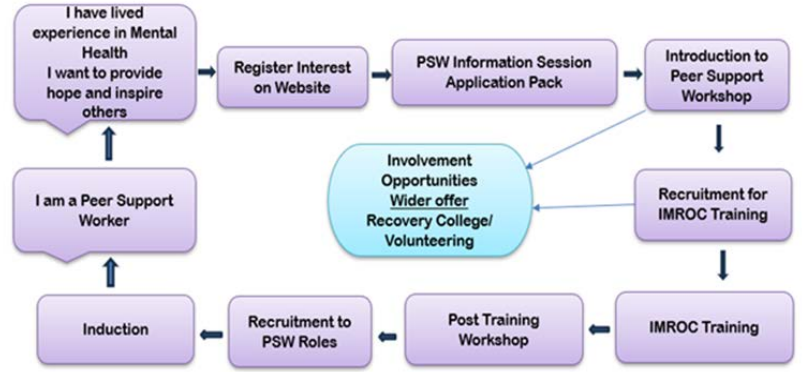
Post Training Workshop Celebrations



ImROC Training (Implementing Recovery through Organisational Change)

- ❑ Peer Support training aims is to improve the lives of people living with long term conditions by expanding access to peer support that is accessible, meaningful, effective and empowering, all centred around the person they support.
- ❑ Aims to ensure that peer support is fully understood by employers as a distinct and complementary contribution, by peer support workers who are well supported and supervised in work, and supporting organisations to influence and grow recovery focused, trauma informed and equitable culture and systems.
- ❑ Training provides learning space aiming to equip trainees with a strong understanding and commitment to providing values led support.
- ❑ The Peer Training courses offer a pathway of development to support individuals on their journey from someone in the receipt of support through the transition to supporter and then as their career progresses.

LPT Peer Support Pathway



CAP Improvements Spotlight Report

Leicestershire Partnership NHS Trust

Project Summary

Over the past year the Central Access Point (CAP) has delivered major improvements, including a significant expansion of mental health call-handling capacity, the rollout of NHS 111 Option 2 as a single, easy route into crisis support, and the introduction of digital mental health chat to widen access. These changes have driven measurable gains in performance, with faster call-answering, reduced abandonment, and more consistent, clinically robust triage. Together, these developments have strengthened the whole crisis pathway, improved patient experience, and reduced avoidable pressure on emergency and acute services.

Strength to Strength

Why we are proud

We are proud of this progress because it reflects real resilience and commitment across our teams. The journey hasn't always been smooth — we've faced staffing pressures, technology challenges, and periods where performance dipped — but each setback pushed us to strengthen our approach, learn quickly, and adapt.

Finishing the year with stronger access, better responsiveness, and a more reliable crisis pathway shows how far we've come, and it gives us confidence as we move into the next phase of improvement.

What we did

Apr-20	2022	Jul-05
MHCAP established with VCSE crisis support provided by TP	Introduced safe and well calls due to increased volumes and ensure safety	Re-located to Anstey Frith House due to team expansion
Apr-24	**Nov-24**	**Jan-25**
NHS 111 MH Option implemented	New TP contract for call handling commenced	Soft launch of Chat Mental Health
Apr-25	**Jul-25**	**Sep-25**
Hard launch of Chat Mental Health	Merged local 0808 line with NHS 111 line	Crisis SPA night calls now routed through MHCAP

Outcomes and Impact

- More trained staff now support 24/7 crisis lines.
- Increased resilience has reduced call abandonment and improved response times.
- People can now call 111 and select Option 2 to reach local mental health crisis teams directly.
- Digital access has expanded through the rollout of online mental health chat, giving people an alternative to phone-based crisis support.
- With more staff, better digital tools, and clearer pathways, call-handling performance has improved
- Triage processes have become more reliable and clinically robust

Staff and Patient Feedback

"It's been a challenging year, but seeing our call response times improve has made all the hard work worth it."

The person I spoke to really listened and helped me feel calmer.

"The new triage processes mean we can get people to the right support faster, and that's something we're genuinely proud of."

Next steps

- Complete the TUPE of staff over from Turning Point and embed the expanded call-handling workforce so performance remains stable through peaks in demand.
- Continue refining NHS 111 Option 2 so it becomes the default, trusted route into crisis support for the public and partners.
- Strengthen supervision, coaching, and reflective practice for call handlers and clinicians to maintain quality as the service grows.
- Improve handover processes between call handlers, crisis teams, home treatment teams, and inpatient units so people experience a seamless pathway.

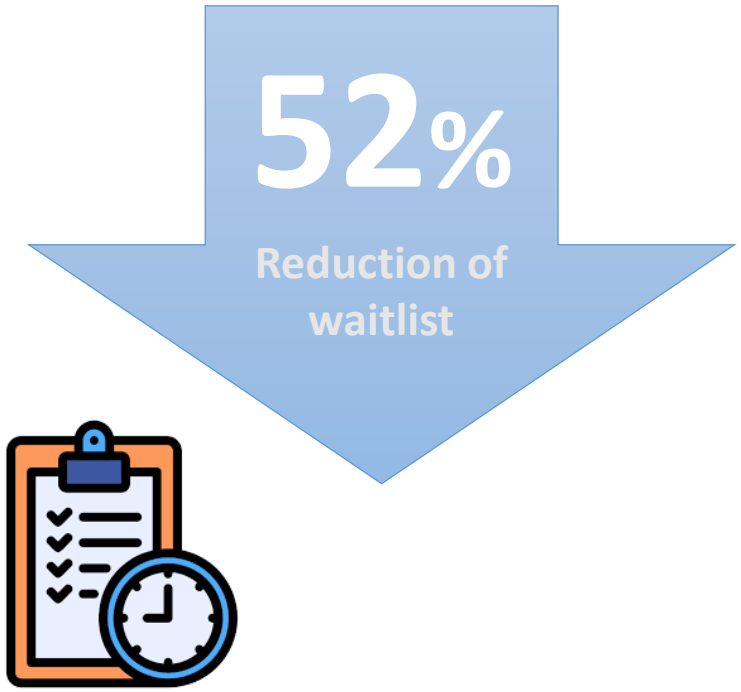
TSPPD Waitlist Initiative – Spotlight Report

Leicestershire Partnership NHS Trust

Output Summary

Therapy Services for People with Personality Disorder (TSPPD) was facing a **significant challenge**, with a waitlist peaking at **585 people before February 2025 w**ith **referrals continuing to rise**, the team recognised the need for a new approach to manage demand and improve access.
Introducing the **Waitlist Initiative** as part of enhanced operational planning.
This innovative approach included:

- Use of EPR to define treatment needs to streamline process
- Prioritising cases based on clinical need. - Waiting list has been divided into who requires which TX offer
- Enhancing team collaboration and capacity planning – through TSPPD consulter meetings & professional meetings
- Using a digital offer to streamline process- New SDS with digital materials launched across the county to improve flow.



Why we are proud

- Turning the waitlist **challenges into a transformation**
- **Designing and delivering** the Waitlist Initiative – using a proactive solution that has already shown measurable impact.
- **Collaboration and commitment** across the team and directorate – the senior management team sharing the same vision has been vital to its implementation and progress across the team.
- **Achieving a 52% reduction** in 5 months. – The pace as which the team have managed to implement change and achieve this.
- **Digital Innovation** – using the digital offer to help assist.

What we did

- Looking at the root cause
- Collaboration across the system and a shared system-wide vision/solution
- TSPPD Senior Management team pulling together with a shared mission.
- Team enhanced its operational planning to work on this.
- Weekly task groups as well as using time in operational meetings to focus on this.

Outcomes and Impact

•Waiting list previously remained static at approximately 1000 people.
•In just **five months**, the waitlist has been reduced from 585 to approximately **280** – a **52% reduction**.
•Service users are now moving through the pathway more quickly and effectively.

Staff and Patient Feedback

- Contact with patients have been very positive
- We have worked together and really felt more motivated and organised by this initiative
- We have had to challenge ourselves in terms of new ways of working

Next steps

- Sustain and continue with the waitlist initiative.
- Share learning
- Focus on outcomes for service users and review of F&F results and bespoke to the digital offer also.
- Plan for future demand and continue embedding into Business as usual.

Health Inequalities – Respiratory and Breathlessness focus

Leicestershire Partnership NHS Trust

Project Summary

All CHS services to use of data insight within services to identify and address health inequalities, supported by the Thinking AHEAD app.
Embed health inequality considerations into all Continuous Improvement and Transformation initiatives, particularly those affecting access, experience, and outcomes.
The work aligns with Together We Thrive and the NHS Long Term Plan, positioning the Trust to demonstrate clear, organisation-wide action on health inequalities as Integrated Health Organisations develop.

Why we are proud

All CHS services have actively engaged with the project, reviewed areas of focus, engaged with staff and patients to understand challenges and improvement ideas.
As the work progresses there have been incremental improvements in DNA's being seen in services

What we did

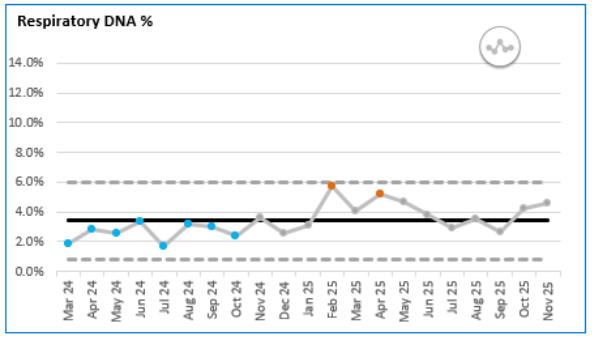
Respiratory:

Service increased clinic spaces across LLR to support access to service and equity in service provision.
Service attendance at MDT meetings with UHL, EMAS, social prescribing to review; patients who are DNA, patient that decline input, patients that might have housing challenges or financial issues.
Service increased presence in rehab venues and GP practices.
Respiratory case finding project to identify patients who are at risk of admission over winter and provide proactive support before the period arrives, resulting in hospital admission avoidance. (Engagement and feedback from lived experience partners helped inform proposal.)

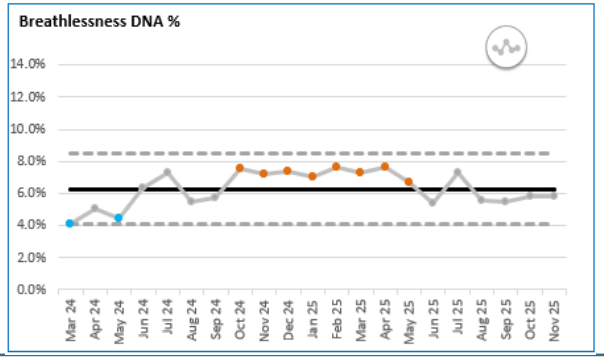
Breathlessness:

Engagement with GP practices - awareness of service pathways.
Webpage updated to include more information - service provision and updated service education - material up to date/user friendly.
QR codes added to waiting list letters that takes patient to service webpage for further guidance.
Patients that DNA'd were contacted to attend workshop to understand barriers in accessing the service, outcomes reported through EQOC.
Health and wellbeing promotion events with social prescribing team to raise awareness of service and increase access.
Review of PRISM referral form to mitigate referrals being incorrectly sent to UHL.
Service have created 'Right 2 Rehab' video that's published on the Chartered Society of Physiotherapy website, video below highlights long covid patient journey and aims to increase awareness of service, further detail within the following link
https://www.csp.org.uk/blog/2025/11/helping-people-breathe-live-better

Outcomes and Impact



DNAs staying below peak with marked improvements between July and Sept.



DNAs staying below peak with marked improvements since August

Staff and Patient Feedback

Engagement and feedback from lived experience partners helped inform respiratory case finding project proposal.

Patients that DNA'd were contacted to attend workshop to understand barriers in accessing the service, outcomes reported through EQOC.

Table top exercise with staff to determine areas of focus for services just commencing use of Thinking Ahead app

Next steps

To continue as a project with three project groups for next year:

- Embed Thinking Ahead app within CHS services
- In depth DNA analysis within CHS services
- Reaching out to communities (to understand challenges attending appointments)

L

Leicestershire Partnership NHS Trust

Alert, Advise and Assure Highlight Report

Finance and Performance Committee – 23 April 2026

Meeting Chair and Report Author – Melanie Hall / 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
			No issues to highlight	

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
LPT & NHFT Collaborative, Commissioning and Contracting Group Triple A Report	FPC/26/040	Group Director of Strategy and Partnerships	Three alert items were reported, the first related to the on-going financial sustainability of the IMPACT collaborative as previously discussed, and work continued to resolve the position. The second issue was around quality and safety aspects at a medium secure hospital in Northamptonshire where NHS England was working to find a solution. The third item related to quality concerns raised about a community provider for people living in LLR with learning disability and autism. Local authority and commissioners were working to resolve these. Assurance was received that the alert item raised at the previous FPC meeting around lack of clarity on SDF funding had been resolved and was not a risk in terms of the opening contract value for 2026/27.	BAF11

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Accountability Framework Meeting Triple A Report	FPC/26/041	Managing Director / Deputy CEO	A review was underway with the ICB and HEIM on current ADHD pathways with a view to identifying improvements based on learning from other Trusts. FPC and QSC chairs had agreed with the Director of Governance and Risk that a joint FPC and QSC update on ADHD pathway developments would best be served by inclusion in a future Board development workshop as both committees addressed the issue from different perspectives.	N/A

ASSURE: Inform the Board where positive assurance has been received

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Board Assurance Framework	FPC/26/031	Director of Governance and Risk	FPC received assurance that robust systems were in place to secure an effective risk framework. The only significant change for 2026/27 was the addition of BAF12 which related to NHS reforms and enhanced national performance oversight.	BAF10 BAF11 BAF12
Summary of Draft Annual Accounts 2025/26	FPC/26/034	LPT Chief Finance Officer	LPT had achieved all of its statutory duties around revenue and capital and its secondary duties for cash and Better Payment Practice Code, key points to note; • Underspends in CHS and FYPC had offset the overspends in DMH and LDA. • An overspend of corporate reserves was reported due to unmet planning assumptions and VAT liabilities. • Substantive pay costs had increased in-year partly due to planned increases in substantive staffing to cover the left shift of staff from bank and agency. A detrimental impact from national insurance and pay award increases had also been seen. • Agency spend had reduced year on year. The highest recorded spend had been in 2022/23 at £33m and a reduction of 71.5% had been seen in agency spend since then. • The capital plan had been delivered, the operational capital expenditure for the year was £15.9m excluding IFRS16 lease costs. The capital expenditure risk reported under 'advise' in February FPC's triple A report to Board had been fully mitigated. • The closing cash balance for 2025/26 was £21m which gave 18 days of operational cash against a plan of 11 operating days.	BAF10 BAF11

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
			• The draft accounts would be submitted to NHS England on 27th April and the external audit would commence on 5th May. The Board was expected to approve the accounts at its EGM on 24th June prior to final submission on 26th June. • FPC would receive a further update on loss-making services in August, responding to the advise item raised in February's Triple A report.	
Patient Level Costing Information System (PLiCS) and Update on Community Currencies	FPC/26/035	LPT Chief Finance Officer	FPC was fully assured on the approach taken to completing the PLiCS submission. Discussion took place on the challenges and approach to applying community currencies in the future.	BAF11
Purchasing Card and Purchasing Via the Internet Policy	FPC/26/036	LPT Chief Finance Officer	The policy had undergone a routine review and no major changes had been made. FPC approved the policy subject to a couple of very minor amendments.	BAF11
Deep Dive into Neighbourhoods	FPC/26/039	Group Director of Strategy and Partnerships	An update was received on development of neighbourhoods in LLR, noting there were more than twenty neighbourhoods in LLR and Northamptonshire. FPC noted positive aspects included good community understanding and relationships, a very strong mental health neighbourhood focus particularly through the work of LPT's mental health teams, good engagement from local authorities and commitment from the system. Work was progressing on trying to replicate good progress across all areas and the challenges around use of community assets.	BAF02
Board Performance Report M1 2026/27	FPC/26/042	LPT Chief Finance Officer	• Children's Audiology had moved to special cause improvement and was on track with its improvement trajectory. • LD Health Checks completed year to date was reported at 84% against a target of 75%. LPT had been recognised nationally for delivery in this area. • A number of access targets had improved this month, DMH had made improvements to performance in two out of its four targets and ADHD was continuing its long term trend of improvement. CHS CINSS performance had improved this month. • Over 52 week waits in DMH were reporting a consistent position with previous months and most of the long term trends were decreasing. FYPC was reporting a similar position to previous months with the exception of Community Paediatrics Assessment in ND and Treatment waits. • An update on progress of implementation of SNOMED was received noting the new approach being taken for 2026/27. A comprehensive update would be presented to the August FPC meeting.	BAF04

