Group Trust Board of Directors

Minutes of the meeting in public held on Thursday 29 January 2026 at 3.00pm via Microsoft Teams

Present
Faisal Hussain, Interim Group Chair
Josie Spencer, LPT Non-Executive Director/Deputy Chair
Julia Curtis, NHFT Non-Executive Director/Deputy Chair
Melanie Hall, LPT Non-Executive Director and NHFT Associate Non-Executive Director
Hetal Parmar, LPT Non-Executive Director
Liz Anderson, LPT Non-Executive Director
Angela Hillery, Group Chief Executive
Jean Knight, LPT Managing Director/Deputy Chief Executive
David Maher, NHFT Managing Director/Deputy Chief Executive
Sharon Murphy, LPT Executive Director of Finance and Performance
Bhanu Chadalavada, LPT Medical Director
Itai Matumbike, NHFT Chief Medical Officer
Linda Chibuzor, Group Chief Nurse
Tim Harrison, LPT and NHFT Non-Executive Director
Duncan Orme, NHFT Non-Executive Director
Judit Seymour, NHFT Non-Executive Director
Robin Burgess, NHFT Non-Executive Director

In Attendance:
Sam Leak, LPT Executive Director of Community Health Services and Interim Executive Director of Families, Young People and Children's Services, Learning Disabilities and Autism
Tanya Hibbert, LPT Executive Director of Mental Health
Sarah Willis, Group Chief People Officer
David Williams, Group Executive Director of Strategy and Partnerships
Paul Sheldon, Group Chief Finance Officer
Kate Dyer, LPT Director of Governance and Risk
Richard Smith, NHFT Director of Corporate Governance
Anne Rackham, NHFT Chief Operating Officer
Chris Skelton, LPT Associate Non-Executive Director
Joanne Lancaster, NHFT Associate Non-Executive Director
Sonja Whelan, LPT Corporate Governance Coordinator (Minutes)

GTB/25-6/021	**Welcome and Apologies for Absence** Apologies for absence were received from Natasha Fox, NHFT Associate Non-Executive Director. Peter Bryan, Ezra Kanyimo and Liam McDonale from the NHS England Advanced Foundation Trust team were welcomed as observers to the meeting, along with all others observing via the livestream function.
GTB/25-6/022	**Service Presentation: Health Inequalities** David Williams delivered the service presentation which focused on Health Inequalities and Unwarranted Variation.

	Slides where shown on screen and attention was drawn to NHS England's (NHSE) definition that '*health inequalities are unfair and unavoidable*'. It was explained that individuals experiencing health inequalities often lived with poorer health for longer, faced multiple health conditions, had higher obesity rates, experienced premature mortality, and had limited access to prevention. The Board was reminded of the importance of considering the organisations' role in influencing the wider social determinants of health. Examples shared at recent Board meetings were referenced; at LPTs Public Board earlier in the week, volunteers had described the positive impact that volunteering had made to their wellbeing and at NHFTs Board meeting, discussions had focused on partnership working and the importance of collaborative approaches. It was noted that only around 20% of the social determinants of health inequalities related directly to healthcare provision, reinforcing that improvement relied on collective responsibility across systems and communities. The current work underway to address unwarranted variation was then outlined, including reviews of access and referral practices, data management, care pathway design, and approaches to reducing variation within the workforce. An anonymised service user story ("Amy's story") was then shared which described an individual who, following involvement with the criminal justice system, had received a Mental Health Treatment Requirement (MHTR). The story highlighted the challenges that had prevented the individual from seeking help earlier, the sensitive and culturally appropriate support provided, and the positive outcomes achieved, including having stopped drinking alcohol, improved management of chronic pain, enhanced self-confidence and strengthened family communication. Amy's story illustrated the factors that had contributed to her initial contact with services, the barriers that had prevented seeking help earlier, and the support that had been provided. It also prompted consideration of why individuals may feel unable to approach the NHS at an earlier stage. The importance of the Group's commitment to neighbourhood working, partnerships, and collaboration with voluntary and community organisations was emphasised, particularly in supporting people who may feel unable to attend their GP surgery due to concerns about being seen within their community – compromising their anonymity. Neighbourhood and crisis cafes for children, young people and adults were given as examples of accessible support being provided. This patient story was one example of the impact of services and the importance of addressing health inequalities and unwarranted variation. Also highlighted was work undertaken to improve healthy weight monitoring for people with a learning disability. The Board was informed that analysis had shown that around 15-17% of people with a learning disability or autism had not had their weight recorded, representing a missed opportunity for prevention and early intervention. Given the significant disparity in life expectancy for this group, the importance of strengthening recording and monitoring practices was highlighted. It was reported that targeted support for the workforce had led to a 57% increase in BMI recording and improvements in malnutrition screening. A nutritional and healthy living network had been developed to equip care providers, primary care networks and day centres with practical toolkits; with progress monitored through quarterly BMI data. This work demonstrated how

	addressing data gaps and providing appropriate resources could reduce unwarranted variation. Wider partnership work aligned to the organisations' role as anchor institutions was described, including relationships with MIND, neighbourhood and crisis cafes, and collaborations with Leicester City Football Club and Northampton Saints Rugby Club. These partnerships offered mental health and wellbeing sessions for young people in settings where they felt more comfortable seeking support, helping to improve early engagement and prevention. Fearon Hall Community Centre in Loughborough, Leicestershire, was supporting a wide range of community services including debt advice, counselling, activity space and space for hot meals. The Group, supported by NHSE, would be working with Fearon Hall as an early adopter site for a 24/7 mental health neighbourhood centre, with a visit from the NHSE national lead for neighbourhoods expected in the coming weeks. The importance of supporting staff through workforce equality initiatives including the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), diverse leadership training, and reverse monitoring was highlighted. Staff networks continued to offer support and opportunities for learning. The role of volunteering in building confidence and supporting career pathways was also highlighted as contributing positively to socio-economic factors. In conclusion, addressing health inequalities and unwarranted variation remained a key strategic priority for the Group, supported by strong community partnerships and system wide approaches. The Chair offered thanks for the insightful presentation and invited questions or comments. Angela Hillery emphasised the importance of the topic and welcomed the work taking place across the Group, while stressing the need for full and consistent embedding. The importance of ensuring staff had access to meaningful data on access and opportunity was reiterated. Sharon Murphy and Paul Sheldon were asked to consider how the impact of neighbourhood work could be measured, not only in relation to the examples presented but also in terms of economic, clinical, and financial outcomes. In response, it was noted that mechanisms were already in place within both organisations for staff, service managers and teams to review service data; including population demographics, ethnicity, and service usage, which supported local decision making and service transformation. Both organisations were also reviewing 'Did Not Attend' data and planned to expand this to include 'Was Not Brought', which was particularly relevant for people with a learning disability and for children and young people. This would better support understanding of non-attendance patterns and inform improvement actions. An App was available across both organisations to support staff in viewing and interpreting this data. The challenge of embedding this consistently across the Group was acknowledged. Tanya Hibbert advised that the LLR Board had recently discussed further work on health inequalities and, through the Mental Health Collaborative, smoking cessation and breast cancer screening had been identified as key priorities

	given their significant impact on quality of life and life expectancy, and because breast cancer screening outcomes locally remained amongst the poorest. Examples of compassionate practice were highlighted, including linking screening with annual health checks, and providing additional support for individuals experiencing anxiety or phobias that made attending appointments difficult. It was noted that the initiatives described in the earlier presentation would strengthen this work through improved availability and use of data. David Maher noted the importance of distinguishing between poorly designed person-centred care and genuine health inequalities, as clarity was essential to ensure improvement efforts were directed appropriately. He reported that NHFT, working with local authority partners, was progressing work on wider determinants of health such as employment and housing and suggested that the Group consider revisiting this area as part of the forthcoming 10-year review to embed these principles more systematically. He emphasised the significant health gains associated with physical health checks for people with learning disabilities and those with severe mental illness, noting their impact on reducing inequalities and improving mortality. He also stressed the importance of delivering care closer to deprived communities, advising that more localised models of care were likely to achieve better outcomes as neighbourhood approaches continued to develop. Reference was made to the earlier points on breast and cervical screening, with emphasis on the need for person-centred approaches that adapted to support individual needs. An example was given of work undertaken with people with a learning disability to explain cervical screening which demonstrated how lived experience could be used effectively to support understanding and engagement. Jean Knight reported that LPT had been focusing on how to embed this approach into everyday practice and a recent discussion at the LPT Executive Management Board had centred on making this a “golden thread” across all services; this had since been taken forward into the Transformation and Quality Improvement Group (TQIP). TQIP had considered how to bring together the wide range of work taking place across services to ensure visibility, share learning, and adopt or adapt improvements emerging from pilots and ongoing changes. It was noted that while LPT was proud to serve such a varied and diverse community, challenges such as health literacy and supporting people to attend appointments remained. It was confirmed that all services were using the data described earlier to ensure they were targeting and supporting individual communities at neighbourhood level and tailoring services to population need. Paul Sheldon highlighted that from a financial perspective and through both value programmes, the need to reshape services to meet patient needs was grounded in the information presented. This insight opened numerous opportunities for how services could be delivered and comes at a time when a renewed drive was needed to shape the next phase of transformation over the next 3-5 years. The importance of focusing on patient pathways and outcomes was reinforced, rather than relying solely on clinical pathways or tick boxes, and the need for a holistic, patient centre approach was stressed. Hetal Parmar explained that the sector he worked in (education) comprised 15 schools serving 10,000 young people and an estimated community reach of

	30-40,000 people. He reported that 13 of these schools were in the top 20% most deprived areas nationally and highlighted that collaborative working across such networks could significantly strengthen efforts to address inequalities and asked how partnership could work together more effectively. David Maher had recently attended an anchor meeting in Northamptonshire, where an academy CEO highlighted that literacy rates in some of the most deprived areas they served were around 50%. He explained that, through the social value networks, work was underway to engage charitable and social enterprise organisations that provide reading support to families and children, and that the organisation hoped to contribute to this as part of its social value commitment. Work was also being undertaken to develop a collective view on broader social value priories, for example, while the organisation had adopted the living wage, this was not yet mirrored across all partners within the local authority footprint. Efforts were therefore being made to influence partners in this area, recognising that adopting the living wage was an important step towards supporting more prosperous and thriving communities. Bhanu Chadalavada advised that alongside the significant clinical work underway to improve access and outcomes, there was a continued focus on teaching and research. He reported that the University of Leicester was supporting work to strengthen inclusion healthcare within medical education, ensuring it becomes an essential competency for medical students and improving their understanding of the challenges faced by specific populations. Also highlighted was an upcoming research conference on 17 February 2026, jointly delivered by NHFT and LPT. The conference would showcase system wide collaborative projects, including initiatives to improve the management of long-term conditions in people with learning disabilities and to enhance access to general mental health services for post-partum women. No further questions or comments were raised.
GTB/25-6/023	**Declarations of Interest in respect of items on the agenda (verbal)** There were no declarations of interest in respect of items on the agenda.
GTB/25-6/024	**Minutes of the previous meeting held 25 September 2025 (Paper A)** Melanie Hall’s title was incorrectly listed and should be amended to read LPT and NHFT Non-Executive Director. The minutes were then approved as an accurate record of proceedings. **Resolved:** The Board approved the minutes subject to the correction noted above.
GTB/25-6/025	**Matters Arising Action Log (Paper B)** There were no outstanding actions recorded.
GTB/25-6/026	**Group Trust Board Workplan (Paper C)** The Group Trust Board Workplan was presented for information. No questions or queries were raised.
GTB/25-6/027	**Chief Executive Report (Paper D)**

	Angela Hillery presented this report which provided an update on current national issues and policy developments that affect the Group. The key areas highlighted were:- • An update on the Advanced Foundation Trust (AFT) and Integrated Healthcare Organisation process was received. Learning continued to be shared across the Group and LPT also wanted to enter the pipeline. With one ICB across the cluster, it was considered beneficial for both organisations to be in the pipeline. • Ongoing work relating to Talent Matters and Developing Diverse Leadership was reported. A continued focus remained on talent, diversity, and leadership development across the Group and both the Group CEO and Group Chief Nurse had attended the Development Senior Leadership Programme to support sessions. • Planning activity continued across both organisations; the importance of understanding the cluster approach while recognising differences in population needs and organisational contexts was stressed. • The Mental Health Bill had received Royal Assent and preparation work had been commissioned by Itai Matumbike, NHFT Chief medical Officer, on behalf of the East Midlands Alliance (EMA). Participation across EMA had been strong, and thanks were offered to both Itai Matumbike for leading the work and Bhanu Chadalavada, LPT Medica Director, for supporting colleague involvement. This work had produced significant learning resources and had informed recent board development activity. • It was recognised that both organisations would continue to undergo change driven by evolving ways of working, value programme requirements, national pressures, and the acquisition of services from ICBs and other partners. The Leading through Change programme developed by Sarah Willis, Group Chief People Officer, and colleagues was welcomed, as it aimed to equip leaders and staff to navigate organisational change more effectively. • An update was provided on CQC activity, with both Trusts undergoing active inspections. The Group CEO continued to contribute to national work on the well led framework and welcomed the CQCs intention to co-produce elements of its transformation. • Digital development remained central to the THRIVE Strategy and the Group had been shortlisted for work on ChatHealth, developed by LPT and now used more widely, including in NHFTs crisis services. This was recognised as a strong example of Group wide digital innovation. • National developments in mental health and community health were described. The positive involvement of the Group in several national programmes was noted although it was recognised there were further opportunities for the Group to increase its contribution moving forward. • Significant national work was underway to improve understanding of mental health prevalence.

	• A new modern service framework, particularly around severe mental illness (SMI) was expected to be introduced, and understanding this was encouraged. • CEO involvement in the Penny Dash programme would provide further insight into data and productivity which were areas recognised as critical for effective delivery of services. • Working collaboratively as an East Midlands Alliance and the wider Midlands and East networks continued to provide valuable opportunities for learning, support, and constructive challenge. The Group was progressing productivity and benchmarking work within this forum, including activity focused on length of stay in acute inpatient services across a range of trusts. Work was also underway to review productivity in children and young people's mental health services across the wider footprint, with further benchmarking activity being introduced for community mental health teams. This work was described as pioneering, as comparable benchmarking had not previously existed. • Both LPT and NHFT Managing Directors had recently presented the National Oversight Framework (NOF) position for their respective organisations at Trust Board meetings; it was highlighted that further development for the framework was expected for 2026-27 and this would be shared in due course. The Chair offered thanks for a comprehensive report and invited questions. Julia Curtis raised that, in relation to the Mental Health Bill receiving Royal Assent, the NHFT Quality Committee had undertaken a focused session following the joint Board workshop to ensure the organisation was prepared for the new requirements. Josie Spencer, Chair of the LPT Quality and Safety Committee, had joined the session. The mental health legislation teams in both organisations were working closely together, and much of the future learning would be undertaken jointly, given that the Bill would apply to both organisations in almost identical ways. In reference to the earlier presentation on health inequalities, Liz Anderson asked whether the organisation was among those receiving funding for health visiting vaccinations given the importance of reaching people who do not routinely access services. It was advised that although the funding intention had been signalled nationally, formal confirmation had not yet been received. **Resolved:** The Board received this report for information.
GTB/25-6/028	**Environmental Analysis (verbal)** No updates were reported.
GTB/25-6/029	**Group Board Assurance Framework (Paper E)** Kate Dyer presented this report which outlined strategic risks that could prevent the Group from its objectives. The report set out the strategic risks in common across both Trusts relating to shared objectives within the Group THRIVE Strategy which had been prioritised for Group delivery. Since the last Group