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Overview of Exercise Echo One – Pan ICS Cyber Tabletop Exercise	FPC/26/044	Head of EPRR	FPC received a comprehensive update on the exercise and lessons learnt and took full assurance from LPT's approach and action plan. There was discussion on how best to keep FPC updated on cyber risk management activity, in addition to the summarised triple A report from the Data Privacy Group. A proposal to bring a consolidated 6 monthly deep dive was agreed to support FPC in oversight of BAF01 (*cyber and data security disruption*).	BAF01
Deep Dive into Key Strategic Estates Projects	FPC/26/047	NHFT Chief Finance Officer	FPC took assurance from a detailed paper demonstrating the ambition and complexities in the strategic estates plan and the work ongoing for 2026/27. Future updates would be developed and provided through the Estates and Medical Equipment Group triple A report.	BAF09

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

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Accountability Framework Meeting Triple A Report	FPC/26/041	Managing Director / Deputy CEO	NHS England had awarded £166k to support the development of a digital medicines reconciliation service integrated with LPT's electronic prescribing and medicines administration system provider. This funding would enable the implementation of a more streamlined, standardised and digitally enabled approach to medicines reconciliation.	N/A
Transformation and QI Delivery Group Triple A Report	FPC/26/043	Managing Director / Deputy CEO	An end of year review had been carried out and a number of celebrating outstanding items were reported which was testament to the huge amount of excellent work that was taking place across the Trust. They included; • Community nursing wound care planning • Innovation in the Breathlessness Service • The overhaul of DMH's crisis pathway • CHS's self care pilot • The community currencies programme within specialist palliative care • Roll out of Airmid, the Brigid app and e-prescribing projects.	N/A

Leicestershire Partnership NHS Trust

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Trust Finance Report for the period ended **30 April 2026**

For presentation at the **TRUST BOARD MEETING 26 May 2026**

Contents

Executive dashboard - overall performance against targets

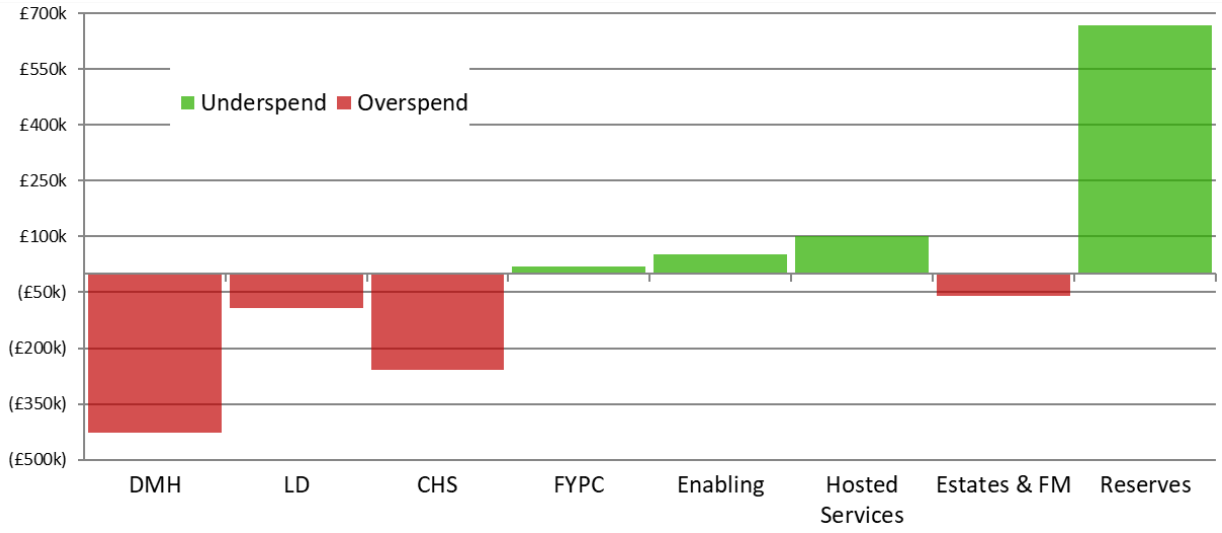
Statutory targets	Year to date	Year end f'cast	Comments	Further detail
1. Income and Expenditure break-even.	G	G	The Trust is reporting a YTD deficit of £0.52m at the end of April (in line with plan). The forecast year end position is currently a breakeven, also in line with plan.	APP. A
2. Remain within Capital Resource Limit (CRL).	G	G	The YTD capital spend for April is £203k, which is within funding limits.	APP. F
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	G	The reported YTD I&E deficit for April is in line with plan. The planned breakeven is forecast to be achieved.	SUMMARY REPORT
5. Achieve Efficiency Savings targets.	G	A	Savings at the end of month 1 (April) are £1.35m, on plan. The £27.6m target for the year is expected to be delivered, however further development of directorate schemes is required to assure full delivery of their individual targets.	APP. B
6. Manage agency staff spend in line with plan	A	G	YTD agency spend at the end of April is £552k. This is higher (£76k) than planned YTD spend, but remains within the NHSE agency spend cap (on pro-rata basis).	APP. C
7. Comply with Better Payment Practice Code (BPPC).	G	G	Cumulatively and in month the Tust achieved all of the 4 BPPC targets.	APP. E
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 £25.7m at the end of April. This is £6.98m above planned cash levels. The planned cash forecast for the year is £13m.	APP. G
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. April's cash level of £25.7m was 22 days.	APP. G
10. Deliver capital investment in line with plan	A	G	YTD capital expenditure is £203k. This is below planned spend for the month. See 'Capital Section' in summary report.	APP. F

Summary report – financial position as at 30 April 2026

YEAR TO DATE POSITION

- The overall year-to-date income and expenditure plan (being a planned YTD deficit of £522k) has been achieved at the end of April.
- Within the wider position, the collective year-to-date operational budget position shows an overspend (£667k).
- Central reserves are underspent by £667k, offsetting the operational overspends and delivering the overall balanced position for the Trust. The individual directorate variances can be seen in the table below:

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



DIRECTORATE POSITION SUMMARY

Note that as per standard practice within the Trust, only high level financial reporting is undertaken for month 1, due to the draft status of the prior year final accounts and the ongoing financial audit. Detailed variance analysis information is therefore not available, however key emerging directorate issues are outlined below:

- **The Mental Health Directorate** is £428k overspent at the end of month 1. This includes a £187k overspend against medical staffing budgets, with the majority of the remainder caused by slippage against CIP efficiency target budgets.
- **The Community Health Service** is £257k overspent. This predominantly relates to CIP efficiency target budgets not being met, particularly where these have been profiled in equal 12ths across the year.

- **The FYPC** financial position at month 1 shows an underspend of £18k. Whilst specific efficiency scheme targets have slipped, the current level of vacancy underspends is sufficient to offset any CIP target negative impact.

- **The LDA** financial position is £92k overspent. This is due to overspends within the Agnes Unit relating to the DMH patient, and also slippage against CIP targets.

- **Enabling budgets** are underspent by £52k. This is due to a high level of vacancies. CIP delivery is on target for M1.

- **Estates budgets** are overspent by £60k. This is directly due to initial CIP scheme slippage.

- **The Central Reserves position** is underspent by £667k. The reserves year-to-date budget for month 1 (aligned to our plan phasing across the year) is a £522k deficit. The actual reserves position is a net I&E surplus of £145k gain due to one-off technical adjustments. This results in the £667k favourable variance against the month 1 deficit budget, which offsets the combined directorates' overspend.

FORECAST INCOME AND EXPENDITURE POSITION

- The forecast for the end of the year remains in-line with plan at this stage of the year, with no material deviations anticipated. The phasing of the income and expenditure position across the year assumes a consistent improvement each month, beginning with the April planned deficit of £522k, rising to a £542k surplus for the month of March 2027. This delivers our overall break-even for the year (as shown in the table below). However the reliance on continual improvement (e.g via CIP schemes coming on line) does present significant risk. All directorates continue to develop CIP schemes to ensure 100% of schemes are classed as fully developed by 28th May, in line with NHSE expectations.

- The overall Trust monthly surplus / deficit planned positions are as follows:

	Actual M1 £000	*Forecast M2 £000*	*Forecast M3 £000*	*Forecast M4 £000*	*Forecast M5 £000*	*Forecast M6 £000*	*Forecast M7 £000*	*Forecast M8 £000*	*Forecast M9 £000*	*Forecast M10 £000*	*Forecast M11 £000*	*Forecast M12 £000*	*Year 26/27 £000*
Monthly surplus / (deficit)	(522)	*(477)*	*(422)*	*(362)*	*(202)*	*(100)*	*118*	*218*	*323*	*398*	*486*	*542*	*0*
Cuml. YTD surplus / (deficit)	(522)	*(999)*	*(1,421)*	*(1,783)*	*(1,985)*	*(2,085)*	*(1,967)*	*(1,749)*	*(1,426)*	*(1,028)*	*(542)*	*0*	*0*

Finance Report for the period ended **30 April 2026**

APPENDICES

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 30 Apr 2026	YTD Actual M1 £000	YTD Budget M1 £000	YTD Var. M1 £000
Revenue			
Total income	38,023	36,476	1,547
Operating expenses	(38,195)	(36,649)	(1,547)
Operating surplus (deficit)	**(172)**	**(172)**	**(0)**
Investment revenue	50	50	0
Other gains and (losses)	0	0	0
Finance costs	(165)	(165)	0
Surplus/(deficit) for the period	**(287)**	**(287)**	**(0)**
Public dividend capital dividends payable	(235)	(235)	0
I&E surplus/(deficit) for the period (before tech. adjs)	**(522)**	**(522)**	**(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	**(522)**	**(522)**	**(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:	**(522)**	**(522)**	**(0)**
Trust EBITDA £000	**814**	**814**	**(0)**
Trust EBITDA margin %	**2.1%**	**2.2%**	**-0.1%**

APPENDIX B – Efficiency savings performance

At the end of month 1, CIP performance is reported in line with the year-to-date plan which is delivery of £1.4m total savings. There are some shortfalls within year-to-date directorate targets which are being offset by corporate schemes over-delivery.

Forecast savings for the year are reported in line with the planned £27.6m savings target. Presently £3.3m of the annual savings is assumed to be delivered through additional staff rationalisation schemes currently being explored.

CIP year-to-date performance and forecast by directorate

	M1 YTD PERFORMANCE (£'000			FORECAST OUTTURN (£'000)		
Directorate	**YTD plan**	**YTD actual**	**YTD variance**	**Annual Plan**	**FOT**	**Variance**
DMH	466	343	(124)	6,795	5,509	(1,286)
CHS	305	233	(72)	5,434	4,303	(1,130)
FYPCLDA	237	237	0	4,980	4,302	(678)
Enabling & HIS	235	235	(0)	2,119	2,168	49
Estates	215	155	(60)	2,574	2,284	(290)
Corporate / contingency	(111)	144	256	5,726	5,726	0
Unallocated Trust plans-in-progress					3,334	3,334
Grand total CIPs	**1,347**	**1,347**	**0**	**27,628**	**27,628**	**0**

APPENDIX C – Agency expenditure

Dir.	2026/27 Agency Expenditure	25/26 Outturn £000s Actual	25/26 Avg mth £000s Actual	26/27 M1 £000s Actual
DMH	Consultant Costs	-3,671	-306	-276
	Nursing - Qualified	-1,419	-118	-65
	Nursing - Unqualified	-79		0
	Other clinical staff costs	-19	-2	0
	Non clinical staff costs	0	0	0
	Sub-total - DMH	**-5,188**	**-426**	**-341**
LD	Consultant Costs	0	0	0
	Nursing - Qualified	-104	-9	-45
	Nursing - Unqualified	-19		-7
	Other clinical staff costs	0	0	0
	Non clinical staff costs	0	0	0
	Sub-total - LD	**-123**	**-9**	**-52**
CHS	Consultant Costs	-118	-10	0
	Nursing - Qualified	-2,719	-227	-103
	Nursing - Unqualified	-179		-16
	Other clinical staff costs	-112	-9	-5
	Non clinical staff costs	0	0	0
	Sub-total - CHS	**-3,127**	**-246**	**-125**
FYPC	Consultant Costs	-139	-12	0
	Nursing - Qualified	-601	-50	-29
	Nursing - Unqualified	-29		-3
	Other clinical staff costs	-4	0	0
	Non clinical staff costs	0	0	0
	Sub-total - FYPC	**-773**	**-62**	**-32**
ENAB/ ESTS/ HOST	Consultant Costs	0		0
	Nursing - Qualified	41	3	0
	Nursing - Unqualified	5		0
	Other clinical staff costs	5	0	0
	Non clinical staff costs	-224	-19	-2
	Sub-total - Enab/Host	**-172**	**-16**	**-2**
TOTAL TRUST	Consultant Costs	-3,927	-327	-276
	Nursing - Qualified	-4,803	-400	-242
	Nursing - Unqualified	-300	-25	-26
	Other clinical staff costs	-130	-11	-5
	Non clinical staff costs	-224	-19	-2
	Total	**-9,383**	**-782**	**-552**

Agency spend for April (month 1) is £0.55m. This is higher than the planned spend of £0.48m.

The average monthly agency spend last financial year was £0.78m.

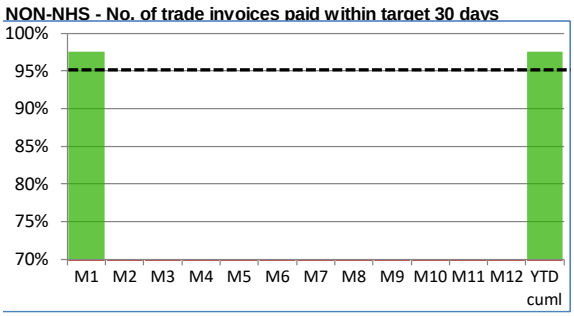
LPT planned spend for the year is £4.9m. The NHSE agency spend cap is £6.7m for the year. Phased in equal 12ths the cap would equate to monthly spend of £0.56m, putting the M1 spend just within the cap if applied on a pro-rata basis.

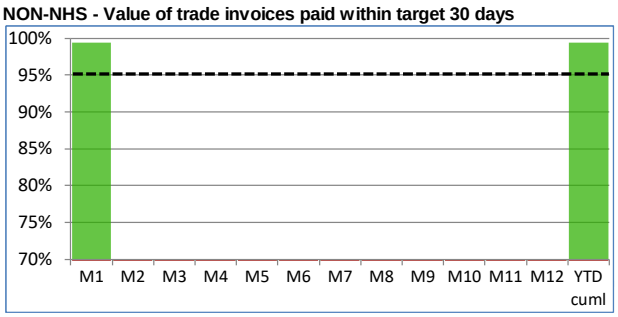
APPENDIX D – BPPC performance

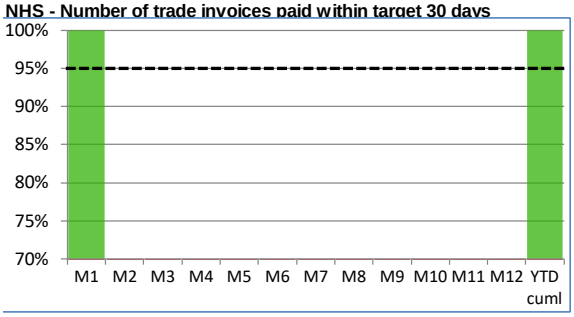
The specific BPPC target is to pay 95% of invoices within 30 days. The Trust achieved all 4 cumulative targets relating to the value and the number of invoices paid within the target period, split between NHS and Non-NHS invoices.