	Trust Board meeting held 25 September 2025, several changes had been made which had been reviewed and approved by the Group Strategic Executive Board (GSEB) in advance of being presented to the Group Trust Board for final approval. The key points were highlighted as follows:- • A proposal to combine the LPT and NHFT risks around the use of workforce strategies; now that a Joint People and Culture Committee (JPCC) had been established and the risks, both of which were similar in content, would be reviewed together as a Group risk. • To accommodate the amalgamation of the risks relating to workforce, two sections of THRIVE on the BAF, would be separated; this would change the numbering of the risks on the Group BAF in the next iteration to Group Trust Board. • A proposal to a change in title for Group BAF3 (detail contained in report). • Closure of 13 actions from the Group BAF action log (detail contained in report). Judit Seymour observed that BAF1 (digital transformation) did not yet reflect the full breadth of digital related risks, particularly in comparison with BAF5 and suggested broadening the definition to include areas such as cyber security, data management and digital training. She also noted that the targets for BAF2 and BAF5 had already been met by month nine and proposed that future targets be more stretching. Kate Dyer confirmed that the definition of the digital risk would be reviewed as part of the development of the 2026–27 BAF; elements of the digital framework were currently held within the individual Trust BAFs, and work would be undertaken to bring these together to ensure the Group-level digital risk more fully reflected the breadth and depth of digital transformation and ongoing operational digital requirements. It was also explained that the Group's risk appetite was intentionally open, reflecting the need to take opportunity-based risk within the current NHS context. As a result, some targets appeared to have been met early, although this reflected strong controls and an openness to taking proportionate risk rather than a lack of stretch. It was acknowledged this may not be immediately clear from the wording of the current BAF, but this would be strengthened during the development of the 2026–27 version. Melanie Hall asked about BAF5, noting that the risk remained at 12 due to the absence of defined costs for delivering the Green Plan. Assurance was sought that the costing work referenced would be completed in time to inform next year's budget, and clarification was requested on whether the risk rating was likely to decrease once costs were identified or increase if funding could not be secured. Paul Sheldon explained that the key constraint for both Trusts remained access to sufficient revenue and capital to deliver the programme. He reported that work was underway across the Group to cost the full Green Plan and develop a clear categorisation of actions for the new financial year; those requiring minimal investment, those that could be funded through external grants (eg recent solar panel funding), and those requiring internal or system investment. Many schemes would deliver financial as well as environmental benefits, and future discussions may need to adopt an "invest to save"

	approach. Once the costing work was complete and external funding opportunities assessed, the risk score could be re-visited with greater clarity. David Maher requested that, when the BAF is next reviewed, the Group refine the cyber risk to ensure alignment with the sub-regional cyber forum, noting the importance of maintaining consistent mitigations across the system. Kate Dyer confirmed that cyber risks were currently held individually within each Trust but that all digital and cyber risks were being reviewed and advised that the risk would be reframed as part of the 2026–27 BAF. **Resolved:** The Board received this report and approved the proposed changes.
GTB/25-6/030	**Joint People and Culture Committee AAA Highlight Report: 10 December 2025 (Paper F)** Tim Harrison presented this report and drew attention to the following key points:- • The brevity of the report was acknowledged, and the focus of this first meeting was on gaining assurance regarding the topics discussed, understanding the range of papers presented, and working towards greater consistency in the nature of papers considered. • The refreshed Terms of Reference, reflecting the combined approach, were approved. • The number of attendees was noted as high and would be considered further at future meetings. • The Valuing our People Management Group report was presented for awareness. Sickness was identified as a key risk and remained a priority for both LPT and NHFT. • The NHFT People Priorities summary would now align with LPT. • The LPT Workforce Development Group AAA report was received and the detailed recommendations in the sickness deep dive were commended. • The Joint People Dashboard received feedback; a more detailed review would take place in the upcoming People Packs. • LPT and NHFT People Packs received; the LPT pack was noted as a mature document; NHFT's pack was presented in a new format to support consistency. Assurance was received on both. • Joint Risk Report received; work was ongoing to align risks into a single Group risk report. • Celebrating Outstanding: Joint People Dashboard was acknowledged as a significant step forward in reporting, the LPT AFM report highlighted some outstanding contributions including a DAISY award winner, and LPT had been shortlisted for an HSJ Award in the Staff Wellbeing Category.

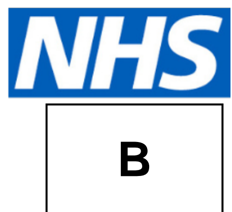
	Sarah Willis added that bringing the work together demonstrated the value of operating as a Group. This approach had enabled more effective use of capacity and capability across both organisations and supported shared learning and greater efficiency. The Chair acknowledged the significant amount of work involved and asked that thanks be conveyed to all those involved. Josie Spencer sought clarification on how the minutes should reflect the position on sickness absence, noting that while the report provided assurance, both LPT and NHFT continued to experience significant sickness challenges. Sarah Willis explained that the assurance received at the Joint People and Culture Committee (JPCC) related to the quality and reliability of the KPI information being presented. LPT had previously undertaken a deep dive into sickness absence, which had provided assurance through its committee structure last year. However, sickness levels remained elevated across both LPT and NHFT. As a result, a further deep dive had been commissioned, and Terms of Reference had been developed to examine all aspects of sickness absence. This work would provide assurance on the data currently being reported, but the deep dive and Terms of Reference, when brought to the JPCC, would generate further discussion. **Resolved:** The Board received this report for information and assurance.
GTB/25-6/031	**THRIVE Strategy Update (Paper G)** David Williams presented this report which provided an update on progress against the delivery of the THRIVE Strategy across the Group. The differences in the way NHFT and LPT classify and code projects was explained, meaning that project numbers between the two organisations were not directly comparable. It was noted that any elements identified as being off-track were monitored through each organisation's governance processes. Examples of progress within the Technology ambition, including the trial of ambient voice technology and ongoing development of robotic process automation was highlighted, both of which aimed to reduce manual administrative tasks and free clinical capacity. It was noted these initiatives also contributed to wider ambitions such as valuing people and improving efficiency. Links across several THRIVE themes were drawn and work to identify and tackle unwarranted variation was referenced, including the use of health inequalities and attendance data to reduce DNAs. Also summarised was the Responsive work set out in Appendix 2, referencing improvements in urgent care pathways, inclusive recruitment, co-production and initiatives to grow internal talent. As the Group progressed into the next phase of reporting, there would be a continued focus on improving consistency of understanding and the comparability of reporting across NHFT and LPT. This included ongoing work towards a common classification and reporting approach. Julia Curtis thanked David Williams for the report, noting it was easy to read and understand and that the visuals were particularly effective. She referenced the earlier point that any off-track elements were monitored through established governance routes and asked whether, within the period covered by this report, there were any areas that were significantly off-track. David Williams confirmed there were no elements currently off-track and explained that an escalation

	process was in place through the Executive Management Boards, should any programme or project require wider engagement. Duncan Orme agreed with the comments on the quality and readability of the report. He highlighted his interest in outcomes and outcome measurement throughout the development of the THRIVE Strategy and asked, in relation to the asthma project under Healthy Communities, whether there was scope to better understand how outcomes were being measured and improved. He added that he was happy to discuss this further outside the meeting if the example was not the most appropriate. David Williams confirmed that further information could be provided and suggested that a service visit might offer useful insight into the work in practice and indicated this would be explored further outside the meeting. Discussion followed whereby the importance of strengthening the way outcomes are measured and reflected within the THRIVE Strategy was highlighted, and members noted ongoing work within services to define and measure outcomes, supported by workshops and co-production activity. It was noted that opportunities existed for further discussion outside the meeting regarding approaches to outcome measurement. The value of increasing the visibility of outcome related work within future THRIVE reporting was emphasised. Also noted was that more granular outcome measures would support clearer understanding of the wider benefits of strategic changes, including how improvements in one area may positively impact others. **Resolved:** The Board received this report for information and assurance.
GTB/25-6/032	**East Midlands Alliance (EMA) Common Board Paper (Paper H)** David Williams introduced this report which provided a summary of the work and plans of the East Midlands Alliance including the discussions and agreements from the EMA Board meetings held in October and December 2025. The value of collective learning and collaboration was emphasised, and the common themes within the paper were outlined, highlighting work on health innovation, patient safety, population health and inequality reduction, alongside workforce support and quality improvement – key areas expected to improve outcomes. Melanie Hall commended the paper for clearly demonstrating the breadth and depth of activity, and drew attention to the Impact Forensic Collaborative, which had been discussed at the LPT Finance and Performance Committee, where monitoring the potential future impact and associated risk share opportunities would continue. She also highlighted the positive reference to the New Horizons programme, recognising its value in supporting international nurses and the wider challenge of sustaining their retention and wellbeing, and asked about the opportunity to implement the programme locally now that centralised funding had ceased. Sarah Willis responded that this required further consideration and confirmed she would explore the options and seek clarification.

	Julia Curtis shared activity relevant to the EMA, reporting that Josie Spencer had convened a meeting of the six Quality and Safety Committee Chairs across the Alliance to support shared learning and collaboration. She advised that the Group had begun by sharing their workplans and that this 'behind the scenes' work was helping to align quality and safety approaches across the organisations. **Action:** Sarah Willis to review the feasibility of implementing the New Horizons programme locally. **Resolved:** The Board received this report for information.
GTB/25-6/033	**Group Value Programme Update (Paper I)** Paul Sheldon introduced this report which provided an update on progress towards a Group Corporate and Enabling Service across LPT and NHFT against the changing national and local financial context. Paul Sheldon reported that the corporate services benchmarking return continued to show significant opportunities for efficiency, alongside NHS England's requirement to limit growth in corporate services. He noted that the recent Group level changes across digital, estates and facilities and organisational development were already delivering benefits through shared learning, increased resilience and recurrent savings. Work was also progressing to align with developments across the two ICBs and to establish a single commissioning hub for the EMA. He confirmed that the Transitional Group was operational, with key risks identified, and emphasised the importance of ongoing engagement with staff side. Further changes would be across people directorates, corporate governance and contracting and procurement. To date, £1.7m of recurrent savings had been delivered across both Trusts, with finance teams working jointly to validate and track these savings. Josie Spencer acknowledged the challenge of maintaining momentum and, given that the Transition Group reported into the Group SEB and respective Finance and Performance Committees, while the Group Board met relatively infrequently, asked how oversight and pace would be maintained between Board meetings. Paul Sheldon confirmed that both organisations' Finance and Performance Committees were monitoring outcomes and tracking savings through their respective value programmes. He acknowledged the cyclical momentum of the programme and advised that, although the Group Board does not meet often enough to oversee any development, the two Boards would be convened if any significant issue or decision required their timely consideration. Sharon Murphy commented that this programme represented a key area in which the Group could clearly quantify benefits and noted that, despite the absence of redundancy funding, working as a Group had enabled opportunities to implement changes that released savings while strengthening organisational resilience. Angela Hillery emphasised that the balanced approach to risk demonstrated the importance of continuing to drive recurrent opportunities across both organisations. Sub-committees played a central role in maintaining organisational oversight and ensuring clarity on what each organisation

	required from the programme. Given the scale of opportunity, it was essential to maintain a collective and focused approach to delivering he agreed changes. **Resolved:** The Board received this report for information and assurance.
GTB/25-6/034	**Joint Performance Report (Paper J)** The Board received an overview of joint LPT-NHFT performance. It was reported that both organisations continued to demonstrate strong operational performance, supported by positive direction of travel in finance and productivity indicators, as reflected in the NHS Oversight Framework (NOF). Quality improvement capability remained strong, with NHFT progressing work on the AFT pathway and an ambition for LPT to join in due course. Workforce metrics showed low turnover and high appraisal and training compliance across both Trusts, though sickness absence remained above target. Ongoing pressures were noted in urgent community response services. Length of stay challenges were also highlighted, particularly where patients had complex restrictions. Capital constraints continued to impact some estate-related improvements, notably at the Bradgate Mental Health Unit (BMHU). The Board noted the increasing opportunities for shared learning and alignment across the Group, including work on access and flow, long waits, neurodevelopmental pathways, job planning, data quality and demand management, as well as ongoing development of joint workforce and estates approaches expected to support future improvement. Jean Knight highlighted that, within LPT, the majority of community long waits related to children, young people and adults awaiting neurodevelopmental assessments. This had been raised with commissioners in LLR and both the Group CEO and LPT Medical Director were continuing discussions with colleagues on how this issue could be addressed across the wider footprint with Northamptonshire. The volume of neurodevelopmental waits remained a significant concern for both LPT and its population. Melanie Hall thanked colleagues for the evolving report and asked about the process and timing for incorporating additional metrics to reflect emerging Group programmes and queried how the report would continue to develop as Group arrangements matured. Jean Knight acknowledged that achieving the right balance would be key and advised that work was underway to develop an integrated organisational performance report which would provide an opportunity over the next six months for the Group Board to shape how shared and individual metrics were enhanced. Exploring this further at a future Board Development Workshop was suggested Angela Hillery stated that while sharing data across the Group was beneficial, it was also important to understand what the information demonstrated, the difference it made, and which elements should be considered jointly at Group level versus those that should continue to be viewed within each individual organisation. **Resolved:** The Board received this report for information.

GTB/25-6/035	**Any other business** There were no other items of business.
	Close - date of next public meeting(s): Thursday, 28 May 2026 commencing at 3.00pm Tuesday, 29 September 2026 commencing at 3.00pm Thursday, 28 January 2027 commencing at 3.00pm



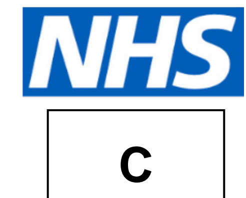
Public Group Trust Board of Directors 28 May 2026

Matters arising from the Public Group Trust Board of Directors meeting held 29 January 2026

Action sheet

Minute no.	Action/ issue	Lead	Due date	Status	Evidence
GTB/25-6/032	Further consideration of implementing the New Horizons programme locally to be reviewed now that centralised funding had ceased.	Sarah Willis	20.05.26	Complete	The *New Horizons* programme has been reviewed; however, it will not be implemented locally at this time as neither Trust is currently recruiting international nurses. Existing support arrangements remain in place, with coaching and mentoring continuing to be available internally to all staff.

Leicestershire Partnership and
Northamptonshire Healthcare
Associate University Group



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Group Trust Board Workplan 2026/27 v2

Standing Items	Item Type	Frequency/Lead	28 May 2026	29 Sept 2026	28 Jan 2027
Apologies/Welcome	Verbal	Every meeting/ Chair	X	X	X
Service Presentation *(30mins)*	Presentation	Every meeting/ Chair	X	X	X
Questions from the Public		Every meeting/ Chair			
Declarations of Interest in respect of items on the agenda	Verbal	Every meeting/ Chair	X	X	X
Minutes of Previous Meeting	Paper	Every meeting/ Chair	X	X	X
Matters Arising (Action Log)	Paper	Every meeting/ Chair	X	X	X
Group Trust Board Workplan	Paper	Every meeting/ Chair	X	X	X
Chief Executive Report	Paper	Every meeting/ Chief Executive	X	X	X
Environmental Analysis	Verbal	Every meeting/ Group CEO, Group Chair, Managing Directors	X	X	X
Environmental Analysis **(confidential agenda)**	Verbal	Every meeting/ Group CEO, Group Chair, Managing Directors	X	X	X

Standing Items	Item Type	Frequency/Lead	28 May 2026	29 Sept 2026	28 Jan 2027
Governance and Assurance					
Board Assurance Framework	Paper	Every meeting Directors of Governance and Risk	X	X	X
Group Partnership Agreement Annual Review	Paper	Annual Directors of Governance and Risk	X		
Group Terms of Reference	Paper	Directors of Governance and Risk	X		
Group Board Annual Effectiveness Review	Paper	Every meeting Directors of Governance and Risk	Timing tbc	Timing tbc	Timing tbc
Group Board Development Programme	Paper	Annual Directors of Governance and Risk	X		
Quality, Safety and Compliance					
Framework for Quality Assurance and Improvement (FQAI) *(Annual report on medical appraisal and revalidation)*	Annual Chief Medical Officers			X	
People and Culture					
Joint People and Culture Committee AAA Highlight Report	Paper	Every Meeting Chair, JPCC	X (11.02.26 & 09.04.26)	X (10.06.26 & 13.08.26)	X 08.10.26 & 10.12.26)
Annual National Staff Survey Results	Paper	Annual Group Chief People Officer	Timing tbc	Timing tbc	Timing tbc
Strategy and System Working					
THRIVE Strategy Update	Paper	Every Meeting Group Executive Director of Strategy and Partnerships		X	X
Annual Delivery Plans • *To be populated*		Annual Group Executive Director of Strategy and Partnerships	*As required*	*As required*	*As required*

			28 May 2026	**29 Sept 2026**	**28 Jan 2027**
Standing Items	**Item Type**	**Frequency/Lead**			
East Midlands Alliance Common Board Paper	Paper	As required Group Executive Director of Strategy and Partnerships	*As required*	*As required*	*As required*
Group Performance					
Group Value Programme Update	Paper	Every meeting Group Chief Commissioning Officer	X	X	X
Joint Performance Report	Paper	Every meeting Managing Directors	X	X	X

Leicestershire Partnership and
Northamptonshire Healthcare
Associate University Group

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Group Trust Board 28th May 2026

Chief Executive Report

Purpose of the Report

This paper provides an update current national issues and policy developments that affect the Group. The details below are drawn from a variety of sources, including system meetings and information published by NHS England (NHSE), NHS Providers, the NHS Confederation, and the Care Quality Commission (CQC). It provides an opportunity for the Chief Executive to update on any key aspects for Trusts and Group consideration.

Analysis of the Issue

Advanced Foundation Trust and Integrated Healthcare Organisation status

Following the invitation for NHFT to enter the first wave AFT application process, the required submissions have now been completed and formally submitted to NHS England. We are currently awaiting confirmation of the outcome and next steps. The opportunity to learn and share insights from the AFT process across the Group has been taken. Achieving AFT status remains a gateway requirement for IHO designation, and engagement with system partners, including the ICB and NHS England, will continue as this work progresses.

I have recently had the opportunity to share my thoughts and experiences on the AFT/IHO process at two external events, speaking at the NHS Providers Chairs & Chief Executives Network Meeting in March and participating as a guest speaker, alongside other peers, at the recent HSJ Provider Summit. These were both opportunities to share the learning that we have experienced going through these processes.

Group Value

LPT and NHFT have savings targets of 6.5% for 2025/26 which was difficult to deliver and both trusts face a savings target of over 6% again in 2026/27. Corporate Benchmarking shows a potential £15.9m opportunity to reduce corporate service costs, particularly in Digital, People, and Corporate Nursing/Governance. The Group Value Programme was established in 2024 and has progressed a series of changes to move toward a shared Corporate and Enabling Service model.

With the full year effect of savings from 2025/26 and new changes implemented across both trusts in 2026/27 the programme estimates recurrent full year savings of c.£3.0m. These savings are those which have been validated with more in development and are in addition to those delivered in previous years.

We recognise that any change is difficult, particularly alongside the day-to-day pressures of delivering quality care for the population we serve. I would like to thank all of our staff across both organisations for the hard work, flexibility and professionalism they continue to show as these

changes are implemented. We remain committed to listening to colleagues and responding to feedback as we progress the programme and we continue to support staff through the leadership for change programme as we deliver our value programmes across both trusts.

St Andrews

We are currently conducting due diligence on a proposal to provide a range of inpatient services on the current St Andrew's Healthcare Northampton site. We are working closely with partners including NHSE on this. We will continue to keep our Board informed of developments.

Planning

Both Trusts have now received feedback from NHSE on their submission for the medium-term plan for 2026/27–2028/29 and five-year Strategic Commissioning Plan. Work continues to take place on the delivery of these plans in both Trusts.

Stronger Foundations – System Response

A collective single-system response has recently been submitted by LNR to NHSE in response to the Stronger Foundations next steps request. This followed a request from NHSE for ICBs, working with provider partners, to set out how they will bring the benefits of the 10 Year Health Plan to life through strategic commissioning, neighbourhood development and accelerated progress on key priorities for 2026/27, including the interventions, outcomes, delivery arrangements and any national support required. Coordinated by the ICB on behalf of health partners, the submission sets out a shared strategic approach for 2026/27 and beyond, key priority areas include prevention, children and young people, frailty, preventable mortality, digital transformation and productivity. The response was developed through joint work at all levels alongside engagement with general practice and local authority partners. This reflects growing alignment across both systems around a common set of priorities. Detailed delivery planning is now being taken forward to bring measurable actions and impact.

Staff Survey

Following the staff survey results from both Trusts, which were reported in the Managing Directors' reports in March 2026, improvement plans are now underway. A programme of work has been established to build on what is working well and to strengthen the areas colleagues have told us matter most to them. I would also like to thank staff across both Trusts for taking the time to participate in the survey, which is reflected in both Trusts achieving response rates above the national average; it is particularly pleasing that both Trusts also scored above average across all People Promise indicators.

Joint Nursing Conference

On Wednesday 13th May we held our International Nurses Day 2026 Group event to recognise and celebrate our amazing nurses. This year's theme was “Our Future. Empowered Nurses Save Lives.” This was our first year celebrating as a Group event and was a fantastic opportunity to bring both organisations together in one shared space that allowed people to build new relationships and share insights across the Group.

The contents of the day gave attendees an insight into roles beyond traditional nursing, exploring the variety of directions a career in nursing can lead; into management, digital health and prison healthcare. The day also focused on quality improvement and supporting our nurses of the future.

Thank you to all involved for their hard work in planning and facilitating this event.

CQC

In my role as a CQC Executor, I have recently participated in a Well-led inspection of another NHS organisation. This work provides valuable opportunities to capture learning and share best practice from across the sector.

Children and Young People's Mental Health – CAMHS Day Services

The East Midlands Alliance (EMA) has announced the launch of new Child and Adolescent Mental Health Services (CAMHS) Day Services across the region, representing a significant step forward in providing more community-based, less restrictive care for children and young people. Delivered through the East Midlands CAMHS Collaborative, the new services will offer intensive, specialist support as an alternative to inpatient admission, enabling young people to remain closer to home while continuing with elements of daily life such as education and family relationships.

Leicestershire Partnership NHS Trust will be the first to go live at the Beacon Unit at Glenfield Hospital, with Lincolnshire Partnership NHS Foundation Trust introducing a further service later in the year. This development supports the collaborative's ongoing ambition to improve outcomes for children and young people by expanding flexible, preventative care and reducing reliance on inpatient settings

Equality, Diversity and Inclusion – Patient and Carer Race Equality Framework (PCREF)

Chief Executives from across the East Midlands Alliance recently met to review regional progress in implementing the Patient and Carer Race Equality Framework (PCREF), a key national programme aimed at reducing racial inequalities in mental health services and supporting organisations to become actively anti-racist. The session provided an opportunity to share learning, reflect on challenges, and review local progress against the framework's core areas of leadership and governance, data and transparency, and effective patient and carer feedback mechanisms. Updates highlighted the positive work underway across providers, including the embedding of PCREF within organisational strategies and its inclusion within the Care Quality Commission inspection framework. The discussion reinforced the Alliance's collective commitment to improving access, experience and outcomes for people from ethnic and cultural minority communities through strong system leadership and collaboration.

NHS Excellence Awards – Regional Recognition

I was delighted to see that both systems were recognised in the recently announced NHS Excellence Awards. The East Midlands Child and Adolescent Mental Health Services (CAMHS) Provider Collaborative has been recognised as the regional winner in the Improving Health Outcomes category. Led by Northamptonshire Healthcare NHS Foundation Trust and working in partnership with NHS and voluntary sector organisations, the collaborative was recognised for its transformational impact in improving access to care, reducing waiting times, and significantly

lowering inpatient admissions and lengths of stay through a strengthened focus on community-based provision.

The Leicester, Leicestershire and Rutland Chronic Kidney Disease Integrated Care Delivery (LUCID) programme was the winner for the Delivering value award.

Congratulations to all those involved in both programmes for their hard work.

Mental Health strategy

The Department of Health and Social Care has launched a call for evidence to inform the development of a new cross-government mental health strategy for England, intended to support a fundamental shift from crisis intervention to prevention and earlier support. The strategy is part of the wider 10 Year Health Plan for the NHS and will seek to improve access, consistency and outcomes for people by addressing variation in provision, strengthening community-based support and ensuring people are able to access help earlier and more proportionately. The strategy will also consider the role of schools, workplaces, the voluntary sector and local government in promoting positive mental health. We welcome this significant national development that we will be engaging with and continue to monitor closely as further detail emerges.

Further information can be found here: Government to transform mental health care with new strategy - GOV.UK

Severe mental illness Modern Service Framework

NHS England and the Department of Health and Social Care have launched a national call for proposals to inform the development of a Modern Service Framework for Severe Mental Illness, aligned to the Governments 10 Year Health Plan. The framework will set out the long-term outcomes the system should achieve and define what high-quality, evidence-based and equitable care looks like, underpinned by a shared ambition that by 2035 people with severe mental illness will live longer, healthier and more fulfilling lives. Organisations across health and social care, including VCSE and those with lived experience, are invited to submit interventions or areas of activity, including those that address inequalities. We will be working with system partners to put forward out proposals and welcome the opportunity to engage in this important area.

Medicines Safety – Psychotropic Medication

Across the East Midlands, Health Innovation East Midlands has been working in partnership with LNR ICB to support the safer use of psychotropic medicines for people with a learning disability who are at risk of behaviours that challenge. This work forms part of the national Medicines Safety Improvement Programme and is focused on reducing harm associated with the over-prescribing of psychotropic medication, while promoting safer, more person-centred approaches to care. The programme demonstrates the value of system-wide collaboration in improving medicines safety, addressing health inequalities and strengthening quality of care for some of the most vulnerable people across our communities

UK Threat Level

In line with national guidance received from the Joint Terrorism Analysis Centre (JTAC) we recognise the UK threat level has moved to severe and being led by our ICB, and working with our staff and system partners, we are ensuring we take the appropriate steps to ensure that we comply with all associated requirements for the safety of our staff and those we serve.

Further information can be found here Threat Levels | MI5 - The Security Service

Vaccination Programmes

NHS England has launched the spring COVID-19 vaccination programme, available to people over 75, those with a weakened immune system. The programme targets those most at risk of severe illness, including people aged 75 and over, older residents in care homes and individuals who are immunosuppressed, appointments available daily through GP practices and community pharmacies. NHS England has highlighted that protection from previous vaccination can diminish over time and that COVID-19 continues to circulate year-round, making booster vaccination an important preventative measure. The programme builds on evidence cited as part of the UK COVID-19 Inquiry, which estimated that vaccines had saved hundreds of thousands of lives, and reinforces the NHS's ongoing commitment to protecting the most vulnerable and reducing avoidable hospital admissions

The NHS respiratory syncytial virus (RSV) vaccine programme has now also been extended to include all adults over 80 and people living in a care home for older adults. The vaccine can be booked via a GP practice, by speaking to staff in care homes and some community pharmacies in parts of England are also offering this.

Further information can be found here: NHS England » Lifesaving spring COVID-19 jab offers protection to millions of vulnerable people

NHS England » Millions of older people to get vaccine against serious lung infection

Medical Workforce – Medical Education and Training Review

NHS England and the Department of Health and Social Care have appointed Professor Dame Jane Dacre to lead the implementation phase of the Medical Education and Training Review, which aims to modernise postgraduate medical training across the UK. The review follows the publication of a Phase 1 diagnostic report, informed by more than 8,000 responses, which identified key challenges within the current training system and set out 11 recommendations focused on four priorities: increasing training flexibility, better aligning service and training, addressing recruitment bottlenecks, and improving team working and staff experience. The implementation phase will involve close collaboration with doctors, regulators, medical schools, royal colleges and system partners, with the objective of delivering practical reforms to ensure medical training is better aligned with the needs of patients and the future NHS workforce

Further information can be found here: NHS England » New medical training chair to bring system from "dial up" to modern era

Care Quality Commission – Regulatory Approach Update

The Care Quality Commission (CQC) have recently published an update on progress to evolve its approach to assessing and rating health and social care providers, following consultation on its

Better regulation, better care proposals. CQC confirmed it is moving away from a single assessment framework and developing four sector-specific assessment frameworks covering adult social care, mental health care, primary care and community services, and hospitals. The updated approach retains CQC's five key questions (safe, effective, caring, responsive and well-led) and introduces clearer, sector-specific rating characteristics to support more transparent and consistent judgements. The update also confirmed plans to remove scoring from assessment methodology, with ratings to be determined directly at key question level, and set out CQC's ongoing engagement with providers, the public and partners as the draft frameworks continue to be refined.

Further information can be found here: Our March update - Care Quality Commission

Relevant External Meetings attended since last Trust Board meetings

April/May 2026
Mental Health Supply Side Review Working Group
Industrial action briefing call, NHSE CEO
Regional Director of Commissioning Integration, NHSE
CEO at Mersey Care NHS Foundation Trust
National Director Appointed for Mental Health, LD, and Autism, NHSE
LNR ICB CEO
East Midlands Alliance CEO Meeting
HSJ Provider Summit
NHSE Midlands NHS Leadership Meeting
West Northants SEND CEO
NHSE NHS Oversight Framework 26/27 Webinar
National Director Appointed for Mental Health, LD, and Autism, NHSE
Director of System Architecture at NHSE
National CEO Working Group
LNR System CEOs
NHSE NHS Leadership Event
Deputy Director of System Co-ordination & Oversight at NHSE
Director of Intensive Support, NHSE
LNR Chairs & CEOs Meeting

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

Abbreviations:

AFT = Advanced Foundation Trust

CEO = Chief Executive Officer

CAMHS = Child and Adolescent Mental Health Services

CQC = Care Quality Commission

EMA = East Midlands Alliance

HSJ = Health Service Journal

ICB = Integrated Care Board

IHO = Integrated Healthcare Organisation

JTAC = Joint Terrorism Analysis Centre

LD = Learning Disability

LNR = Leicestershire, Northamptonshire & Rutland

NHSE = NHS England

RSV = Respiratory Syncytial Virus

SEND = Special Educational Needs and Disabilities

VCSE = Voluntary, Community and Social Enterprise

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:	Group Trust Board
Paper sponsored by:	Angela Hillery, Chief Executive
Paper authored by:	Sinead Ellis-Austin, Head of Chair/CEO Office
Date submitted:	19th May 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:	September 2026

THRIVE strategic alignment:	☒ Technology ☒ Healthy communities ☒ Responsive ☒ Including everyone ☒ Valuing our people ☒ Efficient and effective
Board Assurance Framework considerations:	
Is the decision required consistent with the Group'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

NHS
Leicestershire Partnership and
Northamptonshire Healthcare Group

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Group Trust Board 28 May 2026

Board Assurance Framework 2026/27 Opening Report

Purpose of the Report

The first full report of the 2026/27 Board Assurance Framework for the Group Trust Board, containing opening detail around the determination of baseline scores and risk zoning.
This Group BAF report replaces the individual risk reports previously provided to the Trust Board meetings for Leicestershire Partnership NHS Trust (LPT) and Northamptonshire Healthcare NHS Foundation Trust (NHFT).

Introduction and Background

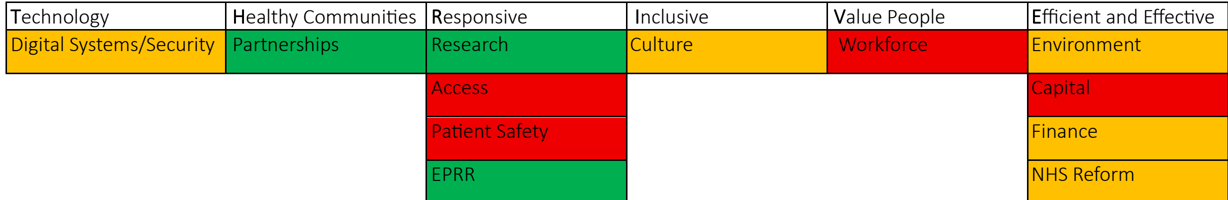
This paper provides a guide to the initial risk profile and scoring for each strategic risk on the 2026/27 Board Assurance Framework (BAF).

This guide provides the following key developmental updates;

- A summary of our risk profile aligned to our strategy THRIVE.
- A guide to the scoring and profile of risk zoning at the start of the year.
- A summary of the BAF risks.
- The full BAF slide pack for 2026/27 is provided separately.

Summary

The risks to LPT and NHFT achieving the group strategy 'THRIVE' are summarised below. There are 12 strategic risks in total spread across the six components of THRIVE;



Technology	Healthy Communities	Responsive	Inclusive	Value People	Efficient and Effective
Digital Systems/Security	Partnerships	Research	Culture	Workforce	Environment
		Access			Capital
		Patient Safety			Finance
		EPRR			NHS Reform

Any changes to the impact or likelihood scoring, risk zoning, controls, assurance and progress with mitigating actions will be reported at each meeting of the Group Trust Board during the year, and within both individual trust boards where tailored risk reports will be received which also detail the relevant underpinning corporate risk profile in each trust.