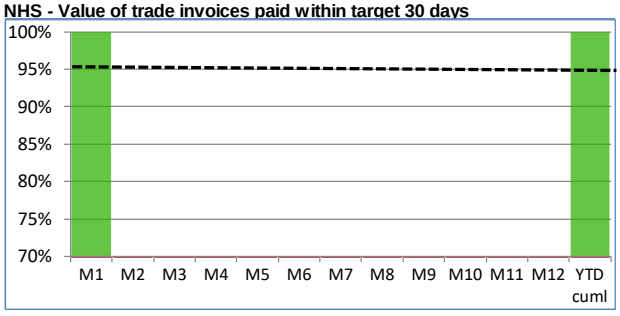
Better Payment Practice Code	April (Cumulative)	
	Number	£000's
Total Non-NHS trade invoices paid in the year	1,572	11,086
Total Non-NHS trade invoices paid within target	1,534	11,021
% of Non-NHS trade invoices paid within target	**97.6%**	**99.4%**
Total NHS trade invoices paid in the year	30	5,406
Total NHS trade invoices paid within target	30	5,406
% of NHS trade invoices paid within target	**100.0%**	**100.0%**
Grand total trade invoices paid in the year	1,602	16,492
Grand total trade invoices paid within target	1,564	16,427
% of total trade invoices paid within target	**97.6%**	**99.6%**

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









APPENDIX E - Capital Programme 2026/27 update

Trust Board has approved an opening capital plan of £19.8m. This includes £8.5m Operational Capital, £6.8m PDC funding to support Constitutional Standards & Left Shift schemes (which has not yet been fully approved by NHSE), and Estates Safety Critical Infrastructure Risk (CIR) funding of £1.55m. The plan also includes the deferred Mental Health Out of Area Placements (OAPs) funding of £1.8m from 2025/26.

	Annual Revised Plan	Apr Actual	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation	11,817	203	11,817	0
Cash reserves	779	0	779	0
Capital borrowings repayments	(4,117)	0	(4,117)	0
Total System operational capital	**8,479**	**203**	**8,479**	**0**
IFRS-16 new leases	**1,040**	**0**	**1,040**	**0**
MH OAPS - Deferral from 2025/26	1,800	0	1,800	0
Constitutional Standards/Left Shift	6,821	0	6,821	0
Estates Critical Infrastructure Risk (CIR)	1,550	0	1,550	0
National Programmes (PDC)	**10,171**	**0**	**10,171**	**0**
PFI capital lifecycle costs	**131**	**0**	**131**	**0**
Total Capital funds	**19,821**	**203**	**19,821**	**0**
Application of Funds				
Estates	**£'000**	**£'000**	**£'000**	**£'000**
Strategic schemes	0	0	0	0
Capital staffing	(510)	(25)	(510)	0
Estates backlog programme	(3,784)	0	(3,784)	0
Estates rolling programme	(1,420)	0	(1,420)	0
Medical devices	(170)	0	(170)	0
Directorate investment	(11,010)	(20)	(11,010)	0
PFI Agnes Unit capital lifecycle costs	(131)	0	(131)	0
	(17,025)	**(45)**	**(17,025)**	**0**
IM&T investment	**(1,756)**	**(158)**	**(1,756)**	**0**
Operational Capital	**(18,781)**	**(203)**	**(18,781)**	**0**
IFRS16 - Right of Use Leases	**(1,040)**	**0**	**(1,040)**	**0**
Total Capital Expenditure	**(19,821)**	**(203)**	**(19,821)**	**0**
(Over)/underspend	**0**	**0**	**0**	**0**

Capital expenditure to date:

Capital expenditure up to the end of April totals £203,000. This is £1.49m below planned spend of £1.69m for Month 1.

The underspend reflects lower-than-expected spend on work-in-progress projects carried forward from 2025/26 and delays in commencing Public Dividend Capital (PDC) schemes pending final approval, including Constitutional Standards/Left Shift schemes. Spend will increase when approvals are secured and delivery progresses. The Capital team is actively reviewing programme phasing and re-profiling schemes, to ensure all capital duties are met. A monthly capital expenditure forecast will be included in next month's report.

Capital changes since last month:

There was no overall increase in funds in the month, just virements between schemes, as detailed below.

		Opening Plan	Changes	Revised Plan	Comments
		£'000	£'000	£'000	
M01 Position		**(19,624)**	**0**	**(19,624)**	
Changes to Plan over £100k					
Feilding Palmer Boilers	Estates	-210	-126	-336	GMP has been confirmed at £336k, £210k in opening plan
Wakerley Ward refurb	Estates	-900	126	-774	Slippage on scheme used to fund Feilding Palmer shortfall in plan
Net Change in month			0		
Net Change in month < £100k			0		
Net Change in month			**0**		

APPENDIX F SoFP, cash and working capital

PERIOD: April 2026	2025/26 31/03/26 Draft £'000's	2026/27 30/04/26 April £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	135,011	134,515
Intangible assets	3,310	3,190
IFRS16 - Right of use (ROU) assets	19,421	19,224
Trade and other receivables	821	821
Total Non Current Assets	**158,563**	**157,750**
CURRENT ASSETS		
Inventories	461	461
Trade and other receivables	7,155	14,741
Short term investments	0	0
Cash and Cash Equivalents	20,941	25,664
Total Current Assets	**28,557**	**40,866**
Non current assets held for sale	**0**	**0**
TOTAL ASSETS	**187,120**	**198,616**
CURRENT LIABILITIES		
Trade and other payables	(26,927)	(36,478)
Borrowings	(4,958)	(4,974)
Provisions	(5,031)	(4,971)
Other liabilities	(7,701)	(10,520)
Total Current Liabilities	**(44,617)**	**(56,943)**
NET CURRENT ASSETS (LIABILITIES)	**(16,060)**	**(16,077)**
NON CURRENT LIABILITIES		
Borrowings	(39,040)	(38,733)
Provisions	(704)	(704)
Total Non Current Liabilities	**(39,744)**	**(39,437)**
TOTAL ASSETS EMPLOYED	**102,759**	**102,236**
TAXPAYERS' EQUITY		
Public Dividend Capital	112,834	112,834
Retained Earnings	(28,595)	(29,118)
Revaluation reserve	18,520	18,520
Other reserves	0	0
TOTAL TAXPAYERS EQUITY	**102,759**	**102,236**

Non-current assets

Property, plant, and equipment (PPE) amounts to £134.5m, and includes capital additions of £203k, offset by depreciation charges.

Right of Use (ROU) leased assets total £19.2m.

Current assets

Current assets of £40.9m mainly includes cash of £25.7m, and receivables of £14.7m.

Current Liabilities

Current liabilities amount to £56.9m with trade and other payables making up £36.5m of this balance.

Other liabilities of £10.5m relate to £7.7m of deferred income carried over from 2025/26, and nearly £3m of Quarter 1's income.

Net current assets / (liabilities) show net liabilities of £16.1m.

Taxpayers' Equity

April's deficit of £0.52m is reflected within retained earnings.

The Public dividend capital balance is £113m at the end of April.

Cash

The closing cash balance at the end of April is £25.7m; an increase of £4.7m since the start of the year and an additional £7m compared to April's planned cash of £18.7m. This delivers 22 operating cash days - 6 days above the planned level of 16 days for Month 1. Favourable working capital movements both at year-end and in Month 1, including additional deferred income, has resulted in this improved cash position. A detailed cashflow analysis will be provided next month.

Receivables

Current receivables (debtors) total £14.7m, an increase of £7.6m since the start of the year. The increase mainly relates to Quarter 1 accruals and prepayments, which is expected in the first month of each quarter.

Receivables	Current Month April 2026					
	NHS	Non	Emp's	Total	% Total	% Sales Ledger
	£'000	£'000	£'000	£'000		
Sales Ledger						
30 days or less	209	1,929	2	**2,140**	**13.75%**	**57.4%**
31 - 60 days	275	100	6	**381**	**2.45%**	**10.2%**
61 - 90 days	9	22	3	**34**	**0.22%**	**0.9%**
Over 90 days	866	102	206	**1,174**	**7.54%**	**31.5%**
	1,359	2,153	217	**3,729**	**23.96%**	**100.0%**
Non sales ledger	3,624	7,388	0	**11,012**	**70.76%**	
Total receivables current	**4,983**	**9,541**	**217**	**14,741**	**94.72%**	
Total receivables non current		821		821	**5.28%**	
Total	**4,983**	**10,362**	**217**	**15,562**	**100.00%**	

Debt greater than 90 days stands at £1.174m; this is a decrease of £177k 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 1 is 7.54% (last month: 16.79%).

The bad debt provision is now £187k and covers all outstanding Non-NHS debt greater than 12 months.

Payables

The current payables position in month 1 is £36.5m – an increase of £9.6m since the start of the year. Creditor balances are always higher at the start of the financial year. Other liabilities of £10.5m relate to £7.7m of deferred income carried over from 2025/26 (of which the majority relates to Provider Collaborative income and Secure Digital Environment (SDE) funding), and nearly £3m of Quarter 1's income.

Governance Table

For Board and Board Committees:	Trust Board, 26th May 2026
Paper sponsored by:	Sharon Murphy, Chief Finance Officer
Paper authored by:	Chris Poyser - Head of Corporate Finance; Jackie Moore – Financial Controller; Dawn Bennett – Finance Manager (Capital & Technical); Hasmita Thakkar – Assistant Finance Manager (Corporate).
Date submitted:	18th May 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)	BAF 11 - Inadequate control, reporting and management of each Trust's 2026/27 financial position could mean we are unable to deliver our financial plan resulting in a breach of our statutory duties and medium-term financial plan.
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

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Leicestershire Partnership NHS Trust

Public Trust Board – 26th May 2026

Integrated Performance Report – April 2026 (Month 1)

Purpose of the Report

To provide the Trust Board with an overview of Trust performance against an agreed set of KPI's for April 2026 (M1 of 2026/27).

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 Trust Board in their review of the report and looking ahead to the next reporting period:

- The Integrated Performance Report presented to Board and associated committees in May 2026 uses the format and content agreed at Board Development Sessions and EMB.
- Data from SystmOne sourced information is reported from the new data warehouse, named IRIS, as of the 1st April 2026, with the exception of the Looked After Children Metrics located in the FYPCLDA Waiting Times Dashboard. Development of the data for these are metrics are being progressed with a view reporting these from IRIS at the earliest opportunity.
- Trajectories will be added into Exception Pages on a phased approach commencing with the report presented in June 2026
- Metrics based on the Mental Health Core Data Pack (MHCDP) are displaying performance as of Feb-26 in the NHS Oversight Framework Dashboard, as the MHCDP has not been updated at the time of reporting.
- The metric 'No. of episodes of seclusions' is based on a revised definition, as agreed in the wider review of indicators, and now includes ALL episodes of seclusion in the month. As a result this is not directly comparable to previous reporting, which was based on seclusions over 2 hours.

- Metrics in the Operational Planning Dashboard are reported using local data to support timely reporting.
- The calculation for the 'Normalised Workforce Turnover' metric has been updated to align with NHFT.

Summary performance across the Trust's agreed indicators can be found in the Exception Reports Summary / Summary Matrix and Summary Dashboard sections of the Integrated 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 higher values*
  - CINSS (6 weeks) - Incomplete Pathway
- Trend moving from *common cause* to *special cause concerning with higher values*
  - Delayed Transfers of Care
  - The number of patient safety incidents reported within the Trust during the reporting period
  - No of episodes of seclusions
  - Total number of Restrictive Practices
  - All LD - Treatment waits - No of waiters
- Trend moving from common cause to special cause improving with lower values
  - E.coli bloodstream infections
  - Cognitive Behavioural Therapy - Treatment waits - No of waiters
  - Children's Physiotherapy - No of waiters
- Trend moving from special cause improving with higher values to special cause concerning with lower values
  - ADHD (18-week local RTT) - Incomplete pathway
- Trend moving from *special cause improving with lower values* to *common cause*
  - The number of patient safety incidents that resulted in severe harm or death
  - No. of Medication Errors
  - Community Paediatrics - assessment waits over 52 weeks - No of waiters

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.

Assurance on all other metrics remains unchanged**.**

Decision Required

The Trust Board is asked to:

- Approve the Performance Report.

Governance Table

For Board and Board Committees:	Trust Board
Paper sponsored by:	Jean Knight, Managing Director and Deputy Chief Executive Anne Rackham, Group Chief Integration and Delivery Officer
Paper authored by:	Pardeep Dhami, Information Analyst Prakash Patel, Head of Information Anne Senior, Associate Director
Date submitted:	19.05.2026
Name and date of other committee / forum at which this report / issue was considered:	This report will be presented to the May 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

Integrated Board Performance Report

April 2026 (Month 1)

Our group strategy

CONTENTS

TRUST EXCEPTION REPORTS MATRIX SUMMARY

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

TRUST EXCEPTION REPORTS SUMMARY - Consistently Failing Target

Operational Performance - Waiting Times						
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%	Mar-26	66.2%	65.5%	F	
Memory Clinic (18 week Local RTT) - Incomplete pathway	>=92%	Mar-26	48.3%	48.1%	F	L
ADHD (18 week local RTT) - Incomplete pathway	>=92%	Mar-26	5.4%	6.6%	F	L
CINSS (6 weeks) - Incomplete Pathway	>=95%	Mar-26	57.4%	51.4%	F	H
Speech Therapy - Voice, Respiratory and Dysfluency - Routine (6 weeks) - Incomplete Pathway	>=95%	Mar-26	23.1%	22.0%	F	
Community Paediatrics (18 weeks) - Incomplete pathway	>=92%	Mar-26	9.4%	9.1%	F	L
Childrens Audiology (6 week wait for diagnostic procedures) - Incomplete pathway	>=99%	Mar-26	32.4%	32.0%	F	H

Quality & Safety						
Safe staffing - No. of wards not meeting >80% fill rate for RNs - Day	0	Apr-26	3	3	F	

Workforce						
Vacancy Rate	<=10%	Apr-26	9.4%	9.8%	F	L
Sickness Absence	<=5.0%	Mar-26	5.2%	5.5%	?	