Risk Scoring

Baseline impact and likelihood scores, and the initial zone rating have been determined as an opening position for the 2026/27 Board Assurance Framework.

Top scoring risks

By current **impact** score (4 in top place with a score of 5)	By current **likelihood** score (4 in top place with a score of 4)	By current **zoning** (4 in top place rated red)
- Access to Services - Patient Safety - Workforce - Capital Funding	- Workforce - Capital Funding - Financial Position - NHS Reforms	- Access to Services - Patient Safety - Workforce - Capital Funding

Non Multiplication Risk Zoning

Risk zoning is applied based on an assessment of the impact and likelihood scorings, the level of controls and assurances available, and the degree to which mitigation action is aimed at filling a control weakness or contributing to best practice. These are applied at the start of the year and reviewed monthly along with the wider BAF risk reviews undertaken by the lead executive directors. Any changes during the year will be provided along with a rationale to the individual Trust Boards and the Group Trust Board.

The rationale includes the separate scoring for Impact (I) and Likelihood (L) for each risk based on the following;

Score	1	2	3	4	5
Impact	Insignificant	Minor	Moderate	Major	Catastrophic
Likelihood	Rare	Unlikely	Possible	Likely	Certain

Red Zone Rationale

Red Zone	Rationale
Access to Services	I5xL3 Increasing demand, low funding, critical to safety, some gaps in controls and assurance
Patient Safety	I5xL3 Criticality remains, ongoing need for maturity, some gaps in controls and assurance
Workforce	I5xL4 Criticality remains with ongoing long term mitigations required, some gaps in controls and assurance
Capital Funding	I5xL4 Crucial for maintaining and improving delivery and meeting legal requirements. Some gaps in controls and assurance

Amber Zone Rationale

Amber Zone	Rationale
Digital Systems and Security	I4xL3 Increased threat and key gaps exist with evidence of some strong controls and assurance in place
Culture	I4xL3 Strong staff feedback with long term cultural development programmes, some gaps in controls and assurance
Therapeutic Environment	I4xL3 Strategic commitment with reliance on capital funding, some gaps in controls and assurance
Financial Position	I4xL4 Challenging environment remains with strong controls and external and internal assurance
NHS Reforms	I4xL4 Significant reform creating uncertainty with some controls and good external and internal assurance in place.

Green Zone Rationale

Green Zone	Rationale
Partnerships & Collaboratives	I4xL2 Good system approach, further maturity anticipated with strong controls and assurance in place
Research and Innovation	I4xL2 Strategic commitment, group priority, progressing maturity with plans to address the gaps in controls and assurance
Emergency Preparedness	I4xL2 External threat remains but strong controls in place with strong external and internal assurance

Summary

BAF No.	BAF Title	Zone
BAF01	If we do not have robust arrangements for maintaining and improving digital systems, cyber and data security disruption, we will not have sufficient resilience to provide access to mature digital systems to ensure the provision of safe care.	
BAF02	If we do not continue to evolve our partnerships and collaboratives, we will not reduce health inequalities and deliver improved outcomes for our communities.	
BAF03	If we are unable to build a sustainable approach to the continual development our research, innovation and professional learning capability, our ability to attract the best people, operate on the leading edge of service delivery and exert influence within the sector will decline over time.	
BAF04	Without providing people with timely access to services and appropriate support, we cannot provide high quality safe care for our patients which will impact on clinical outcomes.	
BAF05	If we do not continue to review and improve our systems and processes for patient safety, we may not be able to safeguard our population and provide the best experience and clinical outcomes for our patients and their families.	
BAF06	If we do not have appropriate emergency preparedness, resilience, and response controls in place, we may be impacted by accidents, disruption and system failures affecting our ability to maintain continuity of services.	
BAF07	If we do not understand our culture, staff experiences, and grow levels of wellbeing in ways that help us to lead and grow with compassion, we will not maintain an inclusive culture, resulting in unwanted behaviours and closed cultures.	
BAF08	If we do not effectively embed workforce resourcing strategies and plans, there is a risk of insufficient recruitment, retention, and representation, which will lead to increased reliance on temporary staffing and elevated bank / agency expenditure.	
BAF09	If we are unable to maintain a sustainable infrastructure and therapeutic environment in line with service requirements, patient need and policy, we may be unable to deliver the desired patient outcomes and financial plan.	
BAF10	Inadequate capital funding for our local systems will impact on each Trust's ability to manage key financial, quality & safety risks related to our need for estates and digital investment in 2026/27 and the medium term.	
BAF11	Inadequate control, reporting and management of the 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.	
BAF12	The NHS reforms and performance oversight framework may create an unstable environment with tighter restrictions, which may impact on the pace and delivery of service transformation across our communities.	

Proposal

- To continue to receive regular risk reports at the Group Trust Board and individual Trust Board meetings.
- To continue to receive assurance over mitigating programmes of work at the relevant Level 1 Committees.

Decision

- To approve the opening position of the 2026/27 Board Assurance Framework

Governance Table

For Board and Board Committees:	Group Trust Board 28 May 2026
Paper sponsored by:	Kate Dyer Director of Governance and Risk LPT Richard Smith Director of Corporate Governance NHFT
Paper authored by:	Kate Dyer Director of Governance and Risk LPT
Date submitted:	18 May 2026
Name and date of other 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:	Routine reporting to Group Trust Board, and LPT / NHFT Trust Boards and level 1 committees. BAF content also included within the LPT and NHFT Executive Management Boards, Audit and Risk Committees and level 2 delivery group risk reports.
THRIVE strategic alignment:	☒ **T**echnology ☒ **H**ealthy communities ☒ **R**esponsive ☒ **I**ncluding everyone ☒ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations:	ALL
Is the decision required consistent with LPT and NHFT's risk appetites:	Yes
False or Misleading Information (FOMI) considerations:	None
Positive confirmation that the content does not risk the safety of patients or the public:	Confirmed
Equality considerations:	None

Leicestershire Partnership and
Northamptonshire Healthcare
Associate University Group

Board Assurance Framework

May 2026

Quick Guide

Strategic Risk

- We have a group strategy across Leicestershire Partnership NHS Trust (LPT) and Northamptonshire Healthcare NHS Foundation Trust (NHFT). The BAF enables members of both Boards to identify and understand the principal risks to achieving our objectives structured around our 'THRIVE' strategy.
- The BAF is owned jointly primarily by our Group Trust Board and is overseen by our LPT and NHFT Trust Boards and Group Strategic Executive Team structures, alongside our Level 1 (Board Sub) Committees.

Aligning controls and assurances

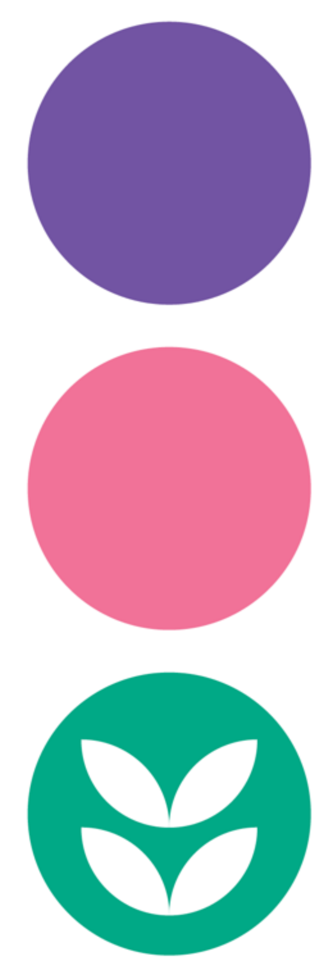
The format presents the controls, assurances, gaps and actions together. This means that we can provide assurance over whether existing controls are working. Where they are not, we can be clear about the action required to resolve this. We are also able to clearly identify where additional controls and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

Three lines of assurance model

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

Cause, Risk and Effect

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



Quick Guide

Leicestershire Partnership and
Northamptonshire Healthcare
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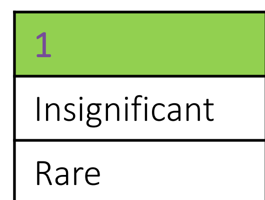
Clarity over scoring stages

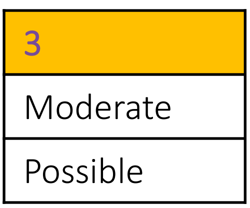
Staging terminology is defined as;

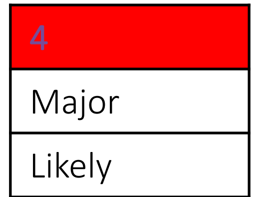
- Initial score. This is the score considering the controls in place at the time that the risk was entered onto the BAF, assuming that they are working.
- Current score. This is the score considering the controls currently in place, assuming that they are working.
- Target score. This is the score once any new mitigating controls have been put in place; this will need to be within our target appetite or will need to be tolerated and justified as such in the covering risk report.

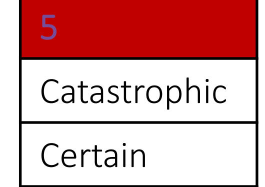
Scoring

The BAF is based on a 5x5 qualitative risk matrix with non-multiplicative colour zoning. Impact and likelihood are each scored 1-5 but the final risk rating is not calculated by multiplying the two numbers. Instead, the rating is determined by a heatmap (zones red amber and green) that reflect risk appetite. This allows us more control, where we can apply custom thresholds to safely apply an eager appetite toward decision making and taking risk.





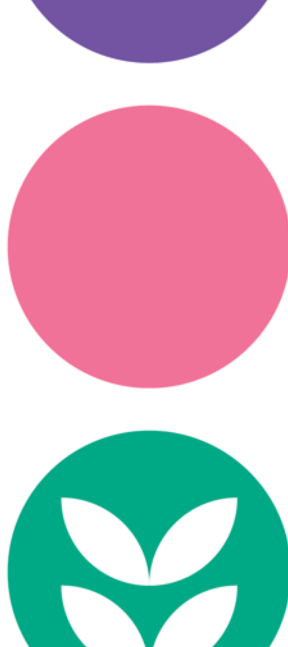




Score	1	2	3	4	5
Impact	Insignificant	Minor	Moderate	Major	Catastrophic
Likelihood	Rare	Unlikely	Possible	Likely	Certain

Risk Appetite

The Trust Boards have applied an eager appetite for each category of risk for 2026/27. This means that we have a willingness to make decisions which may impact on our current business as usual for longer term reward and improvement if appropriate controls are in place. This will require a focus on assurance over the strength of our existing internal control framework, as well as identifying and embedding any new controls.



BAF Summary

BAF No.	BAF Title	Zone
BAF01	If we do not have robust arrangements for **maintaining and improving digital systems, cyber and data security disruption**, we will not have sufficient resilience to provide access to mature digital systems to ensure the provision of safe care.	
BAF02	If we do not continue to **evolve our partnerships and collaboratives**, we will not reduce health inequalities and deliver improved outcomes for our communities.	
BAF03	If we are unable to build a sustainable approach to the continual development our **research, innovation and professional learning capability**, our ability to attract the best people, operate on the leading edge of service delivery and exert influence within the sector will decline over time.	
BAF04	Without providing people with **timely access to services and appropriate support,** we cannot provide high quality safe care for our patients which will impact on clinical outcomes.	
BAF05	If we do not continue to review and improve our systems and processes for **patient safety**, we may not be able to safeguard our population and provide the best experience and clinical outcomes for our patients and their families.	
BAF06	If we do not have appropriate **emergency preparedness**, resilience, and response controls in place, we may be impacted by accidents, disruption and system failures affecting our ability to maintain continuity of services.	
BAF07	If we do not understand our **culture**, staff experiences, and grow levels of wellbeing in ways that help us to lead and grow with compassion, we will not maintain an inclusive culture, resulting in unwanted behaviours and closed cultures.	
BAF08	If we do not effectively embed **workforce resourcing strategies and plans**, there is a risk of insufficient recruitment, retention, and representation, which will lead to increased reliance on temporary staffing and elevated bank / agency expenditure.	
BAF09	If we are unable to maintain a sustainable infrastructure and **therapeutic environment** in line with service requirements, patient need and policy, we may be unable to deliver the desired patient outcomes and financial plan.	
BAF10	Inadequate **capital funding** for our local systems will impact on each Trust's ability to manage key financial, quality & safety risks related to our need for estates and digital investment in 2026/27 and the medium term.	
BAF11	Inadequate control, reporting and management of the 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.	
BAF12	The **NHS reforms** and performance oversight framework may create an unstable environment with tighter restrictions, which may impact on the pace and delivery of service transformation across our communities.	

BAF01	If we do not have robust arrangements for maintaining and improving digital systems, cyber and data security disruption, we will not have sufficient resilience to provide access to mature digital systems to ensure the provision of safe care.	
Date	1 April 2026 - initial score (I4/L3)	Last updated 15 May 2026
Strategic Link	THRIVE: TECHNOLOGY	Exec lead(s) Group Chief Commissioning Officer (PS)
Governance	Trust Information Management & Technology Groups LPT and NHFT Finance and Performance Committees, Group Strategic Executive Board, Group Trust Board LLR/NICB system cyber group	
Context	Access to electronic systems which are fit for purpose, digital transformation, cyber attack	

Current Risk Position: Impact 4 (major) / Likelihood 3 (possible)
Heatmap position: **Amber** (Medium)
Rationale: Increased threat, strong controls, gaps exist

Target Risk Position: Impact 4 (major) / likelihood 2 (unlikely)
Target zone: Amber (Medium)
Rationale: No gaps in control but constant new threats emerging

Control Summary: **Medium**. Controls are strong but there are gaps

Assurance Summary: **Medium**. Good assurance, but gaps

Key Controls	Control Gaps	Key Sources of Assurance	Assurance gaps	Key Actions	Progress
Cause: Lack of robust arrangements					
• Qualified cyber security experts • Multiple technical counter measures • Microsoft MDE active on endpoints/servers • Only privileged user accounts able to install or run programmes • MDM in use on all mobile devices • Back-up procedures • Patches automatically deployed • Quarterly penetration tests • Access to the ICB CISO for advice • MFA enabled on user accounts • VPN are monitored and restricted • Cyber Security assess all software that is required to be installed / DPIAs • Board level cyber training	• Constrained capital • No Security Information and Event Management solution • No pro-active management of security outside core business hours (no cyber on call) • Reliant on EOL software • Clinical Digital Leadership • NHFT no EPMA for CMHTs • Disparity of availability of ambient technology	**1st Line**: **2nd Line:** Trust Information Management & Technology Groups and AAA reports Trust Finance & Performance Committees and AAA report into Boards DSPT Compliance and quarterly audit and penetration test with executive summary to the Data Privacy group. LHIS is ISO27001 accredited **3rd Line:** NHS England Digital Maturity Assessment System oversight Internal Audit Data security and protection toolkit low risk, high confidence SIRO, Deputy SIRO and CDIO all undertaken SIRO training via NHSE	Assurance of security posture/compliance from core IT service suppliers. Impact of training and phishing campaigns	• Group Digital Transformation Plan • Working with ICB CISO to procure a SIEM/SOC to enable our environment to be monitored out of hours procurement – **CIO July 26** • Implement InTune – **CIO June 26** • Work ongoing with NHSE to identify opportunities to remove/update EOL software – **CIO June 26** • DTAC Process needs to be reviewed and consistently applied by Procurement Team to help manage the risk of our supply chain – **July 26** • Outline digital & clinical priorities to improve quality & safety across the board – **July 26**	• Pillar under the new Digital Transformation Group in place to review Cyber opportunities • Mobile phone replacement programme being started along with rollout of InTune
Effect: Insufficient resilience to provide access to digital systems					
• Group Digital transformation programme. • Group Digital Transformation Group • Digital Prioritisation Process – LPT & NHFT	• Digital engagement	**1st Line :** Digital prioritisation process ensures that the most impactful initiatives receive the focus and resources required. **2nd Line:** Digital prioritisation regularly reported to Trust Transformation Committees Options to improve clinical leadership in digital decision making identified **3rd Line:** Clinical Focus and Engagement in decision making to be an essential element of its governance arrangements.			

BAF02	If we do not continue to evolve our partnerships and collaboratives, we will not reduce **health inequalities** and deliver improved outcomes for our communities.		Current Risk Position: Impact 4 (major) / Likelihood 2 (unlikely) Heatmap position: **Green** (Low) Rationale: Good system approach, further maturity anticipated
Date	1 April 2026 - initial score (I4/L2)	Last updated 14 May 2026	Target Risk Position: Impact 3 (moderate) / likelihood 2 (unlikely) Target zone: Green (Low) Rationale: Increasing positive impact on population health
Strategic Link	THRIVE: HEALTHY COMMUNITIES	Exec lead(s) Group Director of Strategy and Partnerships (DW)	
Governance	LPT and NHFT Finance and Performance Committees, Group Strategic Executive Board, Group Trust Board		Control Summary: **High** strong control framework
Context	Healthy Communities are essential to the delivery of our system strategy, preventing ill-health and reducing demand on NHS services		Assurance Summary: **High** strong assurance including 3rd line

Key Controls	Control Gaps	Key Sources of Assurance	Assurance gaps	Key Actions	
Cause: **Not working closely with our community**					
• Services working in partnership across LPT/NHFT and from LPT/NHFT with the VCSE and other stakeholders • Organisational monitoring of system meetings • Named exec leads attending place-based meetings • ICB and ICS meetings • East Midlands Alliance • Learning Disability and Autism Collaborative • Mental Health Collaborative • National Provider Collaborative Innovator	Changes in other organisations impact on system ability to deliver plans	**1st Line**: Discussions in Group Strategic Executive Board and other internal formal meetings. Leadership support within Collaboratives / DMT/CDPMT oversight Directorate/Care Pathway delivery plans	Consistent feedback from system meetings	Environmental analysis and agenda items in Group SEB & EMB e.g. H&WB update JCCG 3A into Group SEB & ICB Meetings feedback	Strong progress in LDA, and Mental Health through our collaboratives. Strong engagement in system working in UEC. System working on integrated neighbourhood teams, now in implementation phase – to Oct 2026
		2nd Line: Integrated care board meetings, system quarterly review meetings with NHS England Joint Collaborative, Commissioning & Contracting Group Transformation Committees/engagement in formal ICB meetings - feedback into Group Strategic Executive Board. Directorates learning for identifying opportunities to use DNA data Work to implement high impact actions for LeDeR			
		3rd Line: Feedback from well-led review, CQC etc; MH Collaborative Project Engagement meetings with CQC, NHS England, ICBs Regional & national recognition of effective joint working			
Effect: **Limited contribution to social value, and providing place-based care**					
• Trusts' Green Plans • People Plan • Social Value Community of Practice • NHSE national policy on integrated care • Group Social Value Charter • ICB 5-year strategy • Group strategy • Co-production programme	Evidencing the impact of learning Evidencing the impact of the Group social value charter	**1st Line :** Individual programmes of work identified to support new workforce into the organisation, health inequalities actions and the development of training through greater partnerships with our universities.		Continue system working with other organisations to produce an impact report **– Group Director of Strategy - June 2026**	
		2nd Line Group social value programme in place with development meetings. Reporting into annual reports. Updates at Group Strategic Executive Board and Group Trust Board.	Success reporting (longer term)		
		3rd Line ICB Health Inequalities Meetings			

BAF03	If we are unable to build a sustainable approach to the continual development our **research, innovation and professional learning capability**, our ability to attract the best people, operate on the leading edge of service delivery and exert influence within the sector will decline over time.		Current Risk Position: Impact 4 (major) / Likelihood 2 (unlikely) Heatmap position: **Green** (Low) Rationale: Progressing maturity
Date	1 April 2026 - initial score (I4/L2)	Last updated 15 May 2026	Target Risk Position: Impact 3 (moderate) / likelihood 2 (unlikely) Target zone: Amber Rationale: Strategic commitment with progressing maturity
Strategic Link	THRIVE: RESPONSIVE	Exec lead(s) Chief Medical Officer NHFT (IM), Chief Medical Officer LPT (BC)	
Governance	LPT and NHFT Quality and Safety Committees, Group Strategic Executive Board, Group Trust Board		Control Summary: **Medium some gaps remain**
Context	Innovation, research for new treatments, redesign of care delivery models with a focus on patient outcomes and experience		Assurance Summary: **Medium** some gaps remain

Key Controls	Control Gaps	Key Sources of Assurance	Assurance gaps	Key Actions	Progress
Cause: **Not engaging in improvement activity, research and innovation**					
• SORT self-assessment • University Hospitals Teaching Status • Leicestershire Academic Health Partners Board (LAHP) • Health Innovation East Midlands • ICB Research Strategy Group • Research Policy – hosting conducting & collaborating • LPT & NHFT integration with system (LANHP partnership working) • Web-based platforms to support QI activity and QI Training Programmes • PSIRP • Associate Professor in CAMHS post approved • Development of Academic Clinical Fellowships • Group Research Strategy and delivery plan	• Funding for academic posts • Clarity over remit for Group roles • Funding for research projects • Funding for Innovation • Capacity of the research teams to support succession planning • Embargo on Bank Usage for externally funded research activity having an impact on research delivery	**1st Line:** Participant Research Experience Survey (PRES) Research activity and income Data being presented quarterly to Accountability framework meeting in LPT **2nd Line:** Joint working group – 'Generating New Knowledge' oversight of Group research and innovation programme Research programme to Quality and Safety Committees Local clinical research network Transformation and QI Delivery Groups NHS IMPACT Self Assessment 2025 June 2025 **3rd Line:** University Led Non-Executive Director - LPT	Assurance over uptake and PRES survey outcomes Assurance over success rate for attracting high quality commercial trials	• Progression from associate university status to university status, **Medical Directors April 26 – application submitted** • Assurance over uptake and PRES survey outcomes **Medical Directors: annual data presented to respective QSCs with research submission – July 26** • Group SORT self-assessment action plan **Medical Directors May 26** • Principal investigators review across the group **– June 26** • Group Joint Roles with medical nursing & AHP research element **– Aug 26** • To agree with Medical Directors and Group Chief Nurse about review of the current structure of Research, Development and Innovation teams to support effective delivery and succession planning – **April 26 – Complete** Joint group in place. • to develop models for interprofessional learning across the Directorates – **Medical Directors – June 2026** • Outline digital & clinical priorities to improve quality & safety across the board **– July 26**	Generation of New Knowledge Workstream Oversight of research participant recruitment numbers to form part of reporting to QSCs
Effect: **Quality and Design of Services**					
• QI programmes • Transformation Programmes • Directorate/ Care Pathway objectives aligned to strategy • Deputy Medical Director for R&D • Trust Leads for QI and Quality Governance • NHFT Dragon's Den established – outcomes reported to EMB QSC. • LPT The Big Pitch outcome measures determined	• Innovation strategy • Success measures	**1st Line** QI programme uptake and feedback, Learning boards **2nd Line** QI and Transformation Committee AAA report to Finance and Performance Committees and Group Strategic Executive Board. **3rd Line** - CQC inspection feedback and ratings	Impact of learning from research into service redesign	• Develop and deliver Innovation Strategy **Medical Director & Director of Strategy Aug 26** (NHFT & LPT are at different stages of the process) • to ensure research team are sharing recent information on new models for shared learning in Directorates, through presentations at Directorates' quality and safety committees **– June 2026 – Medical Directors**	Ongoing discussions with Health Innovation East Midlands re translating national projects to local needs.

BAF04	Without **timely access** to services, we cannot provide high quality safe care for our patients which will impact on clinical outcomes.	
Date	1 April 2026 - initial score (I5/L3)	Last updated 20 May 2026
Strategic Link	THRIVE: RESPONSIVE	Exec lead(s) Group Chief Nurse (LC); Chief Medical Officer LPT (BC)
Governance	Trust Access Groups and Safety Forums LPT and NHFT Quality and Safety Committees, Group Strategic Executive Board, Group Trust Board System LLNR Quality and Safety Committee	
Context	Minimising harm while waiting, improving access to diagnosis and treatment, best clinical outcomes	

Current Position: Impact 5 (catastrophic) / Likelihood 3 (possible)
Heatmap position: **Red** (High)
Rationale: High demand, low funding, critical to safety

Target Position: Impact 5 (catastrophic) / likelihood 2 (unlikely)
Target zone: Red (High)
Rationale: demand, funding and criticality remains, with further maturity of controls

Control Summary: **Medium** some gaps remain

Assurance Summary: **Medium** some gaps remain

Key Controls	Control Gaps	Key Sources of Assurance	Assurance gaps		Key Actions
Cause: **timeliness of access to services**					
• Access Policy • Performance Management Framework • Urgent and Emergency Care Framework • Medical Workforce Plan • LLR ICB 5-year strategy and THRIVE strategy/ Annual Plans • Keeping Patients Safe Whilst Waiting T&F Group • collaborative meetings • Waiting well web page	• National strategy for neurodiversity demand • Local commissioning plans for addressing significant increases in neurodiversity demand • Global shortage of ADHD medication	**1st Line:** Directorate attendance at Access Group and AFM/TOMG WL trajectories and initiatives by service Operational risk profile AFM/EMB	Linkage of health inequalities to access group actions Clarity over policy compliance	• NHSE Patient Safety Healthcare Inequalities Reduction framework consideration & assessment against principles & actions plans underway **– Group Chief Nurse - September 26**	ADHD Solutions closure means reduction in support across LLR as detailed on CRR. Control gaps outside of Trusts' remit to address.
		2nd Line: • Access Group with AAA to AFM/TOMG/EMBs • Board Development session held 30 Oct 25 • Monitoring NHS111/2 activity in directorate and shadow MH • Clinical task and finish group workplan with priorities agreed			
		3rd Line: • Internal Audit CQC feedback and ratings			
Effect: **Clinical Outcomes**					
• Waiting Well Harm Whilst Waiting T&F Group & compliance oversight • Help while waiting website • Clinical Outcome performance measures • Incident reporting & learning from incidents • Quality & Safety Metrics dashboard Report • Accountability framework with key safety & quality metrics	- Data insight & reporting on harm whilst waiting	**1st Line** Directorate/Care Pathway attendance at Access Group and AFM/TOMG for escalation	Clarity over policy compliance measures and rates	• Waiting Well Harm Whilst Waiting T&F Group developing priorities & workplan for 26 -27 – update to Safety Forum **– Group Chief Nurse - July 26** • Accountability and Empowerment Framework 2026-27 – including draft quality framework - for approval at EMB **– Group Chief Nurse - June 2026**	Quality dashboard delivery framework developed (3-year programme)
		2nd Line Monthly performance report with clinical outcomes measures to Quality and Safety Committees and AFM/TOMG Clinical Harm – no overarching policy so local processes in place for consistency	Comprehensive quality dashboard focusing on outcome measures, including those attributed to waiting		
		3rd Line - Annual feedback from Community & Mental Health Survey	External review of waiting times on patient safety		

BAF05	If we do not continue to review and improve our systems and processes for **patient safety**, we may not be able to provide the best experience and clinical outcomes for our patients and their families.		Current Position: Impact 5 (catastrophic) / Likelihood 3 (possible) Heatmap position: **Red** (high) Rationale: Criticality and responsiveness
Date	1 April 2026 - initial score (I5/L3)	Last updated 20 May 2026	Target Position: Impact 5 (catastrophic) / likelihood 2 (unlikely) Target zone: Red (high) Rationale: Criticality remains, ongoing need for maturity
Strategic Link	THR**I**VE: RESPONSIVE	Exec lead(s) Group Chief Nurse (LC)	
Governance	Trust Safety Forums LPT and NHFT Quality and Safety Committees, Group Strategic Executive Board, Group Trust Board System LLNR Quality and Safety Committee		Control Summary: **Medium** some gaps remain
Context	PSIRF, PCREF, Just Culture, Prevention of harm, learning		Assurance Summary: **Medium** some gaps remain

Key Controls	Control Gaps	Key Sources of Assurance	Assurance gaps	Key Actions	Progress
Cause: Patient safety systems, processes and governance improvement & learning, CQC outcomes					
• Service safety checks/huddles & escalation • CQC mock inspections & quality visits • Safety Forum • Psychological Safety Workstream • Complex Case Huddle • System and process learning shared through governance meetings • PSIRF priorities agreed	Thematic Reviews timeliness & opportunity for learning	**1st Line:** Service level oversight; Executive Service Visits & feedback; NED Board Walks; Compliance Team visits; PSIRF	Consistent alignment between complex cases that involve safeguarding, patient safety & patient experience Safety Huddle confirmation of improvements in patient safety	• Suicide prevention work & training **Medical Director, update – QSC April 26 - complete** • Completion of the agreed PSIRF thematic reviews- 1 complete, 2 further dues for completion **Chief Nurse update June 26** • Weekly complex case huddle ongoing – evaluation planned **complete – May 26** • Safety Huddle evaluation audit taking place – reporting March 26 to Safety Forum – **March 26 – complete.**	Staff undertaking STORM training
		2nd Line: EMB, SEB, Q&S Committee, Safety Forum. Policy compliance oversight			
		3rd Line: External reporting (ICB); HOSCs; CQC Visits & outcomes; MHA Visits & reports, learning from national reports			
Effect: Poor outcomes for patients, carers, families					
• Incident reporting • PSIRF • Access & patient flow • Recruitment of a Family & Patient Liaison Officer • Trust wide Discharge Policy • Quality & Safety Metrics dashboard Report	Effective use of technology to support data analysis	**1st Line:** Directorate oversight of local quality & safety systems and processes.			
		2nd Line: Horizon scanning & national leaning Quality/CQC Compliance/IPC monitoring			
		3rd Line: Coronial feedback/NHSE oversight; HOSCs			

BAF06	If we do not have appropriate **emergency preparedness**, resilience and response controls in place, we may be impacted by accidents, disruption and system failures affecting our ability to maintain continuity of services.	
Date	1 April 2026 - initial score (I4/L2)	Last updated 14 May 2026
Strategic Link	TH**R**IVE: RESPONSIVE	Exec lead(s) LPT Managing Director (JK), and Group Chief Integration and Delivery Officer (AR)
Governance	LPT and NHFT Health and Safety Committees and Safety Forums LPT and NHFT Quality and Safety Committees, Group Strategic Executive Board, Group Trust Board	
Context	Maintain organisational resilience. External factors, social, environmental and economic impact	

Current Risk Position: Impact 4 (major) / Likelihood 2 (unlikely)
Heatmap position: **Green** (Low)
Rationale: Strong controls, unpredictability of external environment

Target Risk Position: Impact 4 (major) / likelihood 2 (unlikely)
Target zone: Amber
Rationale: Maintain controls, external threat remains

Control Summary: **High** Robust control framework

Assurance Summary: **High** strong assurance including 3rd line

Key Controls	Control Gaps	Key Sources of Assurance	Assurance gaps	Key Actions
Cause: **A lack of Emergency Preparedness, Resilience and Response Controls**				
• EPRR Policy • Winter planning undertaken & agreed by NHSE • EPRR Group Collaborative • EPRR business continuity workplan including co-production of response plans for cyber risks • LPT & NHFT representation at the Local resilience forums – feedback back into governance • LPT & NHFT representation at the Local health resilience partnership - feedback back into governance		**1st Line:** Task letter return logs & actions		Joint EPRR lead in place and in process of reviewing all related policies Submitted & received full assurance received on the core standards assessment to NHSE
		2nd Line: • Oversight at Audit and Risk Committees and the Finance and Performance Committees • LPT Business Continuity Management System (BCMS) Audit • Post Incident /Exercise Reports • Joint EPRR Lead in post		
		3rd Line: • ICB and system assessment against NHS England EPRR Core Standards • IA audit 24/25 • LPT fully compliant against the EPRR Core Standards 25-26		
Effect: **Continuity of Services**				
• Business continuity plans • Disaster recovery exercises • Industrial Action plans • Director on Call arrangements • Training of strategic, tactical and operational responders • ICC assurance flow via EMBs • System wide countermeasure and mass casualty plans • LPT & NHFT participation in National, regional and local exercises • Checks via on call directors		**1st Line** Business Continuity plans reviewed & agreed within EPRR Group Operational Hub	Completeness and robustness of trust wide continuity plans	Taken part in industrial action audit for national review.
		2nd Line: Training oversight and management Submitted EPRR core standards assessment for 2025/26		
		3rd Line • Internal Audit – Business Continuity August 2022 Significant Assurance • EPRR core standards assessment 2025/26 – full assurance received.		