Operational Performance - Treatment Waits (over 52 weeks)						
Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	SPC Assurance	SPC Trend
Adult Psychiatry – Neighbourhood Teams – Treatment waits	0	Apr-26	0	0	F	L
Cognitive Behavioural Therapy	0	Apr-26	28	25	F	L
Dynamic Psychotherapy	0	Apr-26	0	0	F	L
Therapy Service for People with Personality Disorder	0	Apr-26	10	41	F	L
Medical/Neuropsychology	0	Apr-26	56	56	F	L
ADHD (18 week local RTT) - assessment waits	0	Mar-26	7211	7023	F	H
MHSOP Memory Clinics (18 week local RTT) - assessment waits	0	Mar-26	24	22	F	
Community Paediatrics - assessment waits	0	Mar-26	7385	7154	F	H
Community Paediatrics Treatment (excl ND)	0	Apr-26	25	18	F	
All Neurodevelopment (inc CAMHS, SALT, PAEDS)	0	Apr-26	1523	1562	F	H
CAMHS - Treatment waits (excl ND)	0	Apr-26	95	89	F	
All LD - Treatment waits	0	Apr-26	10	2	?	H
Children's Physiotherapy	0	Apr-26	0	8	F	L

TRUST EXCEPTION REPORTS SUMMARY - Consistently Achieving Target

NHS Oversight						
Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	SPC Assurance	SPC Trend
MRSA Infection Rate	0	Apr-26	0	0	P	
Clostridium difficile infection rate	<=12	Apr-26	0	3	P	

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%	Apr-26	6.3%	7.6%	P	L
Core Mandatory Training Compliance for substantive staff	>=85%	Apr-26	98.5%	98.5%	P	H
Staff with a Completed Annual Appraisal	>=80%	Apr-26	94.5%	94.3%	P	
% of staff from a BME background	>=22.5%	Apr-26	33.8%	33.5%	P	H
% of staff who have undertaken clinical supervision within the last 3 months	>=85%	Nov-25	94.2%	94.4%	P	

Trust Headlines

Overall CQC rating (provision of high-quality care) = 2 **CQC Well Led rating = 2** **Q3 Overall NOF Rating = 2**

Operational Performance - Waiting Times	Operational Performance - Over 52 week waits (access / treatment)	Quality & Safety	Workforce	NHS Oversight - Operational Planning
Waiting times for services identifed as a priority for improvement all have a plan in place to deliver improved compliance with contractual targets. Improvement in performance is variable across the nine services as follows:. Consistent positive change is visible in CINSS (Community Integrated Neurology and Stroke) and in Adult CMHT. Compliance in Adult Speech and Language Therapy and Paediatric Audiology continue to see a small positive change with plans in place to increase the pace of improvement in 2026/27. Community Paediatrics, Memory Service and Adult ADHD continue to recieve high volumes of referrals and are seeing a deteriorating position. All services continue to implement transformation plans including system-wide approaches for Adult ADHD and community paediatrics where wider change is needed to address growth in demand alongside maximising available capacity and are supported by a strong productivity focus. All services hold regular PTL meetings to ensure effective management of their waiting lists and work within the parameters of the Trust's Access Policy. Detailed actions for each service are contained in individual exception reports.	Work continues to deliver reductions in the number of patients waiting over 52 weeks for access or for treatment. Robust reviews of reported waits highlighted significant numbers of waits for follow-ups being recorded as treatment waits. Resolution of this enabled the removal of all over 52 week waits for Children's Speech and Language Therapy, reduced numbers in other services and ensurres only true treatment waits are reported for other services. Psychological therapies have made good progress in reducing the number of over 52 week waiters. For Therapy Services for People with Personality Disorder (TSPPD) this has been as a result of the implementation of a revised pathway linked to the development of neighbourhood teams. Medical Psychology, Dynamic Psychotherapy (DPS) and Cognitive Behavioural Therapy (CBT) continue to balance assessment and treatment activity to reduce the risk of over 52 week waiters. As at the end of April 2026 DPS had sustained FOUR months with no over 52 week treatment waits. We continue to see increasing length of wait and numbers waiting over 52 weeks in services relating to adults and children with neurodevelopmental disorders; achieving sustainable change in these services requires a system-wide transformation programme which is under development with partners in ICB, education, VCSE and primary care. In the interim is continuing its internal transformation activities to deliver the LPT element of the wider offer	Work to address data quality / assurance processes issues have supported a second consecutive month of 100% compliance with gatekeeping standards on mental health inpatient wards. April saw a reduction in patient safety incidents resulting in severe harm or death, reducing from 17 in March to 9 in the month of April. Performance against the 72 hour follow-up standard has also improved - increasing from 91% to 98% (this data is extracted from the national mental health core data pack and so relates to February 2026). The number of complaints increased slightly in month as did the number of compliments, the number of concerns remained stable. None of these changes were outside of expected variance. The numbers of wards not meeting safer staffing standards remains above the target if zero with 3 wards non-compliant for day shifts (same as last month) and 1 ward for night shifts (down from 2 last month). In line with SPC rules the variance for night shifts has now generated an exception report. Numbers of seclusions has increased from 14 to 21 in the period however this is expected to be as a result of the change in the indicator which now inlcudes all episodes of seclusion instead of only those over 2 hrs. The 'clock' for annual health checks restarts on 1 April each year and the apparent reduction in compliance is a reflection of this and is not therefore a perfomance concern.	Performance against workforce standards continues to be high with sickness absence the only area where standards are consistently not met. Further detail and actions in place to address this are contained within the individual exception reports. As indicated on front sheet to this report LPT has aligned reporting of normalised workforce turnover with NHFT, which has led to a reduction in the reported metric. There is a small increase in the costs associated with sickness absence in March 26 however this is as a result of February having fewerr working days and is not an indication of an upward trend.	Delivery against MH length of stay trajectories in April was above target for both adult and PICU and older persons beds. This continues the positive trajectory seen in Q4 of 2025/26. The number of CAMHS patients not meeting the 104 week meaningful help standard is above trajectory and expected to continue this downward trend as data quality issues are addressed. The percentage of children waiting over 6 weeks for a diagnostic test (audiology) is moving positively with fewer children breaching than anticipated. Two Inappropriate Out of Area Placements (OAP) were in situ at the end of the month against a target if zero. Numbers waiting over 52 weeks (all children waiting for ND interventions) were above plan. Performance was marginally below expected levels for community contacts for both adults and children.

NHS Oversight Framework 2025-26

Section	Source	Reporting Frequency	Indicator	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	Q2 Published Score	Q3 Published Score
Access to services	Trust	*Monthly*	Percentage of patients waiting over 52 weeks for community services	**Apr-26**	**36.4%**	**35.6%**		2.74	2.94
	Trust	*Monthly (in arrears) (12-month rolling, year-on-year)*	Annual percentage change in the number of children and young people accessing NHS funded mental health services	**Feb-26**	**12.9%**	**12.3%**			
Effectiveness and experience of care	Trust	*Monthly (in arrears) (3-month average)*	Percentage of adult inpatients with a length of stay over 60 days at discharge	**Feb-26**	**24.0%**	**27.0%**		2.47	2.25
	Trust	*Annual Survey*	CQC community mental health survey satisfaction rate	**2024/25**	**2**				
	Trust	*Monthly*	Percentage of Urgent Community Response patients seen within two hours	**Apr-26**	**TBC**	**87.2%**			
Finance and productivity	Trust	*Annual Plan*	Planned surplus/deficit	**2025/26**	**£313k**	**n/a**		1.39	1.39
	Trust	*Monthly (Year to date)*	Variance year-to-date to financial plan	**Apr-26**	**£0**	**£0**			
	Trust	*Annual*	Relative Difference in Costs	**2024/25**	**95.1%**	**105.2%**			
Patient safety	Trust	*Annual*	Staff survey – raising concerns sub-score	**2024/25**	**6.96**			2.05	2.47
	Trust	*Monthly (in arrears)*	Percentage of crisis response patients to receive face to face contact within 24 hours	**Feb-26**	**72.0%**	**67.0%**			
People and workforce	Trust	*Annual*	NHS Staff survey engagement theme sub-score	**2024/25**	**7.20**			2.45	2.47
	Trust	*Monthly (in arrears) (Rolling twelve months)*	Sickness Absence Rate	**Mar-26**	**0.0%**	**5.5%**			

Operational Planning 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
Operational Planning	TRUST	Monthly (3 month rolling)	Average Length of Stay in Adult Acute & PICU MH Beds	<=55.5	Apr-26	42.0					
	TRUST	Monthly (3 month rolling)	Average Length of Stay in Older Adult Acute MH Beds	<=79.8	Apr-26	73.9					
	TRUST	Monthly	Active inappropriate adult acute mental health out of areas placements (OAPs)	0	Apr-26	2					
	TRUST	Monthly	Percentage of people on waiting lists per system who are waiting 18 weeks or less - Adult Community Services	Plan=97.0%	Apr-26	98.0%					
	TRUST	Monthly	Percentage of people on waiting lists per system who are waiting 18 weeks or less - CYP Services	Plan=19.5%	Apr-26	25.4%					
	TRUST	Monthly	Community Services Waiting List over 52 weeks	Target =0 Plan=7443	Apr-26	7560	7383				
	TRUST	Monthly	Attended Community Care Contacts - CHS	Plan=85493	Apr-26	84632	87658				
	TRUST	Monthly	Attended Community Care Contacts - FYPC	Plan=10714	Apr-26	10599	8035				
	TRUST	Monthly	Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period	Target =0 Plan=500	Apr-26	284					
	TRUST	Monthly	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	Target = 0% Plan=87.9%	Apr-26	66.3%					
	TRUST	Monthly	Reliance on specialist inpatient care for adults with a learning disability and/or autism		Apr-26	24	27				
	TRUST	Monthly	Reliance on specialist inpatient care for children with a learning disability and/or autism		Apr-26	3	3				

Patient Flow 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
Patient Flow	TRUST	Monthly	Daily discharges as % of patients who no longer meet the criteria to reside in hospital		Apr-26	22.8%	33.9%				
	TRUST	Monthly	Out of Area Placement - Inappropriate Bed Days	0	Apr-26	37	20				
	TRUST	Monthly	Occupancy Rate - Mental Health Beds (excluding leave)	<=85%	Apr-26	87.4%	87.5%				
	TRUST	Monthly	Occupancy Rate - Community Beds (excluding leave)	>=93%	Apr-26	94.5%	92.7%				
	TRUST	Monthly	Delayed Transfers of Care	<=3.5%	Apr-26	5.7%	5.7%				
	TRUST	Monthly	Delayed Transfers of Care - DMH	<=3.5%	Apr-26	11.7%	11.7%				
	TRUST	Monthly	Delayed Transfers of Care - CHS	<=3.5%	Apr-26	0.0%	0.0%				
	TRUST	Monthly	Admissions to adult facilities of patients under 18 years old	0	Apr-26	0	0				

Quality & Safety Dashboard

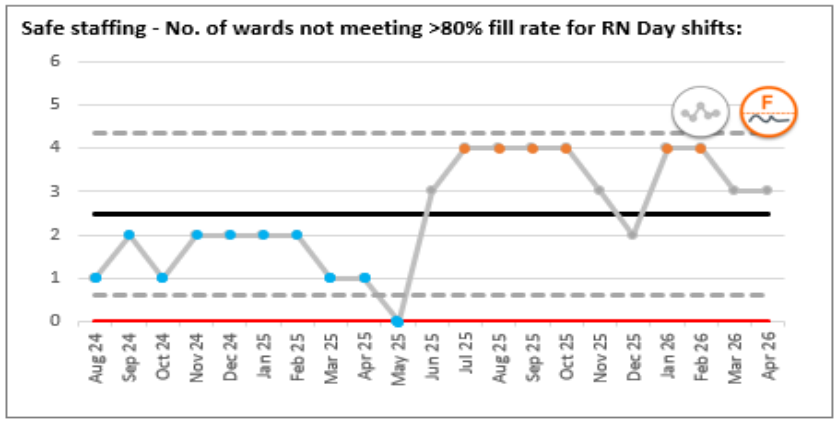
Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Quality Account	TRUST	Monthly	The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period	>=95%	Apr-26	100.0%	100.0%		?		
	TRUST	Yearly	The Trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period		24/25	6.6	6.3				
	TRUST	Monthly	The percentage of inpatients discharged with a subsequent inpatient admission within 30 days - 0-15 years		Apr-26	0.0%	0.0%				
	TRUST	Monthly	The percentage of inpatients discharged with a subsequent inpatient admission within 30 days - 16+ years		Apr-26	7.1%	6.8%				
	TRUST	Monthly	The number of patient safety incidents reported within the Trust during the reporting period		Apr-26	1901	1945			H	
	TRUST	Monthly	The rate of patient safety incidents reported within the Trust during the reporting period		Apr-26	68.6%	66.7%				
	TRUST	Monthly	The number of such patient safety incidents that resulted in severe harm or death		Apr-26	9	17				
	TRUST	Monthly	The percentage of such patient safety incidents that resulted in severe harm or death		Apr-26	0.5%	0.9%				
	MHSDS	Monthly (a quarter in arrears)	72 hour Follow Up after discharge (Aligned with national published data)	>=80%	Feb-26	98.0%	91.0%				
Quality & Safety	TRUST	Monthly	No. of Complaints		Apr-26	35	24				
	TRUST	Monthly	No. of Concerns		Apr-26	51	53				
	TRUST	Monthly	No. of Compliments		Apr-26	192	170				
	TRUST	Monthly	Safer staffing - No. of wards not meeting >80% fill rate for RNs - Day	0	Apr-26	3	3		F		
	TRUST	Monthly	Safer staffing - No. of wards not meeting >80% fill rate for RNs - Night	0	Apr-26	1	2		?		
	TRUST	Monthly	Care Hours per patient day		Apr-26	11.1	11.2			L	
	TRUST	Monthly	No. of Long term Segregations		Apr-26	1	1				

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
	TRUST	Monthly	No. of episodes of seclusions		Apr-26	21	14				
	TRUST	Monthly	No. of episodes of prone (Supported) restraint		Apr-26	1	0				
	TRUST	Monthly	No. of episodes of prone (Unsupported) restraint		Apr-26	0	0				
	TRUST	Monthly	Total number of Restrictive Practices		Apr-26	296	312				
	TRUST	Monthly (In Arrears)	No. of Category 2 pressure ulcers developed or deteriorated in LPT care		Mar-26	138	140				
	TRUST	Monthly (In Arrears)	No. of Category 3 pressure ulcers developed or deteriorated in LPT care		Mar-26	11	7				
	TRUST	Monthly (In Arrears)	No. of Category 4 pressure ulcers developed or deteriorated in LPT care		Mar-26	8	14				
	TRUST	Monthly (In Arrears)	No. of repeat falls		Mar-26	53	48				
	TRUST	Monthly	No. of Medication Errors		Apr-26	100	104				
	TRUST	Monthly	LD Annual Health Checks completed - YTD		Apr-26	2.2%	84.0%				
	MHRA	Monthly	National Patient Safety Alerts not completed by deadline		Apr-26	1	1				
	TRUST	Monthly	MRSA Infections	0	Apr-26	0	0				
	TRUST	Monthly	Clostridium difficile infections	<=12	Apr-26	0	3				
	UHL	Monthly (In Arrears)	E.coli bloodstream infections		Mar-26	0	0				
	GOV	Monthly (YTD)	Percentage of people aged 65 and over who received a flu vaccination		Mar-26	N/A	75.1%				

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

	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
TRUST	0	0	3	4	4	4	4	3	2	4	4	3	3
DMH		0	1	1	1	2	2	1	1	1	1	0	1
LD		0	1	2	2	1	1	1	1	1	1	1	1
CHS		0	1	1	0	0	0	0	0	1	1	2	1
FYPC		0	0	0	1	1	1	1	0	1	1	0	0

Mean	Lower Process Limit	Upper Process Limit
2	0	4



Trajectory graph to be inserted here

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.

Operational Commentary

Actions	Timescales	Consequences	RAG
Work is in progress to align the LD short breaks service (The Gillivers and The Grange) fill rate analysis. Options going through Directorate DMT to enable joint reporting going forward.	30.07.2026	Will improve accuracy and consistency of reporting	
CHS • East Ward – planned staffing is 4 RN (day), this can include a Registered Nursing Associate (RNA) who are not included in the calculation of the RN fill rate. 11 shifts were mitigated by a Registered Nursing Associate. Safe staffing levels maintained as if included the fill rate would be 96.3 %.	N/A	Agreed mitigations implemented to support staffing levels where RN numbers are below agreed levels.	
DMH • Gwendolen – planned staffing is 3 RN (day), this can include a Medicines Administration Technician (MAT) who are not included in the calculation of the RN fill rate. 12 shifts were mitigated with a MAT . Safe staffing levels maintained as if included the fill rate would have been 91.2%.	N/A	Agreed mitigations implemented to support staffing levels where RN numbers are below agreed levels.	
FYPCLDA • The Grange - offers planned respite care and staffing model dependent on individual patient need, presentation and associated risks. As a result, this fluctuates the fill rate for RNs on days. Staffing is supported by Agnes unit and Gillivers.	N/A	Agreed mitigations implemented to support staffing levels where RN numbers are below agreed levels.	