BAF07	If we do not understand our **culture**, staff experiences and grow levels of wellbeing in ways that help us to lead and grow with compassion, we will not maintain an inclusive culture, resulting in unwanted behaviours and closed cultures.		Current Risk Position: Impact 4 (major) / Likelihood 3 (possible) Heatmap position: **Amber** (Medium) Rationale: Good staff survey, strong controls, some gaps remain
Date	1 April 2026 - initial score (I4/L3)	Last updated 30 April 2026	Target Risk Position: Impact 3 / likelihood 2 (unlikely) Target zone: Amber Rationale: retaining strong staff feedback and filling gaps
Strategic Link	THRIVE: INCLUDING EVERYONE	Exec lead(s) Group Chief People Officer (SW)	
Governance	LPT workforce development group NHFT Valuing our People Group Group People and Culture Committees, Group Strategic Executive Board, Group Trust Board		Control Summary: **Medium** some gaps remain
Context	Innovation, research for new treatments and redesign of care delivery models with a focus on patient outcomes and experience		Assurance Summary: **Medium** some gaps remain

Key Controls	Control Gaps	Key Sources of Assurance	Assurance gaps	Key Actions	
Cause: **Not leading with compassion**					
• Medical Leadership Programme • Accountability Framework • Reasonable adjustments framework • Inclusive recruitment programme • EDI policy • People Plan • WRES and WDES • Cultural competency programme • Group TAR programme (including PCREF) • Culture of Care • Staff Safety in the workplace • Joint OD Working group • LPT reasonable adjustments clinics		**1st Line:** Maple & ND Staff Networks; Appraisals with wellbeing element, speak up process, sickness management; Anti racism listening events; Campaign to embed leadership behaviours	Completion of TAR actions	Cultural work to address civil unrest and wider including; • Delivery of TAR actions **Ongoing Group Chief People Officer 31.3.27** • Staff Survey 25-26 – actions & implementation of priority areas **Group Chief People Officer 31.3.27 - complete** • Developing reasonable adjustment clinics in NHFT	Team Time Out 26-27 plans underway Delivery of TAR actions ongoing
		2nd Line: Delivery of the Our Future Our way Programme of work & 4 priorities & leadership behaviours; Reasonable adjustment clinics & meetings established; Leadership Development Conferences ; F2SU Guardian, NED F2SU role and reporting; Group programme reporting to SEB every month for oversight	• Meeting reasonable adjustment requirements (NHFT)		
		3rd Line: LPT Internal Audit Freedom To Speak Up October 2023 significant assurance; LPT Internal Audit Fit and Proper Persons Test significant assurance; LPT Health & Wellbeing 360 Audit rated significant assurance			
Effect: **Unwanted behaviours and closed cultures**.					
• Our Future Our Way • Leadership Behaviours Framework • Wellbeing, sickness management policy • Counselling service • Anti bullying harassment and advice service • Occupational health service wellbeing strategy	• Training on leadership and culture on induction • Closed cultures training	**1st Line:** Annual staff survey results; Deloitte staff survey and focus group feedback; Closed cultures covered in staff inductions; Reverse Mentoring cohort 6	• Delivery of recommendations from quality and safety review • Closed cultures not currently in staff inductions • Impact of leadership development	Delivery of the discovery phase Culture Leadership & Inclusion OFOW Programme of work. Board interviews and staff focus groups taking place – March 2026 - **complete** Commencement of sickness improvement programme – March 2027	• Leadership offer review underway • Developing accountability & empowerment workshop – middle managers
		2nd Line: Mental Health and Wellbeing Lead and Trust Support; Health and wellbeing champions and wellbeing NED role			
		• **3rd Line:** CQC inspection findings	Audit outturn 25/26 CQC reports		

BAF08	If we do not effectively embed **workforce** resourcing strategies and plans, there is a risk of insufficient recruitment, retention and representation, which will lead to increased reliance on temporary staffing and elevated bank / agency expenditure.		Current Risk: Impact 5 (catastrophic) / Likelihood 4 (likely) Heatmap position: **Red** (High) Rationale: Criticality, long term issues
Date	1 April 2026 - initial score (I5/L4)	Last updated 30 April 2026	Target Risk Position: Impact 5 / likelihood 3 (possible) Target zone: Red (High) Rationale: Criticality, long term issues
Strategic Link	THRIVE: VALUING EVERYONE	Exec lead(s) Group Chief People Officer (SW)	
Governance	LPT and NHFT workforce development groups Joint People and Culture Committee, Group Strategic Executive Board, Group Trust Board		Control Summary: **Medium** some gaps remain
Context	Talent management, OD, growth and retention		Assurance Summary: **Medium** some gaps remain

Key Controls	Control Gaps	Key Sources of Assurance	Assurance gaps	Key Actions	Progress
Cause: **Not utilising workforce resourcing strategies**					
• WRES & WDES action plans • People plans • Directorate plans linked to workforce plan • National and local People Plan • Recruitment Pipeline Management • Medical Workforce Plans • Recruitment and retention premium scheme for medics • Nursing Recruitment & Retention High Impact Actions • LLR AHP faculty & Council • Vacancy Control Measures • Workforce operational plan	• High vacancies with supply issues • Medical recruitment challenges • NHS Pay Award • Strike Activity	**1st Line:** Operational risk profile for staffing – oversight at AFM and EMB/SEB; Agency reduction Group/ Value programme	• Actions resulting from recent staff survey findings when available	• Delivery of the workforce and agency reduction plan and value programme 2025/26 **Group Chief People Officer March 26 - complete** • Analysis of staff survey results once embargo is lifted- **March 26 - complete** • People plans NHFT and LPT sign off at Joint People culture Committee Dec 25 Feb 26 – complete • Improving working lives of Drs 10 Point Plan	Engagement with the NHSE price cap work for medical agency costs commenced Feb 2025 - ongoing Joint People Dashboard launched through Joint PCC People plans developed
		2nd Line: • Group People and Culture Committee • System People and Culture Board • Workforce deep dives. • Jobtrain effectiveness Review (LPT)	• Delivery of the workforce and agency reduction plan • Delivery of the Workforce efficiency value programme		
		3rd Line: • Benchmarking against workforce metrics • Internal Audit			
Effect: **High Agency / Bank Usage**					
• Agency/Bank Reduction Plans • Start well, stay well, leave well action groups (NHFT) • 90-day onboarding LPT. • Jobtrain implemented (LPT) • Safe staffing Policy • Workforce dashboard monitoring through EMB • Dynamic Risk Assessment process (DRA) • Workforce Efficiency Panel (WEP) NHFT	Nurse vacancies	**1st Line** • EQIAs DRA and break glass criteria to stop deployment of Thornbury HCA • Workforce safeguards/guardian of safe working hours reports. • Monthly Unify reporting to DoH.		Delivery of the workforce and agency reduction plan **Group Chief People Officer March 26 - complete** Delivery of the NHFT value programme & LPT efficiency programmes supporting workforce transformation – March 2027	• No off-framework usage • THP numbers reducing • Price cap breach reducing
		2nd Line Agency and bank reduction to Group People & Culture Committee through people dashboards	Delivery of the workforce and agency reduction plan / value programme		
		3rd Line • LLR People Programme Delivery Group • Internal Audit			

BAF09	If we are unable to maintain a sustainable infrastructure and **therapeutic environment** in line with service requirements, patient need and policy, we may be unable to deliver the desired patient outcomes and financial plan.		Current Risk Position: Impact 4 (major) / Likelihood 3 (possible) Heatmap position: **Amber** (Medium) Rationale: Strategic commitment with reliance on capital
Date	1 April 2026 - initial score (I4/L3)	Last updated 13 May 2026	Target Risk Position: Impact 4 / likelihood 2 (unlikely) Target zone: Amber (Medium) Rationale: Standards are met and need maintaining
Strategic Link	THRIVE: EFFICIENT AND EFFECTIVE	Exec lead(s) Group Chief Commissioning Officer (PS)	
Governance	LPT and NFHT estates groups LPT and NHFT Finance and Performance Committees, Group Strategic Executive Board, Group Trust Board		Control Summary: **Medium** some gaps remain
Context	Therapeutic, patient experience, fit for purpose, meet standards, agile working, sustainable		Assurance Summary: **Medium** some gaps remain

Key Controls	Control Gaps	Key Sources of Assurance	Assurance gaps	Key Actions	Progress
Cause: unable to maintain and improve our estate					
• Estates Strategy and Delivery Plan • Group Strategic Estates Plan • Accommodation & Space Policy • Estates Annual Plan 24-25 • Green Plan 2026 - 29	• Lack of capital funding • Aging estate with limited options for improvement • Having adequate space for clinics and supervision and training • Lack of clarity around the cost of implementing the Green Plan	**1st Line:** Capital Prioritisation process Sustainability Programme Delivery Group		• Identify alternative sources of capital Engagement internal to prioritise estates safety **Chief Finance Officer, August 26** • Through the Estates Group an updated assessment of clinical, supervision and training space will take place – **May 26**	
		2nd Line: Estates and medical equipment group/Estates Group Finance & Performance/Performance Committees Group SEB			
		3rd Line: System estates groups, Capital prioritisation criteria, CQC engagement meetings and inspection feedback	• Provision of information to support the Task Force on Climate related financial disclosures (TCFD)		
Effect: poor quality environment / unsustainable infrastructure					
• Environmental checklist • Operational risk management • Environmental checklist • Operational risk management • Health & Safety inspections • Estates Annual Plan • Regulatory standards for buildings		**1st Line** Sustainability Programme Delivery Group	Adherence to process for identifying and logging environmental concerns	• Comms to support adherence to process for identifying and logging environmental concerns – June 26	Continued reduction in number of outstanding maintenance jobs
		2nd Line Estates and Medical Equipment Group/Estates Group; Estates log .			
		3rd Line Healthwatch, CQC NHSE and DHSC oversight of green plan and TCFD			

BAF10	Inadequate **capital funding** for LLR system will impact on each Trust's ability to manage financial, quality & safety risks related to estates and digital investment in 2026/27 and in the medium term	
Date	1 April 2026 - initial score (I5/L4)	Last updated 12 May 2026
Strategic Link	THRIVE: EFFICIENT AND EFFECTIVE	Exec lead(s) LPT Chief Finance Officer (SM) NHFT Chief Finance Officer (PS)
Governance	LPT and NHFT capital committees LPT Finance and Performance Committee, Group Strategic Executive Board, Trust Boards	
Context	Delivery within available capital resources. Estates, digital regulatory, constitutional and legal requirements.	

Current Risk Position: Impact 5 (major) / Likelihood 4 (likely)
Heatmap position: **Red** (High)
Rationale: **Crucial to retain fit for purpose estate**

Target Risk Position: Impact 3 / likelihood 3 (possible)
Target zone: Amber
Rationale: Requires sufficient & sustained capital allocations

Control Summary: **High**

Assurance Summary: **Medium** some gaps remain

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: **Inadequate Internal Control**					
• SFIs / SORD • Scheme of delegation • Capital bid approval process	• None	• **1st Line:** Development of each trust's capital plan; Clear capital bid approval processes; SEB & Board approval of capital opening plan & subsequent revisions • 2024/25 accounts – CRL delivered	–	• External audit of 25/26 accounts **CFOs**-June 2026 • Manage Trust's capital plans, **CFOs March 27**	
		2nd Line: Accounting policies / SFIs and SORD [Audit and Risk Committee]	Policy compliance		
		3rd Line: External Audit 2024/25 annual accounts unqualified opinion	25/26 annual accounts audit		
Cause: **Inadequate reporting and management**					
• Monthly finance report with exec level oversight • Capital management committee 3A report • ICS capital Committee	None	**1st Line**: Capital management committee triple A report (LPT)	None		
		2nd Line: Monthly corporate report EMB/SEB/FPC and oversight at the system capital committee including any relevant escalations			
		3rd Line:			
Effect: **Breach of Statutory Duty (CDEL)**					
• National guidance	• None	• **1st Line** monthly finance report assurance on CDEL delivery year to date & forecast	NHSE late approval of material capital bids	Escalation as required to NHSE until approval received. CFOs June 2026	
		2nd Line			
		3rd Line 2024/25 annual accounts and VFM conclusion	25/26 annual accounts audit	External audit of 25/26 accounts **CFOs-June 2026**	
Effect: **Non achievement of capital strategy**					
• National planning guidance	• None	• **1st Line:** LLR Joint Capital Resource Use Plan 2026/27; LPT & NHFT medium term capital plans			
		2nd line: ICS Capital committee reviews organisational delivery across cluster			
		3rd line:			

BAF11	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.		Current Risk Position: Impact 4 (major) / Likelihood 4 (likely) Heatmap position: Amber (Medium) Rationale:
Date	1 April 2026 - initial score (I5/L4)	Last updated 12 May 2026	Target Risk Position: Impact 3 / likelihood 4 (likely) Target zone: Amber Rationale:
Strategic Link	THRIVE: EFFICIENT AND EFFECTIVE	Exec lead(s) LPT Chief Finance Officer (SM) NHFT Chief Finance Officer (PS)	
Governance	Performance and Finance and Performance Committees, Group Strategic Executive Board, Group Trust Board & Trust Boards		Control Summary: Medium
Context	Delivery within available financial resources. Use of resources, productivity and value for money–Performance measures, constitutional and legal requirements. Under delivery could impact our ability to deliver effective compassionate care and patient outcomes without compromising safety.		Assurance Summary: Medium

Key Controls	Control Gaps	Key Sources of Assurance	Assurance gaps	Key Actions	Progress
Cause: **Inadequate Internal Control**					
• SFIs / SORD • Treasury Mgt policy • Scheme of delegation • Code of conduct • Declarations of interest	None	**1st Line:** Expenditure control: non pay controls in place; vacancy control process; DRA agency approval process; No PO no pay policy; segregation of duties in finance teams 2024/25 accounts – break even plan delivered	Spend run rate is not reducing fast enough to deliver plan Reducing cash balances	• Run rate reporting in finance reports - **CFOS June 2026**	
		2nd Line: Accounting policies / SFIs and SORDs	Policy compliance		
		3rd Line: External Audit 24/25 annual accounts unqualified opinions	25/26 annual accounts audit	• External audit of 25/26 accounts - **CFOs June 2026**	
Cause: **Inadequate reporting and management**					
• Monthly Reports with exec level oversight • Value Programme to deliver local efficiencies	CIP programme	**1st Line**: Directorate finance reports; bi-monthly service level run rate reviews; Cost Improvement Plans delivery review	CIP plan not fully identified	• Focus on 100% identified CIP by 28th May NHSE deadline – **CFOs May 2026**	
		2nd Line:	Non recurrent CIP; In year overspends & funding gaps.		
		3rd Line: Annual Internal Audit programme			
Effect: **Breach of Statutory Duty**					
• National guidance	None	**1st Line** monthly finance report assurance on break even delivery year to date & forecast; approval of medium-term recovery plans	Approval of medium-term recovery plan		
		2nd Line			
		3rd Line 2024/25 annual accounts and VFM conclusion	25/26 annual accounts audit	• External audit of 25/26 accounts - **CFOs June 2026**	
Effect: **Non achievement of medium-term financial plans**					
• Financial strategies & plans		**1st Line:** Medium term financial plans presented to Group SEB			
		2nd line: Financial controls & NHSE submissions			
		3rd line: Internal Audit, financial controls & NHSE submissions			

BAF12	The NHS reforms and performance oversight framework may create an unstable environment with tighter restrictions, which may impact on the pace and delivery of service transformation across our communities.		Current Risk Position: Impact 4 (major) / Likelihood 4 (likely) Heatmap position: **Amber** (Medium) Rationale: Significant reform creating uncertainty
Date	1 April 2026 - initial score (I4/L4)	Last updated 11 May 2026	Target Risk Position: Impact 3 (moderate) / likelihood 2 (unlikely) Target zone: Amber Rationale: Decreasing uncertainty
Strategic Link	THRIVE: EFFICIENT AND EFFECTIVE	Exec lead(s) Group Chief Integration and Delivery Officer (AR)	
Governance	LPT and NHFT Transformation and QI Committees and Joint Collaboratives Group LPT and NHFT Finance and Performance Committees, Group Strategic Executive Board, Group Trust Board		Control Summary: **Medium** some gaps remain
Context	Population health, transformation, NHS environment		Assurance Summary: **High** [internal and external]