Achievements

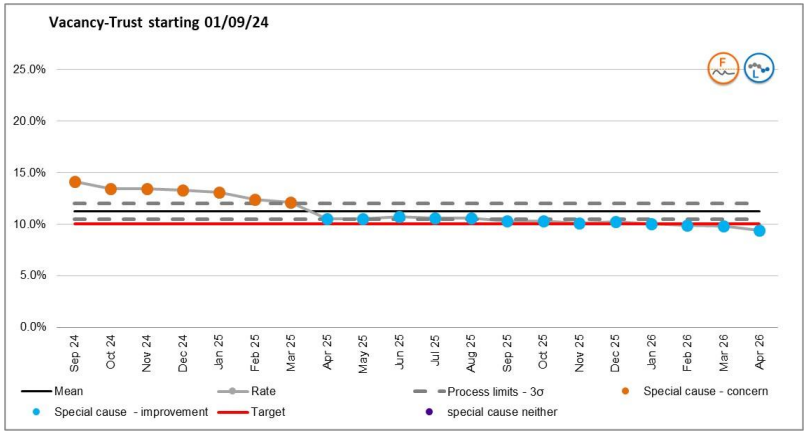
Workforce Dashboard

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Workforce	TRUST	Monthly	Normalised Workforce Turnover (Rolling previous 12 months)	<=10%	Apr-26	6.3%	7.6%				
	TRUST	Monthly	Vacancy Rate	<=10%	Apr-26	9.4%	9.8%				
	TRUST	Monthly (In Arrears)	Sickness Absence	<=5.0%	Mar-26	5.2%	5.5%				
	TRUST	Monthly (In Arrears)	Sickness Absence Costs		Mar-26	£1,157,990	£1,063,148				
	TRUST	Monthly (In Arrears)	Sickness Absence - YTD	<=5.0%	Mar-26	5.2%	5.6%				
	TRUST	Monthly	Core Mandatory Training Compliance for substantive staff	>=85%	Apr-26	98.5%	98.5%				
	TRUST	Monthly	Staff with a Completed Annual Appraisal	>=80%	Apr-26	94.5%	94.3%				
	TRUST	Monthly	% of staff from a BME background	>=22.5%	Apr-26	33.8%	33.5%				
	TRUST	Monthly	Staff flu vaccination rate (frontline healthcare workers)		Apr-26	N/A	45.4%				
	TRUST	Monthly	% of staff who have undertaken clinical supervision within the last 3 months	>=85%	Apr-26	93.2%	94.1%				

EXCEPTION REPORT - Vacancy Rate

	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
TRUST	<=10%	10.5%	10.7%	10.6%	10.6%	10.3%	10.3%	10.1%	10.2%	10.0%	9.9%	9.8%	9.4%
DMH		13.4%	13.8%	12.3%	12.4%	13.1%	13.2%	13.3%	12.7%	12.8%	12.4%	12.4%	12.2%
CHS		10.2%	9.7%	10.0%	10.1%	9.9%	9.3%	8.5%	8.9%	8.4%	8.2%	7.9%	8.2%
FYPCLDA		9.0%	9.9%	10.6%	10.0%	9.3%	9.1%	9.3%	9.7%	9.5%	9.8%	9.5%	9.2%

Mean	Lower Process Limit	Upper Process Limit
11.2%	10.0%	12.0%



Trajectory graph to be inserted here

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.

Operational Commentary

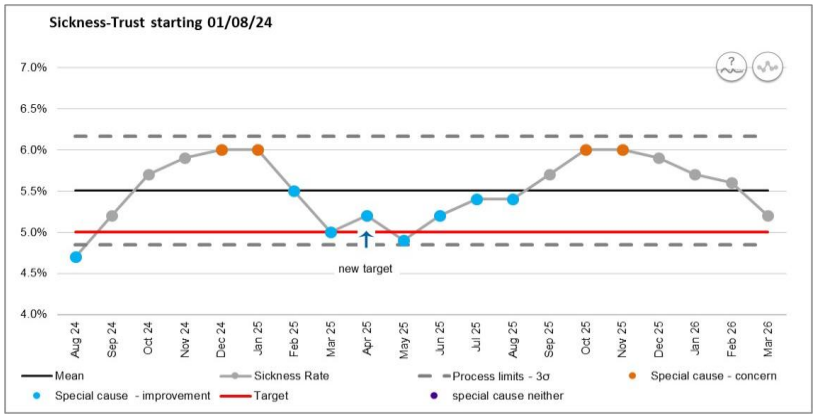
Actions	Timescales	Consequences	RAG
Workforce plan in place. This includes plans to recruit substantively to some vacancies in order to reduce the need to fill vacant post with bank or agency staff.	Mar-27	By the end of 26/27, we plan for a vacancy rate of 8.5%. This is based on an assumption there will be no unplanned changes to budgeted establishments.	
Workforce controls in place within directorate and at exec level to ensure all recruitment and requests to increase/decrease contracted hours are appropriate.	Ongoing	It is possible decisions will be made to delayed or postpone recruitment to vacancies.	
Resourcing Team working with budget holders and finance to review budgeted establishment/vacancies to ensure accuracy of data.	Ongoing	Improved understanding of the vacancy position and of the actions that need to be taken corporately to support services in thier recruitment activity.	

Achievements

EXCEPTION REPORT - Sickness Absence *(Month in arrears)*

	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
TRUST	<=5.0%	5.2%	4.9%	5.2%	5.4%	5.4%	5.7%	6.0%	6.0%	5.9%	5.7%	5.5%	5.2%
DMH		6.2%	5.2%	5.9%	6.1%	6.1%	6.7%	7.1%	7.3%	6.8%	6.6%	6.1%	5.8%
CHS		5.3%	5.4%	5.9%	6.1%	6.3%	6.7%	6.5%	6.3%	6.0%	6.0%	6.2%	5.4%
FYPCLDA		4.7%	4.4%	4.8%	4.8%	5.1%	5.0%	5.5%	5.9%	6.3%	5.6%	5.4%	5.4%

Mean	Lower Process Limit	Upper Process Limit
5.5%	5.0%	6.0%



Trajectory graph to be inserted here

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.

Operational Commentary

Actions	Timescales	Consequences	RAG
360 Assurance audit to take place focusing on: - Are expected working practices for managing attendance being applied promptly, consistently, and fairly across the Trust - Are colleagues appropriately supported to enable them to safely return to work following long term sickness absence at the earliest opportunity.	To be completed by w/c 13 July 2026	Identification areas for development and actions required to improve the management of sickness absence. Identification of best practice for wider learning/sharing.	
Ongoing support from HR Advisory Team to ensure sickness absence is managed in accordance with policy timescales and signposting staff to LPT's extensive health and wellbeing offer.	Ongoing	Managers have clarity on their role and responsibilities for managing sickness absence. Staff feel supported, are treated equitably and are supported to return to work at the earliest opportunity.	

Achievements

Finance 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
Finance	TRUST	Monthly	Variance to Plan - I&E (*£000)*	>=0	Apr-26	£0					
	TRUST	Monthly	Variance to Plan – efficiency (£000)	>=0	Apr-26	£0					
	TRUST	Monthly	Variance to Plan – capital spend (£000)	£0	Apr-26	£1,420,000					
	TRUST	Monthly	Variance to Plan – agency spend (£000) - YTD	>=0	Apr-26	-£76,000					
	TRUST	Monthly	Agency Spend % of Total Pay - YTD	<=1.87%	Apr-26	1.7%					
	TRUST	Monthly	Agency annual expenditure cap – FOT performance	<=6749000	Apr-26	£4,901,000					
	TRUST	Monthly	Bank annual expenditure cap – FOT performance	<=20361000	Apr-26	£20,160,000					

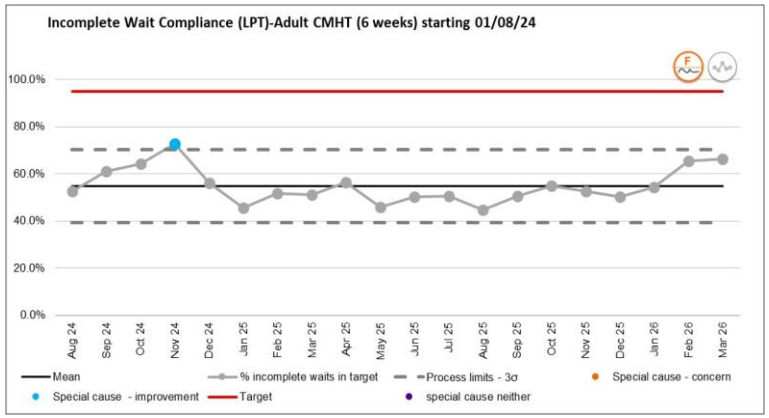
Operational Performance - DMH Waiting Times Dashboard

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Operational Performance - Access Waiting Times	TRUST	Monthly (In Arrears)	Adult CMHT Access (6 weeks routine) - Incomplete pathway	>=95%	Mar-26	66.2%	65.5%				
	TRUST	Monthly (In Arrears)	Memory Clinic (18 week Local RTT) - Incomplete pathway	>=92%	Mar-26	48.3%	48.1%				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - Incomplete pathway	>=92%	Mar-26	5.4%	6.6%				
	TRUST	Monthly (In Arrears)	Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral - complete pathway	>=60%	Mar-26	84.6%	87.5%				
Operational Performance - 52 Week Waits	TRUST	Monthly (In Arrears)	Adult General Psychiatry - Community Mental Health Teams and Outpatients - Assessments waits over 52 weeks - No of waiters	0	Mar-26	13	9				
	TRUST	Monthly (In Arrears)	Adult General Psychiatry - Community Mental Health Teams and Outpatients - Assessments waits over 52 weeks - Longest waiter (weeks)		Mar-26	58	61				
	TRUST	Monthly	Adult Psychiatry – Neighbourhood Teams – Treatment waits - No of Waiters	0	Apr-26	0	0				
	TRUST	Monthly	Adult Psychiatry – Neighbourhood Teams – Treatment waits - Longest Waiter		Apr-26	25	23				
	TRUST	Monthly	Cognitive Behavioural Therapy - Treatment waits - No of waiters	0	Apr-26	28	25				
	TRUST	Monthly	Cognitive Behavioural Therapy- Treatment waits - Longest waiter (weeks)		Apr-26	82	77				
	TRUST	Monthly	Dynamic Psychotherapy - Treatment waits - No of waiters	0	Apr-26	0	0				
	TRUST	Monthly	Dynamic Psychotherapy - Treatment waits - Longest waiter (weeks)		Apr-26	39	51				
	TRUST	Monthly	Therapy Service for People with Personality Disorder - Treatment waits - No of waiters	0	Apr-26	10	41				
	TRUST	Monthly	Therapy Service for People with Personality Disorder - Treatment waits - Longest waiter (weeks)		Apr-26	142	215				
	TRUST	Monthly	Medical/Neuropsychology - Treatment waits - No of Waiters	0	Apr-26	56	56				
	TRUST	Monthly	Medical/Neuropsychology- Treatment waits - Longest Waiter		Apr-26	119	123				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	Mar-26	7211	7023				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - assessment waits over 52 weeks - Longest waiter (weeks)		Mar-26	321	381				
	TRUST	Monthly (In Arrears)	MHSOP Memory Clinics (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	Mar-26	24	22				
	TRUST	Monthly (In Arrears)	MHSOP Memory Clinics (18 week local RTT) - assessment waits over 52 weeks -Longest waiter (weeks)		Mar-26	73	88				

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

DMH	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	>=95%	56.4%	45.9%	50.2%	50.5%	44.6%	50.5%	54.9%	52.5%	50.4%	54.4%	65.5%	66.2%
No of Referrals		413	348	314	448	344	439	539	474	476	520	598	659

Mean	Lower Process Limit	Upper Process Limit
54.9%	39.0%	70.0%



Trajectory graph to be inserted here

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.

Operational Commentary

Actions	Timescales	Consequences	RAG
Substantive recruitment to Consultant posts. Job descriptions and recruitment plan in place. 3 substantive Consultants have been recruited to date.	Aug-26	Increase capacity and reduce waiting times.	
Additional actions put in place to increase capacity and improve flow inlcude: • Additional nurse clinics in place in NW and South to support medic capacity and caseload management. • Band 7 nurse supporting caseload review work in North West Leicestershire – ongoing. • Band 7 Non-Medical Prescriber in post to facilitate annual review for stable depot pts in city teams which will increase medic capacity (numbers currently being established). First patients booked in for annual review week commencing 18th May. • Senior medical/operational and clinical group carrying out review of all workstreams aimed at reducing caseloads and waiting times to formulate a clear phased plan for 26/27 • Nursing staff working with Community Manager and Team Lead to review patients on their caseloads which are open to multiple team members.	Timescales for individual actions TBC	Improve flow through the Neighbourhood Mental Health Teams. Sustained reduction in waiting times. Ensure patients are seen for follow up as planned. Impact of these actions to be monitored at weekly Community Waiting Times Meetings.	
Identified issue within City West in relation to a small number of patients breaching a 52 week wait for assessment. This is due to historical ways of working and medic capacity. This has been escalated and appointments booked.	Jun-26	Patients will be seen, enabling them to be removed from the waiting list.	

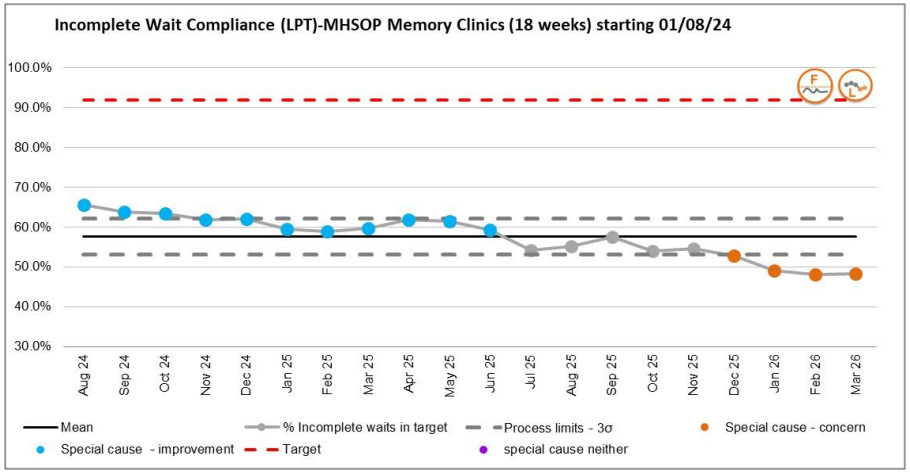
Achievements

% compliance is moving upwards with a signficant improvement seen in the Q4 of 2025/26

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

DMH	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	>=95%	61.9%	61.5%	59.2%	54.1%	55.1%	57.6%	54.0%	54.6%	52.9%	49.1%	48.1%	48.3%
No of Referrals		218	207	240	184	203	279	267	224	230	234	227	267

Mean	Lower Process Limit	Upper Process Limit
57.6%	53.0%	62.0%



Trajectory graph to be inserted here

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.

Operational Commentary

Actions	Timescales	Consequences	RAG
Implementation of One Stop Clinic Clinic and Advanced Pathway A review was carried out on to assess whether the one stop clinic and advanced pathway should continue. The review concluded that there was overwhelming support to continue with both. A paper summarising the findings to be submitted to Quality and Safety signing this off before this becomes business as usual. Workforce review will be carried out to ensure the right capacity and skill mix in the service.	Sep-26	Increase efficiency, flow and patient experience. Reduction in waiting times. Assessment, diagnosis and treatment within one clinic for those over 85 with suspicion of established dementia and so improving patient experience.	
There are gaps in the medical capacity in the team which is limiting our capacity for One Stop Clinics. The Lead Consultant and Clinical Director are identifying replacements to fill the gaps	Jul-26	Increase capacity to assess more patients enabling waiting times / number of over 52 waits to be reduced.	

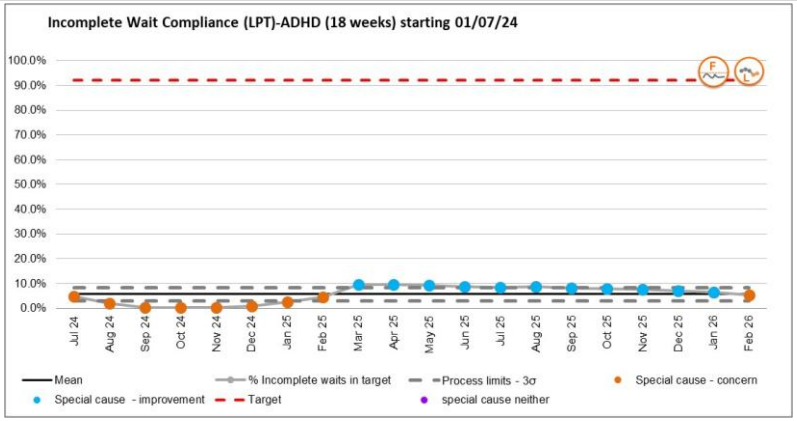
Achievements

One StopClinics and Advanced Dementia Pathway have enabled new approaches to be implemented which offer signficant benefit to patients and carers in terms of waiting time and patient experience.

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

DMH	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	>=95%	9.5%	9.6%	9.4%	8.7%	8.4%	8.8%	8.2%	7.8%	7.6%	7.1%	6.6%	5.4%
No of Referrals		247	216	268	266	239	299	251	257	222	197	216	221

Mean	Lower Process Limit	Upper Process Limit
5.6%	3.0%	8.0%



Trajectory graph to be inserted here

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.

Operational Commentary

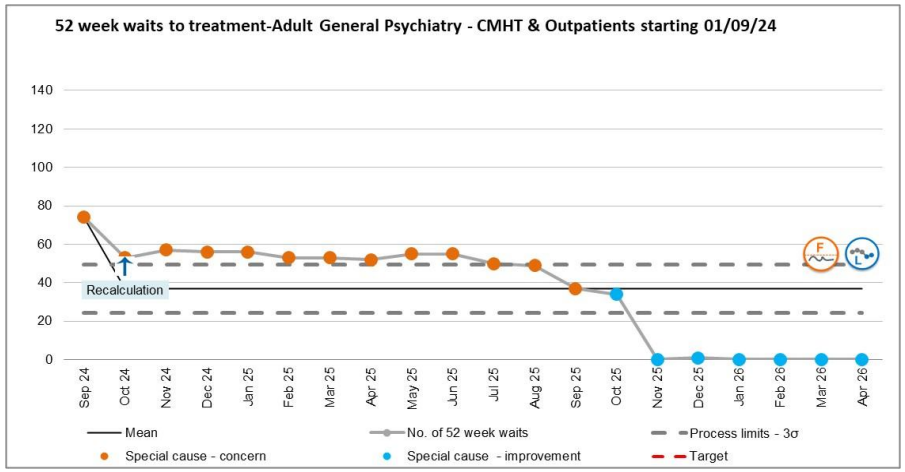
Actions	Timescales	Consequences	RAG
Transformation of the ADHD pathway to improve access and reduce waiting times. A system group has been established to take forward transformation of the pathway, chaired by the Director of Mental Health and co-chaired by ICB Associate Director of Mental Health and LD. In the process of piloting AI Scribe to support improved efficiency across the pathway. Work to be commenced with ICB and HEIM to consider pathway remodelling using local learning alongside that from other Trusts nationally	Sep-26	Improved access and reduction numbers waiting in excess of 52 weeks. Improved service productivity. Improved patient experience. Improved staff experience.	
Improved recording and reporting of waiting times and pathways. Consider recommendations in the NHS ADHD National Improvement Plan. Discussions with SystmOne, Integrated Information and Business Teams to progress. Workshop held with Service Leads, LHIS, Business Team and Integrated Information Team to review SystmOne configuration and reporting and actions are being progressed. SystmOne optimisation taking place to ensure that information is correctly logged and tracking the patient's journey through the pathway. New templates being created.	Jul-26	Waiting times data is consistent across all reports and systems.	
Working with Leicester City Council and the ICB to recommission a replacement service for ADHD solutions. The new provider awarded the contract withdrew. The reserve provider has been awarded the contract and we are currently signing off the data sharing agreement. The service is identifying patients to refer for additional support.	Jun-26	To provide psychological and psychoeducation support to patients whilst they are waiting.	

Achievements

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

DMH	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
	0	55	55	50	49	37	34	0	1	0	0	0	0

Mean	Lower Process Limit	Upper Process Limit
36.7	24.1	49.3



Trajectory graph to be inserted here

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.

Operational Commentary

Actions	Timescales	Consequences	RAG
Sustaining this position will be supported by the actions identifed in the exception report for CMHT	N/A		

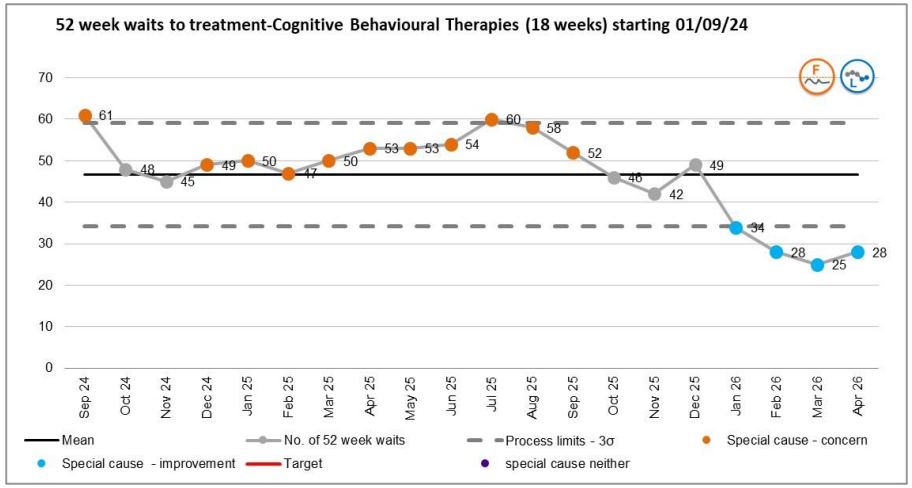
Achievements

As a result of work to review waiting lists, clinical activity and data recording, treatment waits in excess of 52 weeks are expected to be eliminated going forward with 0 waits reported since Dec 2025.

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

DMH	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
	0	53	54	60	58	52	46	42	49	34	28	25	28

Mean	Lower Process Limit	Upper Process Limit
46.6	34.1	59.1



Trajectory graph to be inserted here

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.

Operational Commentary

Actions	Timescales	Consequences	RAG
Neighbourhood Mental Health Teams (NMHTs) are now positioned as the central access point ("front door") for all Cognitive Behavioural Therapy (CBT) referrals. This shift is intended to streamline referral management, improve consistency, and strengthen integration across services. However, several operational pressures are affecting implementation timelines and overall service flow.	Jul-26	Key contributing factor: High referral volumes from primary care, which has created reluctance to absorb additional referrals currently sent directly to CBT. This bottleneck is preventing full implementation of the new referral pathway and risks continued inconsistency in how patients access CBT. PPT service leads currently working with NMHTs to resolve.	
A key strategy for increasing capacity is the expansion of regular, scheduled group CBT delivery, supported by a 12-month rolling programme. This approach is expected to increase throughput, reduce waiting times, and create predictable treatment cycles.	2025/2026 completed - 2026/27 TBC	A refreshed rolling programme is planned for 2026/27, signalling a long-term commitment to group-based delivery as a core productivity driver. The success of the 12-month rolling programme depends on consistent staffing, protected group-delivery time, and robust scheduling.	
Use of Job Plans and Productivity Data: Service leads are increasingly using job plans and performance metrics to shape expectations and provide feedback to clinicians.	Sept 26	Increased expectations around productivity must be balanced with clinician wellbeing and realistic caseload management.	

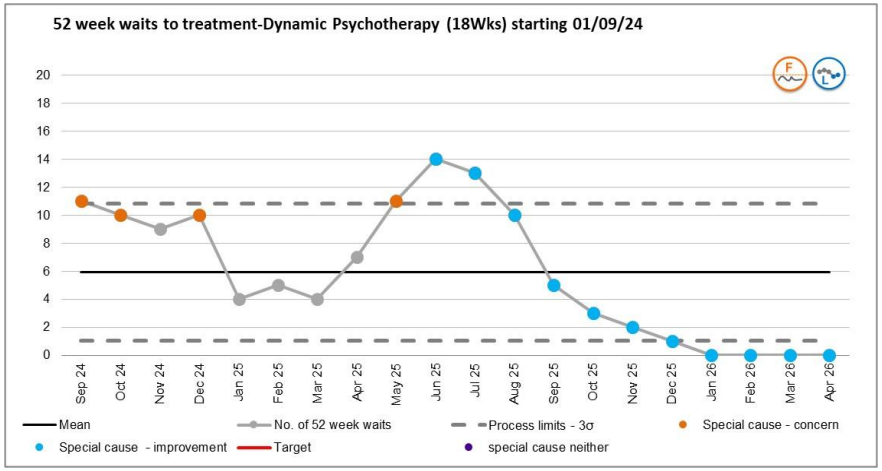
Achievements

The service is moving toward an integrated, data-driven, and productivity-focused model for CBT delivery. While operational pressures—particularly referral volumes—are slowing progress, group-based programmes and strengthened performance oversight provide a clear pathway to improved efficiency and increased treatment capacity.

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

DMH	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
	0	11	14	13	10	5	3	2	1	0	0	0	0

Mean	Lower Process Limit	Upper Process Limit
6.0	1.05	10.9



Trajectory graph to be inserted here

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.

Operational Commentary

Actions	Timescales	Consequences	RAG
All referrals to DPS will go through Neighbourhood Mental Health Teams, the new front door process for those teams and the consultor process. Agree implementation plan at Steering Group Meeting, this is still being worked through to ensure agreement at NMHT level and service level in ensuring the correct clinical processes in place.	July/Aug 2026	A joined-up approach across services is in development, which will improve flow and ensure that patients are being seen by the most appropriate service at the earliest point in referral.	
Plan to stagger MBTi groups, so that there are more beginning points which should reduce the length of wait for those waiting for a group to start. Additional analytic group planned and working on helping patients to consider group offers.	Complete	Increase capacity and reduce waiting times. Action now complete - impact to be assessed.	
Reviewing recording of clinical interventions in 1:1 sessions prior to group therapy to ensure patient pathway is captured accurately in patient EPR system.	Has been actioned - assessing impact	Ensure accurate reflection of activity is reflcted on the waiting list and within performance reports. Action now complete - impact to be assessed.	

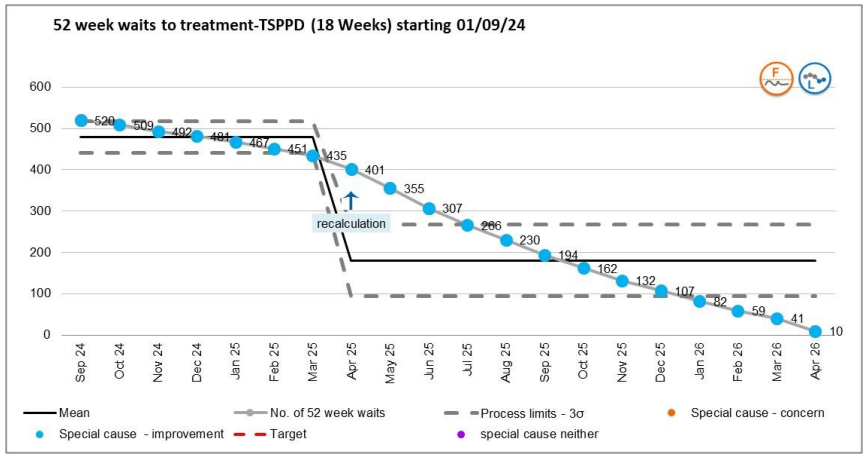
Achievements

Compliance with requirement for no over 52 week treatment waits has been delivered or the last four months, this, alongside r obust management of assessment slots has enabled both access and treatment targets to be met.

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

DMH	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
	0	355	307	266	230	194	162	132	107	82	59	41	10

Mean	Lower Process Limit	Upper Process Limit
180.5	93.8	267.1



Trajectory graph to be inserted here

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.

Operational Commentary

Actions	Timescales	Consequences	RAG
Development of consultation and training support to community services to enhance the primary care offer (small scale). ICB funding no longer available for 25/26. Develop foundational training in Trauma Informed Care. For VCSE Finalise dates and publicise.	TBC	Provide support to VCSE/primary care to prevent referrals for low level support entering secondary care services.	
All TSPPD referrals to come through Neighbourhood Teams and agree the directorate wide secondary care referral criteria. Business as usual will be provided by the Mental Health Neighbourhood Teams during the transition period.	Overdue	Reduced waiting time for secondary mental health input as we focus on the severity of need best served	
Agree and implement a clinical model for the current TSPPD waiting list and governance processes to work through waiting list before transforming provision. Complete waiting list initiative.	Dec-26	Improved service offer, increased efficiency and reduced waits.	
Design new Neighbourhood Team clinical model to be tailored to meet the needs personality difficulties. Part of IN2 and reporting through that project structure.	Overdue	Model for working with people with moderate personality difficulties within Neighbourhood Team.	
Establish the 'Personality Disorder Hub. Senior operational and clinical leads transformation meeting this month to discuss clinical and operational model.	Jan-27	Improve service offer, increase efficiency, and reduce waits.	

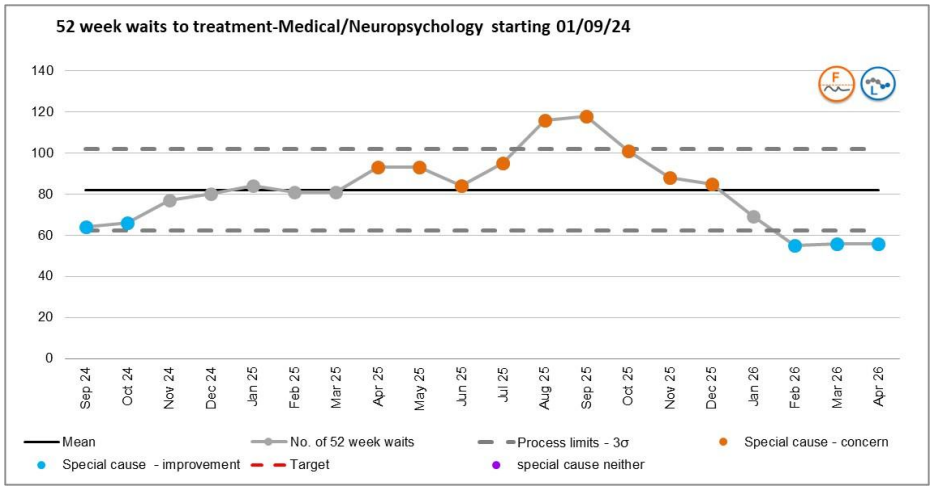
Achievements

Signficant reduction in numbers waiting over 52 weeks over the last 12 months from 355 in March 2025 to 10 at the end of April 2026.

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

DMH	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
	0	93	84	95	116	118	101	88	85	69	55	56	56

Mean	Lower Process Limit	Upper Process Limit
82.1	62.2	102.0



Trajectory graph to be inserted here

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.

Operational Commentary

Actions	Timescales	Consequences	RAG
Group only offer for pain referral introduced and exploring options for additional groups.	Aug-26	Increase capacity and reduce waiting times for treatment.	
Caps to sessions for pain and general medical service being introduced.	Aug-26	Improve flow through the service.	
Assessment weeks running when referrals increase.	Aug-26	Increase capacity to assess patients during periods of increasing demand.	
Waiting list review pilot for General Medical treatment list.	Aug-26	Explore options to reduce waiting times.	
The team are exploring new opportunities to keep waits to treatment down, whilst also delivering access targets of 18 weeks. This is becoming increasingly difficult due to number of referrals and staffing capacity.	Sep-26	Explore options to reduce waiting times.	
Referrals for cancer are increasing and consequently waits are also at risk of increasing, this will be monitored and a potential risk logged.	Sep-26	Maintain oversight of potential increases in demand and escalate as required.	

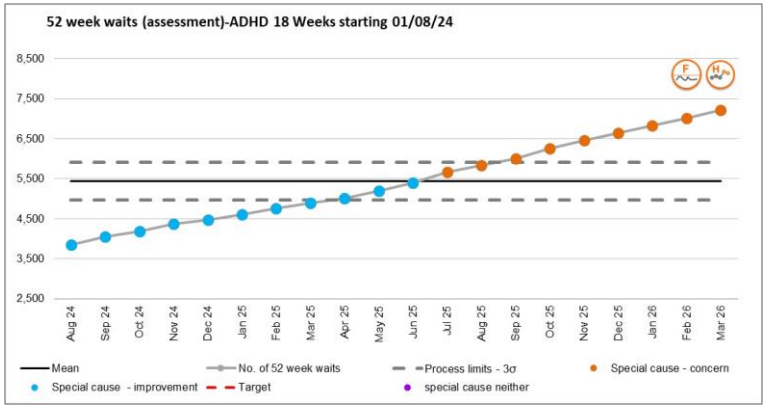
Achievements

Number of over 52 week waits continue to fall with a significant reduction over the past 12 months.