Key Controls	Control Gaps	Key Sources of Assurance	Assurance gaps	Key Actions	Progress
Cause: Slow/ fragmented distribution of policy & guidance, and misaligned readiness for change across partners organisations (ICB, Acute, NHSE)					
• MTP Guidance. • NOF Framework. • Community Services and Neighbourhood programmes.	• Speed and completeness of strategic and technical guidance. • Readiness of partner organisations to transform • Governance structure for delivery of Accountability Framework	**1st Line**:		• Lobby ICB for greater programme management of key system workstreams (SCS, Digital, etc). **Group Chief Integration and Delivery Officer – Sept 26** • Governance redesign for delivery of accountability framework **Directors of Governance NHFT and LPT - Aug 26**	Leadership of transformation programmes
		2nd Line: Accountability Framework meetings and Executive Management Board LNR System Executive, and Priority Programme infrastructure	System coordination of resource and programme management.		
		3rd Line: NOF segmentation and Provider Capability Ratings NHSE CEO Briefing forums	Delays in publication of NOF and MTP guidance		
Cause: Infrastructure for data alignment, visibility and reporting is under-developed, under-construction, or delayed by technical barriers (skills, capability, resource capacity, equipment, etc)					
• BIS Transformation Programmes. • Digital Transformation Programme	• Multiple/ incongruent patient reporting systems. • Data science & engineering skills/ capabilities	• **1st Line**: Model NHS Platform (+ NHS Futures dashboards)	Ability to control methodology	• Capability mapping across BIS/ IIT teams + plans for multi-skilled workforce. • Ongoing development of data dashboards in LPT for supporting the Accountability Framework governance • Use of Organisational Structure to allow 'single language' across PAS's. • Conversion of manual to automated data feeds - **Group Chief Integration and Delivery Officer – March 27**	Org Structure changes underway. Automation proposal paper drafted. Recruitment underway in all areas.
		2nd Line: Tactical (Power BI / QlikView) Dashboards and ward to board oversight of performance	Reconciliation with national datasets Under-developed impact measures		
		3rd Line: Management Information System (MIS) and BI Data Warehouse	Configuration and management of data quality		
		3rd Line: ViH programme reports for increased capacity			
Effect: Pace and Delivery of service transformation for population health					
• Productivity & Efficiency Schemes • Absence Reduction Schemes • Wait List reduction schemes • ViH schemes	• Population Growth • Commissioning structures/ plans. • Changes/ removal of services across partner organisations (affecting demand)	• **1st Line :** Medium-Term Plans (inc. Digital Transformation Programme, Wait List Reduction Programme, Neighbourhood/ Urgent Care Programmes)	New programmes of work (i.e. St Andrews, OPIP, etc). LLNR Commissioning structure (and associated plans/ intentions. Confirmation of AFT status NHFT and invitations for AFT application LPT	• Refine and improve Triple-A reporting for Transformation, to AFM/TOMG **Directors of Governance NHFT and LPT - Aug 26** • Combine reporting for Transformation, Quality Improvement & R&I (for clear oversight of capacity prioritisation). • Preparation for a future AFT application process – **LPT Director of Governance and Risk – Aug 26**	Both actions are underway, being led via the Strategic Transformation Group.
		2nd Line: Triple-A progress reports from Care Delivery Pathway and Directorate Leads			
		3rd Line:			

E2

Group Trust Board 28 May 2026

System Risk Report

Purpose of the report

Briefing Paper (no proposal or decision required). A summary of the risk profile of NHS trusts and Integrated Care Boards across the Leicester, Leicestershire, Rutland and Northamptonshire area

Analysis of the Issue

When consolidated across the region, there are clear risk priorities in common with high risk themes appearing across all organisations. These are mapped in Appendix A and summarised below.

Acute Risk Profile

The risk profile for acute hospitals across Leicester, Leicestershire, Rutland and Northamptonshire indicates that they are unified in their top scoring risk profile primarily relating to significant financial risk against a backdrop of increasing high patient demand for services. There is currently a single board assurance framework for the University Hospitals of Northamptonshire (bringing together Kettering General Hospital and Northampton General Hospital) and a board assurance framework for the University Hospitals of Leicester (bringing together Leicester General Hospital, Glenfield Hospital and the Leicester Royal Infirmary).

Financial Plan Delivery, Sustainability and Efficiency

- There are high risks for UHN around increased regulatory intervention (NHSE) and loss of deficit support funding resulting from non-delivery of the 2025/26 financial plan (rated 25) and one for potential loss of deficit support funding resulting from non-delivery of the financial plan (20).
- UHL is reporting risks rated 20 (RAG rated amber on their BAF) for delivery of the financial plan and for long term financial sustainability

Growing population needs and access to services

- There are risks scoring 20 for UHL around overcrowding and patient flow, an elective care backlog and access to timely and effective cancer care.
- UHN is reporting similar risk (rated 20) around demand on services resulting in longer waits for urgent and emergency care, elective care and cancer care

Integrated Care Partnership Risk Profile

As a newly formed cluster, the Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB) and the Northamptonshire Integrated Care Board (NICB) face a unique set of systemic risks that combine long-standing local health pressures with the complexities of their recent merging of staffing and governance arrangements. The Cluster includes a single unified leadership team and currently reporting individual board assurance frameworks.

Whilst NICB isn't reporting any high scoring risks (20+) there is a clear commonality for the highest risk areas across the two ICB BAFs around financial sustainability. Similarly to the acute profile, financial viability is a high scoring area for LLR ICB (20). NICB has also has risks around delivering the financial plan (15) and longer term financial sustainability (16)

Appendix A Table of risks and indicative RAG rating for key themes for NHS trusts and ICBs across LLNR

Risk theme	LPT and NHFT	UHN	NICB	UHL	LLR ICB
Digital systems and security	✓	✓ Cyber ✓ Transformation	✓ Data ✓ Digital	✓ Digital ✓ Transformation ✓ AI ✓ Cyber (20)	✓ Cyber
Partnerships / HI	✓	✓ Collaboratives ✓ Partnerships		✓	✓ Partnerships ✓ Health Inequalities
Research and innovation	✓	✓ Improvement ✓ Research			
Access to Services	✓	✓		✓ (20)	✓
Patient Safety	✓	✓		✓	
IPC				✓	
Quality of Services			✓	✓	✓
UEC and flow				✓ (20)	
Performance and activity			✓	✓ (20)	
Patient experience		✓		✓	
EPRR	✓				✓
Culture	✓	✓		✓	
Workforce	✓	✓	✓	✓ Talent ✓ Productivity	✓
Environment	✓	✓		✓ (20)	
Sustainability		✓		✓	
Capital funding	✓		✓	✓	
Financial Delivery	✓	✓	✓	✓ (20)	✓
Financial Sustainability		✓(25)	✓	✓	
NHS reforms	✓		✓		✓
Delivering strategy			✓		✓
New Hospital Programme				✓	
Total Risks on BAF	12	15	10	21	10

Leicestershire Partnership and
Northamptonshire Healthcare
Associate University Group

Risk Appetite Statement and Matrix

2026/27

Risk Appetite Statement 2026/27

Leicestershire Partnership and Northamptonshire Healthcare Associate University Group

As part of our group model arrangements, Leicestershire Partnership NHS Trust and Northamptonshire Healthcare NHS Foundation Trust share a vision and strategy 'together we thrive; building compassionate care and wellbeing for all'. Our strategic priorities are grouped together under the acronym THRIVE and align with the work of our partners in health, social care and beyond to improve population health. We aim to support each organisation and our valued partners to shape what this means to them and for our care delivery pathways through our annual and longer-term planning. Our Board Assurance Framework (BAF) provides the key risks to achieving this strategy via the THRIVE headings to ensure alignment between our strategy and our approach to managing risk. Together, our Trust Boards have determined a risk appetite for 2026/27.

Risk Appetite is the amount and type of risk that an organisation is willing to take to meet their strategic objectives. Our Trust Board determines its level of risk appetite each year; this is applied to the Board Assurance Framework and is utilised during decision making discussions as part of our approach to managing risk in our everyday life.

Acknowledging the context that the NHS is currently in, with a critical need for identifying opportunities for finding new ways of working to increase productivity and effectiveness, there is an acceptance that decision making will need to address innovation, changes in our model for delivery and will need to address difficult decisions along the way. As such, we have agreed to an eager appetite for taking risk. This means that we have a willingness to make decisions which may impact on our current business as usual for longer term reward and improvement if appropriate controls are in place and it is right to do so. This is applied to all areas of risk type as decision making at our Trust takes account of every element which may be impacted, for instance, finance, safety, quality, workforce, regulation etc; we rarely make decisions based solely on one area.

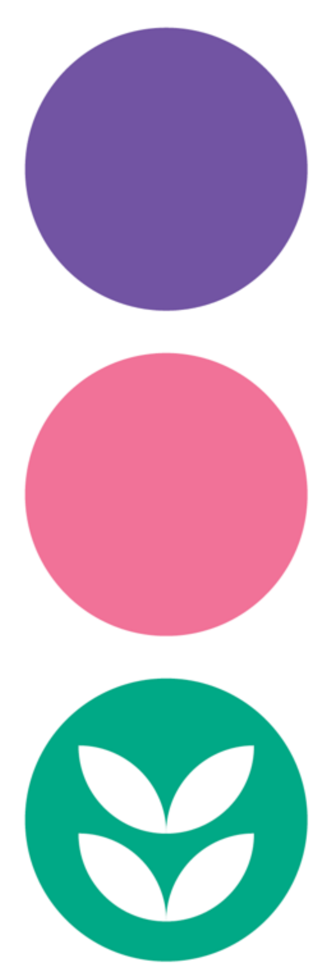
Risk Appetite Statement 2026/27

Leicestershire Partnership and Northamptonshire Healthcare Associate University Group

The definition of an eager approach is provided by each area of risk type in the Matrix provided on the next slide. It is important to note that we consider that impact of each and every decision that we make on the safety of our patients. As such, this is not a component of the risk appetite matrix, but a key part of all decision making

The Boards recognise that there will be appropriate times when a more cautious appetite to risk taking is needed and these will be assessed for individual risks. Our eager approach acts as our upper threshold, not a target. Where we do agree to apply the eager approach, the following will be considered;

- The strength of our control framework, with increased emphasis on third party assurance including our segmentation ratings, our annual provider capability assessments and our Head of Internal Audit Opinions. We will consider the strength of our policy and governance systems and processes.
- Our level of assurance that the controls continue to operate effectively.
- Our approach to scoring for each risk on our BAF. This is based on a 5x5 qualitative risk matrix with non-multiplicative colour zoning. Impact and likelihood are each scored 1-5 but the final risk rating is not calculated by multiplying the two numbers. Instead, the rating is determined by a heatmap (zones red amber and green) that reflect risk appetite. This allows us more control, where we can apply custom thresholds to safely apply an eager appetite toward decision making and taking risk.



Risk Appetite Matrix

Risk Level / Risk Type	None	Minimal	Cautious	Open	Eager
Quality	Zero appetite for any decisions with a high chance of an adverse or uncertain impact on the quality of patient care and the quality of outcomes for the patient.	Appetite for taking very limited clinical risks if essential to the quality of patient care and outcomes. Such risks are properly assessed with mitigating controls in place. Avoid innovation unless established and proven to be effective.	Appetite for taking moderate clinical risks where there is a low degree of inherent risk and the possibility of improved quality of outcomes, and appropriate controls are in place.	We will pursue innovation where there is potential for significant longer-term rewards and improvement on the quality of patient outcomes.	We seek to lead the way and will prioritise new innovations, even in emerging fields.
Finance	No appetite for decisions or actions which may result in financial loss.	Only prepared to accept minimal possibility of material financial impacts or losses or reporting misstatements if essential to safe and effective patient care and outcomes	Limited financial impacts or losses are accepted if they yield upside opportunities elsewhere within the Trust. Value for money is a key focus.	Prepared to invest and/or accept financial impacts or losses for the benefit of improved patient care and outcomes if appropriate controls are in place and value for money is delivered.	Proactively invest and/or accept financial impacts or losses for the benefit of patient care and outcomes, recognising that the potential for substantial gain outweighs inherent risks.
Performance	No appetite for action which may impact on operational service delivery. Focus on capability to protect services and maintain tight control.	Limited action may be taken which may impact on operational service delivery only where it is essential to deliver safe and effective patient care and outcomes. Decision making authority held by senior management.	Appetite for taking moderate risks relating to service delivery where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. Robust performance oversight processes in place.	Willing to take decisions that will impact on the business-as-usual delivery of services to deliver transformation and secure longer term quality improvement.	Appetite to take investment and transformation decisions in areas which are likely to impact on the delivery and accessibility of services in the short term in order to deliver significant improvement for the long term.
People and Culture	Avoidance of any workforce risks that threaten the delivery of safe and effective patient care and outcomes.	Only prepared to accept the possibility of very limited workforce risk impacts if essential to safe and effective patient care and outcomes. Innovation is not a priority.	Prepared to take limited risk with regards to workforce as long as this could yield opportunities elsewhere within the Trust for improvements in workforce, cultural and leadership development.	Appetite to take workforce management decisions which may have short term implications for our workforce for potential longer-term gains.	Seek to lead the way in terms of workforce and cultural innovation, accepting that this may be disruptive in the short term, but would be outweighed by the opportunity to drive improvement.
External	Zero appetite for any decisions that present risks to the Trust maintaining its CQC registration, complying with the law and its policies.	Only prepared to accept the possibility of minor regulatory observations if related actions are essential to the safe and effective patient care and outcomes.	Accept possibility of moderate regulatory observations / judgements as long as appropriate controls are in place and there is a potential for improvement outcomes.	Willing to take decisions that are likely to bring additional scrutiny to outwardly promote new ideas and innovations where potential benefits outweigh the risks.	Comfortable to take decisions that may expose the trust to significant additional scrutiny or judgement as long as there is commensurate opportunity for improvement outcomes for our stakeholders.

Based on models produced by the Good Governance Institute 'Risk Appetite for NHS Organisations, A matrix to support better risk sensitivity in decision taking' developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU January 2012 and the Leeds Teaching Hospitals NHS Trust 'Risk Appetite second edition' March 2023 and tailored for use by Leicestershire Partnership NHS Trust

G

Group Trust Board 28 May 2026
Group Model Partnership Agreement – Annual Review

Purpose of the report

To present an annual review of the group partnership agreement and any proposed revisions.

Analysis of the issue

A group partnership agreement was approved by both trust boards in May 2025 ahead of the launch of the first Group Trust Board meeting in public on 29 May 2025. The agreement (provided in full in Appendix A) outlines the group model approach between Leicestershire Partnership NHS Trust (LPT) and Northamptonshire Healthcare NHS Foundation Trust (NHFT).

The agreement has been reviewed, and it remains valid and relevant for 2026/27.

A minor amendment has been made to section 11.4 and 11.5.2 (marked in tracked changes in the appendix) which makes reference to the establishment of a joint people and culture committee.

Proposed revisions to the Terms of Reference (schedule 4) are the subject of a separate paper on the agenda.

Proposal

Group Trust Board to approve the proposed revisions to the partnership agreement to ensure that it remains valid for the 2026/27 period.

Decision required

Group Trust Board to approve the partnership agreement.

Appendix A

Date: 27 May 2025

Leicestershire Partnership NHS Trust and

Northamptonshire Healthcare NHS Foundation Trust

Partnership Agreement

for the purpose of Joint Working Arrangements and Appointment of a Joint Committee to Exercise Joint Functions as a Group Board

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This Agreement is made between the Parties on

Partnership Agreement PART A – PARTIES

The Parties to this Agreement are

(1) Leicestershire Partnership NHS Trust of County Hall, Leicester Road, Glenfield, Leicestershire, LE3 8RA (**LPT**), and

(2) Northamptonshire Healthcare NHS Foundation Trust of London Road, Kettering, NN15 7PW (**NHFT**)

Together the trusts refer to the Group as the 'Leicestershire Partnership and Northamptonshire Healthcare Associate University Group'.