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

DMH	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	0	5014	5190	5398	5661	5833	6006	6250	6464	6639	6830	7023	7211

Mean	Lower Process Limit	Upper Process Limit
5435.8	4965.4	5906.2



Trajectory graph to be inserted here

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.

Operational Commentary

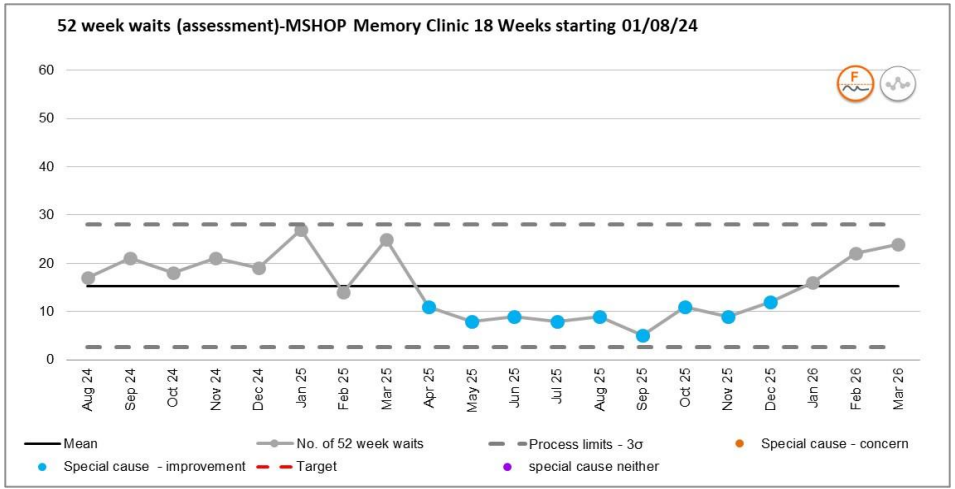
Actions	Timescales	Consequences	RAG
Transformation of the ADHD pathway to improve access and reduce waiting times. A system group has been established to take forward transformation of the pathway, chaired by the Director of Mental Health and co-chaired by ICB Associate Director of Mental Health and LD. In the process of piloting AI Scribe to support improved efficiency across the pathway. Work to be commenced with ICB and HEIM to consider pathway remodelling using local learning alongside that from other Trusts nationally	Sep-26	Improved access and reduction in waiting times. Improved productivity. Improved patient experience. Improved staff experience.	
Improved recording and reporting of waiting times and pathways. Consider recommendations in the NHS ADHD National Improvement Plan. Discussions with SystmOne, Integrated Information and Business Teams to progress. Workshop held with Service Leads, LHIS, Business Team and Integrated Information Team to review SystmOne configuration and reporting and actions are being progressed. SystmOne optimisation taking place to ensure that information is correctly logged and tracking the patient's journey through the pathway. New templates being created.	Jul-26	Waiting times data is consistent across all reports and systems.	
Working with Leicester City Council and the ICB to recommission a replacement service for ADHD solutions. The new provider awarded the contract withdrew. The reserve provider has been awarded the contract and we are currently signing off the data sharing agreement. The service is identifying patients to refer for additional support.	Jun-26	To provide psychological and psychoeducation support to patients whilst they are waiting.	

Achievements

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

DMH	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	0	11	8	9	8	9	5	11	9	12	16	22	24

Mean	Lower Process Limit	Upper Process Limit
15.3	2.6	28.0



Trajectory graph to be inserted here

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.

Operational Commentary

Actions	Timescales	Consequences	RAG
Implementation of One Stop Clinic Clinic and Advanced Pathway A review was carried out on to assess whether the one stop clinic and advanced pathway should continue. The review concluded that there was overwhelming support to continue with both. A paper summarising the findings to be submitted to Quality and Safety signing this off before this becomes business as usual. Workforce review will be carried out to ensure the right capacity and skill mix in the service.	Sep-26	Increase efficiency, flow and patient experience. Reduction in waiting times. Assessment, diagnosis and treatment within one clinic for those over 85 with suspicion of established dementia.	
There are gaps in the medical capacity in the team which is limiting our capacity for One Stop Clinics. The Lead Consultant and Clinical Director are identifying replacements to fill the gaps	Jul-26	Increase capacity to assess more patients	

Achievements

One StopClinics and Advanced Dementia Pathway have enabled new approaches to be implemented which offer signficant benefit to patients and carers in terms of waiting time and patient experience.

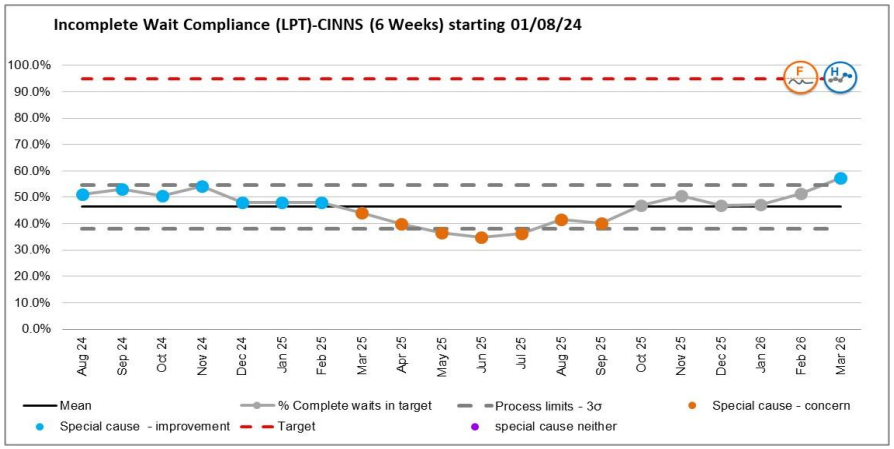
Operational Performance - CHS Waiting Times Dashboard

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Operational Performance - Access Waiting Times	TRUST	Monthly (In Arrears)	CINSS (6 weeks) - Incomplete Pathway	>=95%	Mar-26	57.4%	51.4%				
	TRUST	Monthly (In Arrears)	Speech Therapy - Voice, Respiratory and Dysfluency - Routine (6 weeks) - Incomplete Pathway	>=95%	Mar-26	23.1%	22.0%				

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

CHS	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	>=95%	39.9%	36.6%	34.9%	36.3%	41.5%	40.2%	46.9%	50.6%	46.9%	47.3%	51.4%	57.4%
No of Referrals		203	219	180	189	205	165	188	178	180	174	169	212

Mean	Lower Process Limit	Upper Process Limit
46.3%	38.0%	55.0%



Trajectory graph to be inserted here

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.

Operational Commentary

Actions	Timescales	Consequences	RAG
2nd OT Memory Group to be booked	Aug-26	Increase capacity and throughput of patients; reduce numbers waiting	
Dictation Software Options being explored - awaiting Trustwide progress	TBC	Releasing Time to Care	
SystmOne holistic templates to be reviewed	TBC	Releasing Time to Care	
Trusted Assessor equioment list to be reviewed	TBC	Releasing Time to Care	
Review alternative options for safeguarding & social care related work / liaison	TBC	Releasing Time to Care	
Weekly monitoring of new patient appointments & prospective bookings	Ongoing	Reduce waiting list; reduce longest waiters	

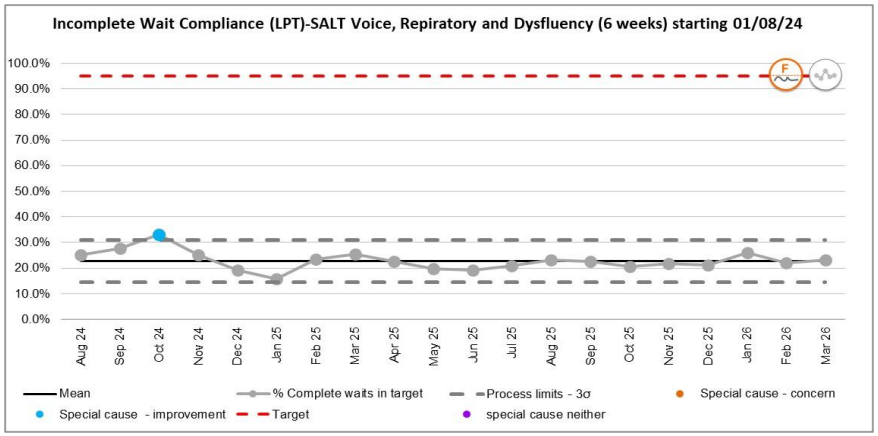
Achievements

Recruitment to vacancies. Increasing compliance. Over-achieving on likely case waiting list trajectory with only 6 patients waiting above 18 weeks without anappointment booked. 95th percentile waiting list has decreased to 16 weeks.

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

CHS	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	>=95%	22.6%	19.7%	19.3%	20.8%	23.2%	22.5%	20.7%	21.9%	21.2%	25.9%	22.0%	23.1%
No of Referrals		72	73	58	63	81	81	72	56	74	88	45	63

Mean	Lower Process Limit	Upper Process Limit
22.9%	15.0%	31.0%



Trajectory graph to be inserted here

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.

Operational Commentary

Actions	Timescales	Consequences	RAG
Recruitment to 1WTE Voice Therapist	Sep-26	Increase clinical capacity; reduce waiting list.	
Individual Job Planning	Aug-26	Validated trajectory in place	
Consider increased use of digital communication for appointments & self-help	Sep-26	Releasing Time to Care; Increase capacity	
Increase use of video & telephone follow-ups	Aug-26	Reduce cancellations; increase capacity; reduce waiting list	
Set up next cohort of Group patients	Sep-26	Reduce waiting list; reduce longest waiters	
Weekly monitoring of new patient appointments & prospective bookings	Ongoing	Reduce waiting list; reduce longest waiters	

Achievements

Over-achieving on likely case waiting list trajectory with 95th percentile wait decreasing. PTL processes strengthened including compliance with Access and DNA Policies.

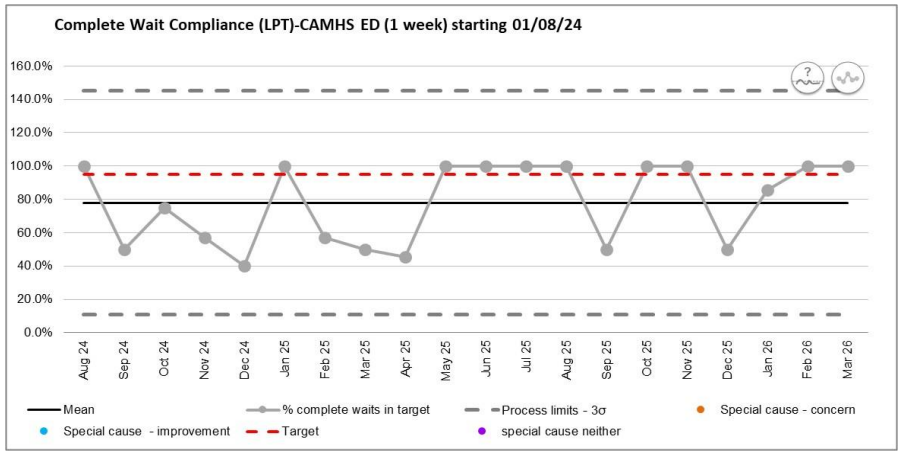
Operational Performance - FYPCLDA Waiting Times Dashboard

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Operational Performance - Access Waiting Times	TRUST	Monthly (In Arrears)	CAMHS Eating Disorder (one week) - Complete pathway	>=95%	Mar-26	100.0%	100.0%		?		
	TRUST	Monthly (In Arrears)	CAMHS Eating Disorder (four weeks) - Complete pathway	>=95%	Mar-26	90.0%	100.0%		?	H	
	TRUST	Monthly (In Arrears)	Community Paediatrics (18 weeks) - Incomplete pathway	>=92%	Mar-26	9.4%	9.1%		F	L	
	TRUST	Monthly (In Arrears)	Childrens Audiology (6 week wait for diagnostic procedures) - Incomplete pathway	>=99%	Mar-26	32.4%	32.0%		F	H	
Operational Performance - 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)		Apr-26	48.4%	55.3%				
	TRUST	Monthly	(5-18yrs) Percent of RHAs sent to LA in month within 12 months of previous assessment (City/County/Rutland)		Apr-26	95.8%	94.7%				
	TRUST	Monthly	(0-4yrs) Percent of RHAs sent to LA in month within 6 months of previous assessment (City/County/Rutland)		Apr-26	96.0%	96.9%				
Operational Performance - 52 Week Waits	TRUST	Monthly (In Arrears)	Community Paediatrics - assessment waits over 52 weeks - No of waiters	0	Mar-26	7385	7154		F	H	
	TRUST	Monthly (In Arrears)	Community Paediatrics - assessment waits over 52 weeks - Longest waiter (weeks)		Mar-26	219	215				
	TRUST	Monthly	Community Paediatrics Treatment (excl ND) - No of waiters	0	Apr-26	25	18		F		
	TRUST	Monthly	Community Paediatrics Treatment (excl ND) - Longest waiter		Apr-26	107	108				
	TRUST	Monthly	All Neurodevelopment (inc CAMHS, SALT, PAEDS) - Treatment waits - No of waiters	0	Apr-26	1523	1562		F	H	
	TRUST	Monthly	All Neurodevelopment (inc CAMHS, SALT, PAEDS) - Treatment waits - Longest waiter (weeks)		Apr-26	287	282				
	TRUST	Monthly	CAMHS - Treatment waits (excl ND) - No of waiters	0	Apr-26	95	89		F		
	TRUST	Monthly	CAMHS - Treatment waits (excl ND) - Longest waiter (weeks)		Apr-26	74	70				
	TRUST	Monthly	All LD - Treatment waits - No of waiters	0	Apr-26	10	2		?	H	
	TRUST	Monthly	All LD - Treatment waits - Longest waiter (weeks)		Apr-26	56	55				
	TRUST	Monthly	Children's Physiotherapy - No of waiters	0	Apr-26	0	8		F	L	
	TRUST	Monthly	Children's Physiotherapy - Longest waiter		Apr-26	48	95				
	TRUST	Monthly	Audiology - No of waiters	0	Apr-26	1	0		?		
	TRUST	Monthly	Audiology - Longest waiter		Apr-26	53	35				
	TRUST	Monthly	Adult Eating Disorders Community - Treatment waits - No of waiters	0	Apr-26	2	0		?	L	
	TRUST	Monthly	Adult Eating Disorders Community - Treatment waits - Longest waiter (weeks)		Apr-26	58	41				

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

FYPCLDA	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	>=95%	45.5%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	50.0%	85.7%	100.0%	100.0%
No of Referrals		8	2	2	3	3	4	5	1	3	10	4	1

Mean	Lower Process Limit	Upper Process Limit
78.0%	11.0%	145.0%



Trajectory graph to be inserted here

Analytical Commentary

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

Operational Commentary

Actions	Timescales	Consequences	RAG
Service to continue to run monthly PTL supported by the Business Team in place, in addition to service led daily PTL's.	Ongoing	Early intervention where chidren at risk of breaching target so improving adherence to KPI	

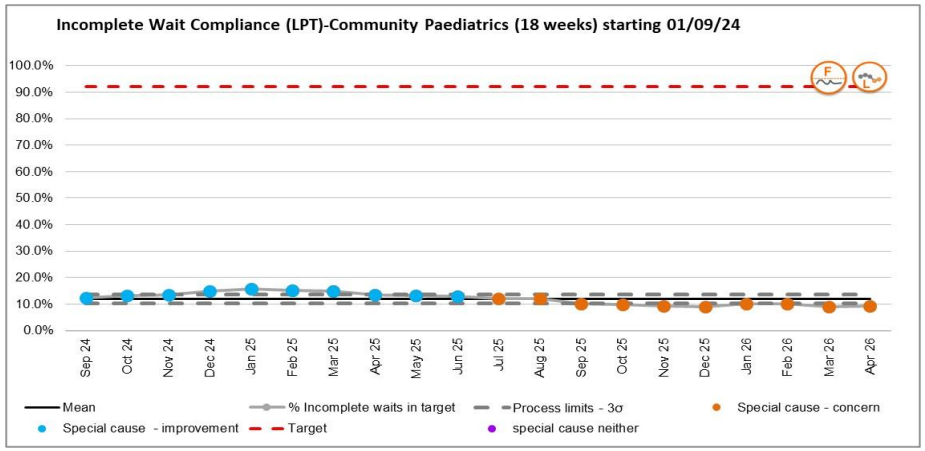
Achievements

Target achieved for 8 out of last 10 months.

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

FYPCLDA	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	>=92%	13.6%	13.2%	13.0%	12.0%	10.2%	9.8%	9.3%	9.0%	10.1%	10.0%	9.1%	9.4%
No of Referrals		271	269	286	290	137	215	295	226	278	299	377	446

Mean	Lower Process Limit	Upper Process Limit
12.0%	10.0%	14.0%



Trajectory graph to be inserted here

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.

Operational Commentary

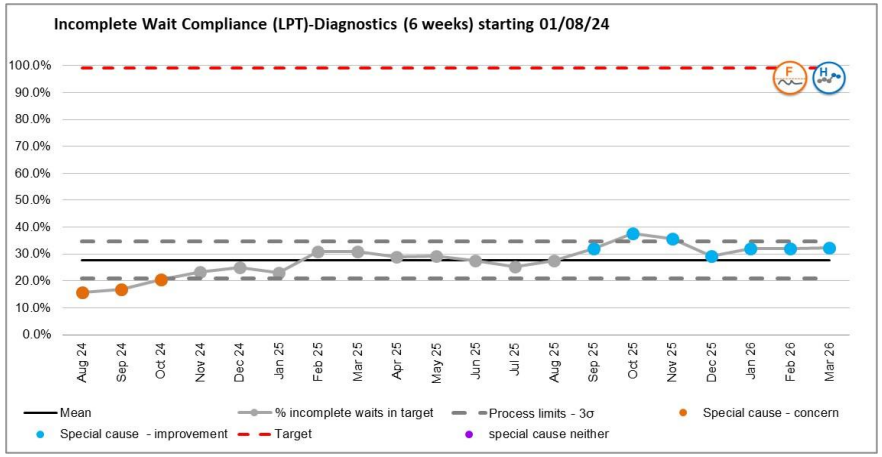
Actions	Timescales	Consequences	RAG
Commencement of capacity and demand work	Jun-26	Understanding of current capacity and demand and identification of potential areas for improvement	
Pathway review- workshop with NHFT	Jun-26	Shared learning and opportunities for improvement	
Exploration of digital health contact	Jul-26	Support waiters and identify those CYP who may no longer require assessment and clock can be stopped / patient discharged.	
Regular PTL, led by DMT, dedicated to reviews of patients with long waits.	May-26	Identification of long waits where intervention is required and support for allocation.	
Participation in piloting the ND profiling tool	Nov-26	Provide support at early identification stage, which may reduce demand for specialist assessment.	

Achievements

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

FYPCLDA	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	>=99%	29.0%	29.2%	27.5%	25.3%	27.5%	32.0%	37.6%	35.7%	29.2%	32.0%	32.0%	32.4%
No of Referrals		310	293	243	206	201	246	271	205	166	238	255	292

Mean	Lower Process Limit	Upper Process Limit
27.7%	21.0%	35.0%



Trajectory graph to be inserted here

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.

Operational Commentary

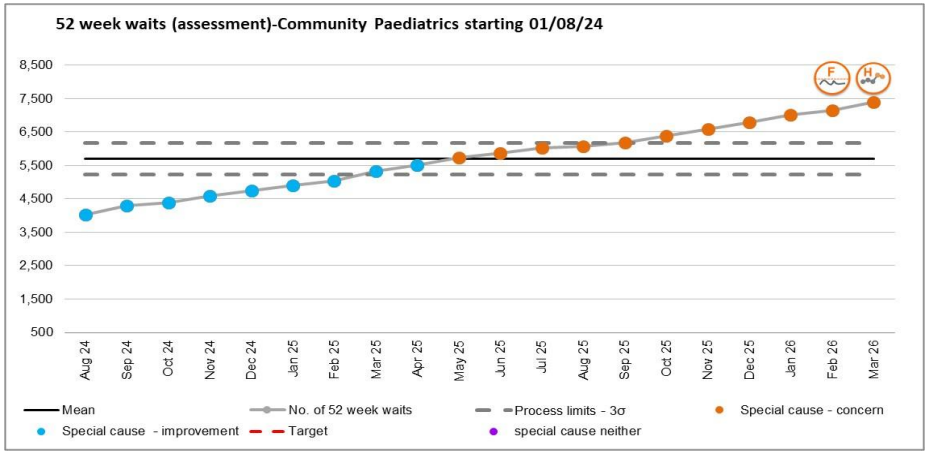
Actions	Timescales	Consequences	RAG
Regular PTL, led by DMT, dedicated to reviews of patients with long waits.	Feb-27	Deliver agreed trajectory for 6 week KPI and early identification of potential breaches, enabling earlier intervention.	
Onboarding of upgraded soundproofed estate	Sep-26	Increased capacity, redcued requirement for repeat tests to support maximim throughput.	

Achievements

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

FYPCLDA	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	0	5509	5723	5858	6022	6067	6182	6380	6585	6782	7003	7154	7385

Mean	Lower Process Limit	Upper Process Limit
5698.1	5226.58	6169.62



Trajectory graph to be inserted here

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.

Operational Commentary

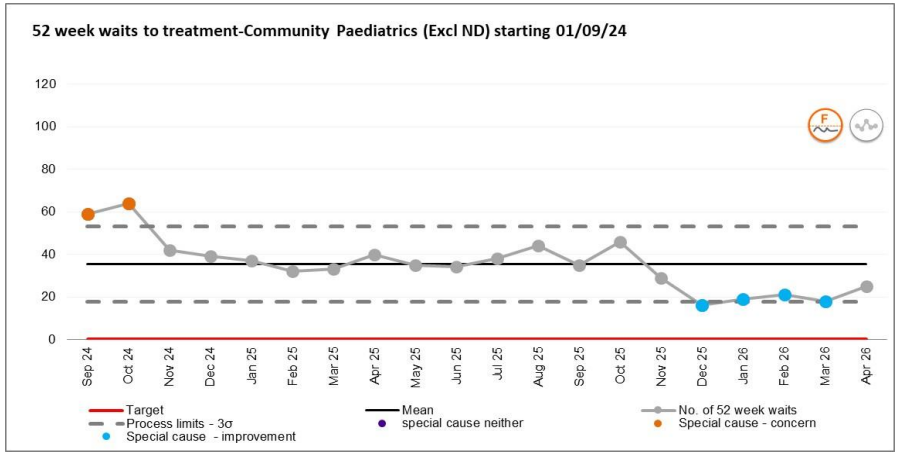
Actions	Timescales	Consequences	RAG
Commencement of capacity and demand work	Jun-26	Understanding of current capacity and demand and identification of potential areas for improvement	
Pathway review- workshop with NHFT	Jun-26	Shared learning and opportunities for improvement.	
Exploration of digital health contact	Jul-26	Support waiters and identify those CYP who may no longer require assessment and clock can be stopped / patient discharged.	
Regular PTL, led by DMT, dedicated to reviews of patients with long waits.	May-26	Identification of long waits where intervention is required and support for allocation.	
Participation in piloting the ND profiling tool	Nov-26	Provide support at early identification stage, which may reduce demand for specialist assessment.	

Achievements

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

FYPCLDA	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
	0	35	34	38	44	35	46	29	16	19	21	18	25

Mean	Lower Process Limit	Upper Process Limit
35.3	17.66	52.94



Trajectory graph to be inserted here

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.

Operational Commentary

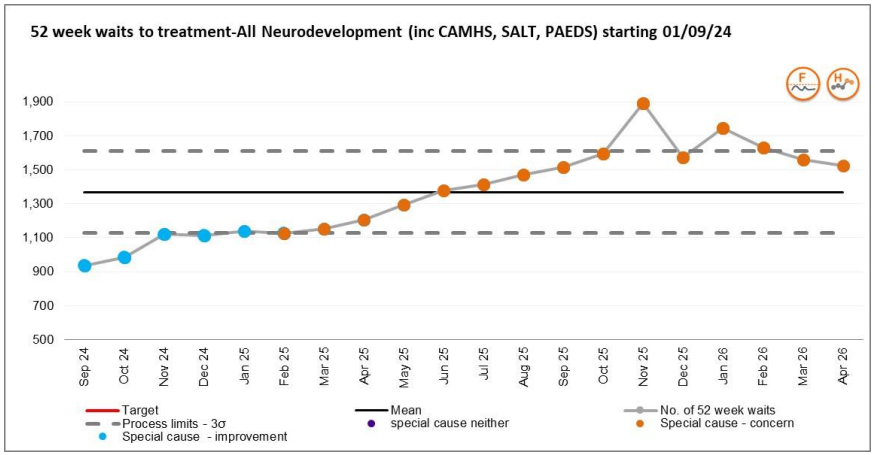
Actions	Timescales	Consequences	RAG
Deep dive into waiting lists to validate and confirm wait is for treatment not secondary follow up.	Jun-26	Confirmation of wait type to identify and report treatment waits only and ensure allocation for clinical contact.	

Achievements

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

FYPCLDA	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
	0	1294	1378	1415	1473	1518	1597	1893	1575	1747	1632	1562	1523

Mean	Lower Process Limit	Upper Process Limit
1369.6	1130.15	1608.95



Trajectory graph to be inserted here

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.

Operational Commentary

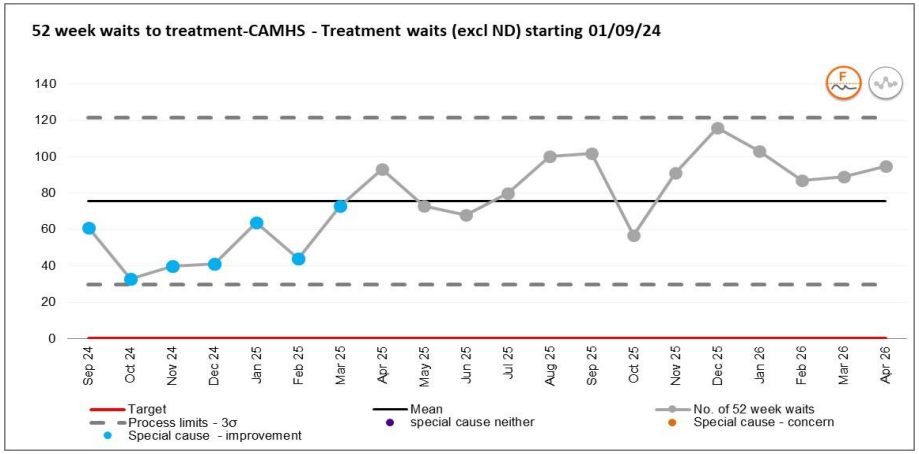
Actions	Timescales	Consequences	RAG
Recruitment and onboarding of non-medical prescriber for CAMHs	Sep-26	Increased capacity enabling increased throughput to enable waiting times to be reduced.	
Participation in piloting the ND profiling tool	Nov-26	Provide support at early identification stage, which may reduce demand for specialist assessment and treatment.	

Achievements

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

FYPCLDA	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
	0	73	68	80	100	102	57	91	116	103	87	89	95

Mean	Lower Process Limit	Upper Process Limit
75.5	29.67	121.23



Trajectory graph to be inserted here

Analytical Commentary

The metric is showing 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.

Operational Commentary

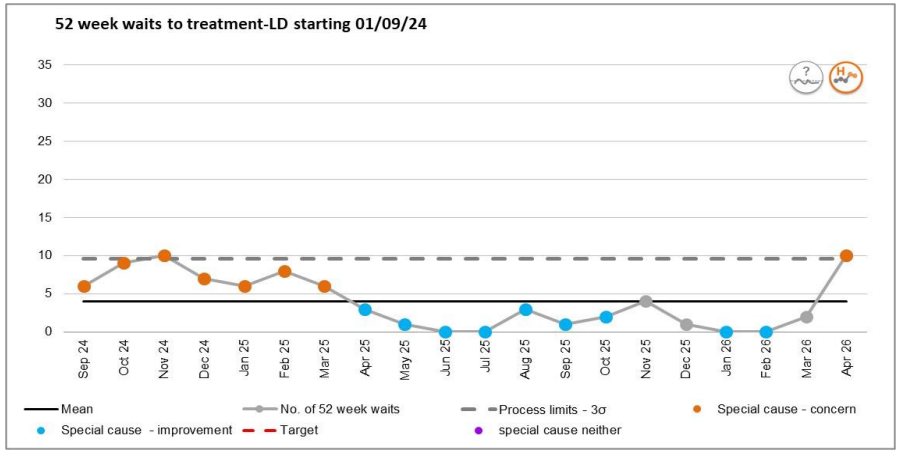
Actions	Timescales	Consequences	RAG
Deep dive into waiting lists to validate and confirm wait is for treatment not secondary follow up.	Jun-26	Confirmation of wait types to ensure CYP on appropriate lists and these are reported through the appropraite governance route	
CAMHs Clinical and Operational Teams to explore ongoing enhanced validation of waits.	Jun-26	Confirmation of waits and more accurate reporting of treatment waits and understanding of other potential delays in pathway.	
Commencement of additional groups to increase capacity.	Jun-26	Reduction of long waiters as increased places available on groups	
Validation of patients and capacity, including identification of requriement for urgent slots, based on current CYP needs.	Jun-26	Confirmation of true waiters and reduction in wait times.	

Achievements

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

FYPCLDA	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
	0	1	0	0	0	3	1	2	4	1	0	2	10

Mean	Lower Process Limit	Upper Process Limit
4	-1.65	9.55



Trajectory graph to be inserted here

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.

Operational Commentary

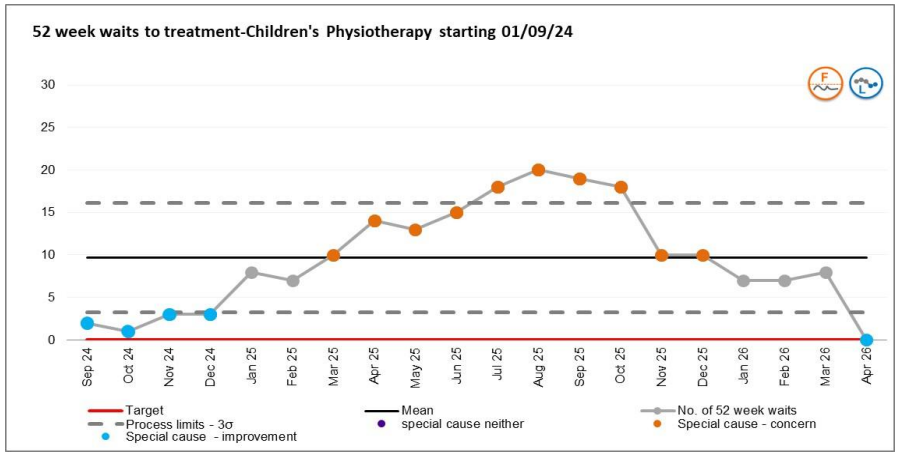
Actions	Timescales	Consequences	RAG
Validation of the wait type	Jun-26	To confirm wait type and ensure patient in on appropriate treatment pathway	
Develop AHP priority action plan (SaLT & OT)	Jun-26	Reduce number of waiters	
Exploration of reason for an increase in waiters for April 2026	Jun-26	To identify rationale and implement focused actions to reduce waits	

Achievements

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

FYPCLDA	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
	0	13	15	18	20	19	18	10	10	7	7	8	0

Mean	Lower Process Limit	Upper Process Limit
9.7	3.21	16.09



Trajectory graph to be inserted here

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.

Operational Commentary

Actions	Timescales	Consequences	RAG
Service to continue oversight of wait through PTL's	Ongoing		

Achievements

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.

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.

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.