Partnership Agreement PART B – BACKGROUND

A. The background to this Agreement (including acronyms and capitalised words that are used in it) shall be interpreted in accordance with the definitions and rules of interpretation set out in Schedule 1

B. LPT is an NHS Trust established by the Leicestershire and Rutland Healthcare National Health Service Trust (Establishment) Order 1998 made by the Secretary of State in accordance with Schedule 4 of the National Health Service Act 2006 (NHSA).

C. NHFT is constituted as an NHS foundation trust in accordance with its constitution dated 24 April 2024.

D. Each Trust must exercise its Functions in accordance with its respective Governance and having regard to Guidance

E. Since 2021 the Trusts have been parties to and collaborated in accordance with the Group Memorandum of Understanding (Group MoU) that they entered into in 2021 and updated in 2025.

F. The Trusts have agreed to exercise their powers under sections 65Z5 and 65Z6 of the NHSA to establish and implement joint working and delegation arrangements as set out in this Agreement and to establish a joint committee to be known as the Group Board to exercise Joint Functions.

G. The Trusts accordingly intend that this agreement will supersede and replace the Group MoU.

H. The Trusts have agreed to data sharing, access to records and mutual operation of all Joint Functions including human resources and joint line management arrangements to facilitate the exercise of Joint Functions.

I. The Trusts have agreed that the Group Board will exercise Joint Functions but will not exercise Reserved Functions.

Partnership Agreement PART C – OPERATIVE PROVISIONS

1. Definitions and interpretation

1.1 This Agreement (including acronyms and capitalised words that are used in it) shall be interpreted in accordance with the definitions and rules of interpretation set out in Schedule 1.

2. Actions taken prior to the Commencement Date

2.1. Both Trusts shall have satisfied or agreed in writing to waive the conditions set out in Clause 2.2 on or prior to the Commencement Date.

2.2. The conditions referred to in Clause 2.1 are:

2.2.1. The Trusts shall have exchanged duly executed copies of this Agreement

2.2.2. The Trusts shall have constituted the Group Board and approved the Group Board Terms of Reference (ToR)

2.2.3. The Trusts shall have updated and adopted Standing Orders that are mutually compatible

2.2.4. Such other conditions that either Trust may have specified in writing before the Commencement Date.

3. Commencement and duration

3.1. This Agreement shall take effect from the Commencement Date and will continue in full force and effect until terminated in accordance with the terms of this Agreement and, in particular but without limitation, in accordance with Clause 18.

3.2. No termination of the Agreement by any of the Trusts shall take effect prior to 31 March 2026.

4. No merger, acquisition or dissolution

4.1. Both Trusts shall remain independent, sovereign organisations constituted in accordance with the NHSA and their respective Governance.

4.2. Nothing in this Agreement commits the Trusts or is intended to commit them to undertake or apply for merger, acquisition or dissolution or any other transaction whose outcome would be the establishment of a single organisation as successor to one or both of them.

4.3. Each of the Trusts shall continue at all times to maintain its own individual governance, registrations, licences, memberships, committees, and other arrangements that it may be required to maintain or hold by Law, Direction or Guidance including:

4.3.1. Standing Orders, Standing Financial Instructions and Scheme of Delegation

4.3.2. CQC registration

4.3.3. NHS provider licence

4.3.4. ICO registration

4.3.5. NHSR Schemes membership

4.3.6. Remuneration Committee

4.3.7. Audit Committee

4.3.8. Auditor Panel

4.3.9. Meetings that the Trusts' Boards must each hold as set out in Clause 8 of this Agreement.

5. Trust Board Appointments

5.1. Voting Non-Executive Directors (NEDs) of LPT shall continue to be appointed by NHS England in accordance with Regulation 3 of the NHSM&P Regulations.

5.2. Voting NEDs of NHFT shall continue to be appointed by its Council of Governors (CoG) in accordance with its Constitution.

5.3. The Trusts acting by their respective Remuneration Committees:

5.3.1. Shall appoint Voting Executive Directors (EDs) in accordance with the scheme set out in Schedule 7, and

5.3.2. May additionally appoint Non-Voting NEDs and Non-Voting EDs in accordance with the scheme set out in Schedule 7.

5.4. In compliance with the NHSA and their respective Governance each Trust will maintain a functioning Board comprising seven Voting NEDs (including the Chair) and five Voting EDs (who must include the Chief Executive Officer (CEO), Chief Finance Officer (CFO), Chief Medical Officer (CMO), and Chief Nursing Officer (CNO)).

5.5. The fifth Voting ED shall be the Trust's Managing Director or such other ED whom the CEO nominates to be a Voting ED.

5.6. The number of each Trust's Voting NEDs shall at all times be greater than the number of its Voting EDs.

6. Appointment of Group Board

6.1. The Trusts agree to establish a Joint Committee to be known as the 'Group Board'.

6.2. The Group Board shall be fully and equally accountable to both Trusts.

6.3. The Group Board ToR and its membership must be agreed by both Trusts and must include the provisions set out in Clause 6.4.

6.4. The provisions referred to in Clause 6.3 are:

6.4.1. All the Voting Directors of both Trusts shall be voting members of the Group Board during their terms of office

6.4.2. The Trusts may appoint Non-Voting Directors and/or other individuals to be voting or non-voting members of the Group Board

6.4.3. The Trusts and Group Board shall have Committees in accordance with Clause 11

6.4.4. The Group Board shall exercise the Joint Functions.

6.4.5. Subject to Clause 6.4.6, meetings of the Group Board shall be held in public

6.4.6. The Group Board may, by resolution, exclude the public from a meeting (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings; and where such a resolution is passed, this Agreement shall not require the meeting to be open to the public during proceedings to which the resolution applies

6.4.7. The proceedings of the Group Board shall not be invalidated by any vacancy in its membership or by any defect in the appointment of a member of the Group Board.

6.5. The Group Board ToR as at the Commencement Date are as set out in Schedule 4.

6.6. The Trusts may agree to amend the Group Board ToR but only by Variation in accordance with Clause 17 of this Agreement.

7. Joint Exercise of Functions

7.1. Subject to Clause 7.2 the Trusts agree that from the Commencement Date:

7.1.1. They shall jointly exercise their Joint Functions

7.1.2. The Group Board shall exercise for them all their Joint Functions,

7.1.3. If the Group Board appoints a Committee in accordance with Clause 11, then the Group Board may authorise the Committee to exercise Joint Functions that the Group Board expressly subdelegates to the Committee in its ToR.

7.1.4. The Group Board may authorise one of the Trusts to contract with a third party on behalf of itself alone or both Trusts jointly and/or severally subject to compliance with the Trusts' standing orders and standing financial instructions.

7.2. Subject to Clause 6.4.7, the Trusts agree that they, the Group Board and their Committees, directors and officers must always comply with this Agreement and with each of the Trust's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation when they are exercising Joint Functions.

8. Meetings of the Trusts' Boards

8.1. Subject to Clause 8.2, the Trusts intend that as far as possible meetings and business of the Trusts' Boards will be undertaken by the Group Board on their behalf.

8.2. In accordance with paragraph 12 of Schedule 4 of the NHSA and paragraph 13 of Schedule 7 of the NHSA, the Board of each Trust must continue to hold any public meetings that it is required to hold including

8.2.1. An annual meeting to approve the Trust's annual audited accounts and annual report

8.2.2. Any other meeting at which must be presented the documents referred to in Clause 8.3:

8.3. The documents referred to in Clause 8.2.2 are:

8.3.1. The Trust's audited accounts and annual report,

8.3.2. Any report on the Trust's accounts made pursuant to paragraph 1 of Schedule 7 to the Local Audit and Accountability Act 2014 in the case of LPT or paragraph 24 of Schedule 7 and Schedule 10 to the NHSA in the case of NHFT, and

8.3.3. Any other documents as may be prescribed.

9. Workforce

9.1. Both Trusts shall continue to employ their own workforces

9.2. Both Trusts agree that in the exercise of their joint working arrangements, members of either Trust's or both Trusts' workforce may be line managed by duly authorised officers of either Trust or both Trusts.

10. Exercise of Reserved Functions

10.1. Both Trusts shall continue to exercise separately their Reserved Functions.

10.2. The Trusts agree that the Group Board shall not at any time exercise their Reserved Functions.

11. Appointment of Committees and Committees in Common

11.1. For the purpose of assisting the exercise of Joint Functions the Group Board may appoint one or more Committees.

11.2. The voting members of a Committee of the Group Board may comprise or include individuals who are or are not voting members of the Group Board.

11.3. For the purpose of assisting the exercise of their Reserved Functions the Trusts may appoint Committees in Common.

11.4. Without prejudice to the generality of Clause 11.4, the Boards of each of the Trusts (acting as independent, sovereign bodies) shall consider and (if agreed by both Boards) arrange for:

11.4.1. Their Audit Committees (including their Auditor Panels) to operate together as Committees in Common and

11.4.2. Their Remuneration Committees to operate together as Committees in Common and

11.4.3. Their People and Culture Committees to operate together as Committees in Common

11.5. In operating as Committees in Common;

11.5.1. Each Trust's Audit Committee, Auditor Panel and Remuneration Committee shall continue at all times to be directly accountable to its respective Trust Board but shall routinely report to the Group Board; and

11.5.2. Each Trust shall ensure that the members of its Audit Committee, Auditor Panel, Remuneration Committee and People and Culture Committee at all times satisfy the independence requirements set out in the Local Auditor and Accountability Act 2014, Local Audit (Health Service Bodies Auditor Panel and Independence) Regulations 2015 and NHS England's *Code of governance for NHS provider trusts* (2022).

12. Operating Principles

12.1. The Trusts shall exercise their Functions having regard to the operating principles set out in Clause 12.2.

12.2. The operating principles referred to in Clause 12.1 are:

12.2.1. Collaboration
12.2.2. Best practice
12.2.3. Shared Learning
12.2.4. Equality

13. Benefits

13.1. The Trusts shall exercise their Functions having regard to unlocking the key benefits set out in Clause 13.2.

13.2. The key benefits referred to in Clause 13.1 are:

13.2.1. Improvement of services
13.2.2. Efficient, effective and economic use of resources
13.2.3. Greater system collaboration
13.2.4. System grip on finances

14. Organisational development

14.1. Both Trusts will develop and adopt a group board development programme having regard to the matters referred to in Clause 14.2.

14.2. The matters referred to in Clause 14.1 include but are not limited to:

- 14.2.1. Group arrangements and opportunities
- 14.2.2. Group strategy development
- 14.2.3. Group governance and risk management
- 14.2.4. Collaboratives and partnerships
- 14.2.5. Learning and development

15. Resourcing the Group Board

15.1 Both Trusts shall be jointly and equally responsible for resourcing the Group Board.

16. Pooled Fund

16.1. The Trusts may enter into arrangements for the Trusts themselves or the Group Board to establish and maintain a Pooled Fund.

16.2. Arrangements for any Pooled Fund must be on terms set out in a Pooled Fund Agreement.

17. Variation

17.1. Except as set out in Clause 17.2 or otherwise in this Agreement, any Variation of this Agreement, including the introduction of any additional terms and conditions, shall only be binding when agreed by written resolutions of both Trusts' Boards.

17.2. The Scheme for Trust Board Appointments set out in Schedule 7 and the Governance Organogram for the Trusts' Appointment of Committees as at the Commencement Date set out in Schedule 5 are intended to be illustrative only and may be updated by resolution of the Group Board without the requirement for Variation set out in Clause 17.1.

18. Termination

18.1. The Trusts acknowledge and confirm that, save in accordance with this Clause 18, neither of them shall be entitled to terminate this Agreement.

18.2. The Trusts acknowledge and confirm that neither of them shall be entitled to terminate this Agreement in consequence of any breach (whether material or otherwise) of any provision of this Agreement by the other.

18.3. Both Trusts acknowledge and confirm that they have considered and understood the position set out at Clause 18.2 above and that the provisions of Clauses 3.2 (and Clause 22 in relation to the Dispute Resolution Procedure) shall apply in the event of any breach of this Agreement.

18.4. Subject to Clauses 3.2 and 18.5 , a Trust may only terminate this Agreement by giving Notice of Termination specifying a minimum notice period that expires on the next 31 March which is not less than six months before that date. The notice period may be shorter where agreed in writing by the other Trust.

19. Consequences of termination

19.1. On or pending expiry or termination of this Agreement, the Parties will agree an Exit Plan to ensure that the services provided by either Trust are not destabilised.

19.2. For a reasonable period before and after termination or expiry of this Agreement the Trusts shall co-operate fully with one another and ensure that the Exit Plan provides for continuity of services and a smooth transition of Trust Boards whilst avoiding any inconvenience or risk to the health and safety of the Trusts' service users, employees or members of the public.

19.3. This clause 19 shall continue in full force and effect on or after termination or expiry of this Agreement.

20. Data sharing and confidentiality

20.1 Each Trust undertakes that it shall not at any time during the period for which this Agreement applies, and for a period of five years after termination of this Agreement, disclose to any person any Confidential Information concerning or in connection with the other Trust or this Agreement except as permitted by Schedule 6.

21. No partnership

21.1 Except as expressly provided in this Agreement, nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between the Trusts, constitute either Trust the agent of the other Trust, nor authorise a Trust to make or enter any commitments for or on behalf of the other Trust.

22. Notices

22.1. A notice given under this Agreement:

22.1.1. Will be in writing in the English language

22.1.2. Will be sent to the intended recipient by email to the following address or such other address as the Party has notified for the purposes of this clause:

22.1.2.1. for LPT, the Chief Executive Officer of LPT in post at the time of the notice

22.1.2.2. for NHFT, the Chief Executive Officer of NHFT in post at the time of the notice

22.2. Any notice or other communication given to a Trust under or in connection with the Agreement shall be in writing, addressed to the authorised representatives at the Trust's principal place of business or such other address as that Trust may have specified to the other Trust in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery, commercial courier or email.

22.3. A notice or other communication shall be deemed to have been received:

22.3.1. If delivered personally, when left at the address referred to in Clause 22.2; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Business Day after posting; if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed; or, if sent by fax, one (1) Business Day after transmission.

22.3.2. If delivered by email, immediately on sending provided it is correctly addressed or if deemed receipt is not within business hours (meaning prior to 5.30 pm and excluding weekends and public holidays in England), then it will be deemed to have been received at 9.00 am on the next day that is not a weekend or a public holiday in England.

22.4. The provisions of this Clause 22 shall not apply to the service of any proceedings or other documents in any legal action.

23. Dispute Resolution

23.1. In accordance with Clauses 3.2, 3.3 and 18 regarding termination of the Agreement, both Trusts agree to this dispute resolution process.

23.2. In the case of dispute, the Managing Directors shall review any dispute referred to them via the Directors of Governance and Joint Chair in writing with 28 days of receipt and propose a resolution.

23.3. In the case of the resolution being rejected, the matter will be referred to an agreed independent mediator who will provide a final and binding determination and resolution.

23.4. In the case of dispute between the Boards leading to consideration of termination, Clauses 3.2 and 3.3 determine the timescale and Clause 18 in respect of notification of termination.

24. Other general provisions

24.1. Each Trust shall (at its own expense) promptly execute and deliver such documents, perform such acts and do such things as the other Trust may reasonably require from time to time for the purpose of giving full effect to this Agreement.

24.2. Each Trust will bear its own costs of negotiating and entering into this Agreement.

24.3. This Agreement is personal to the Trusts and neither Trust shall assign, transfer, mortgage, charge, declare a trust of, or deal in any other manner with any of its rights and obligations under this Agreement without the prior written consent of the other Trust.

24.4. This Agreement (together with the documents referred to in it) constitutes the entire agreement between the Trusts and supersedes and extinguishes all previous discussions, correspondence, negotiations, drafts, agreements, promises, assurances, warranties, representations and understandings between them, whether written or oral, relating to its subject matter.

24.5. No failure or delay by a Trust to exercise any right or remedy provided under this Agreement or by law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy. A waiver of any right or remedy under this Agreement or by law is only effective if it is in writing.

24.6. Except as expressly provided in this Agreement, the rights and remedies provided under this Agreement are in addition to, and not exclusive of, any rights or remedies provided by law.

24.7. If any provision or part-provision of this Agreement is or becomes invalid, illegal or unenforceable, it shall be deemed modified to the minimum extent necessary to make it valid, legal and enforceable. If such modification is not possible, the relevant provision or part-provision shall be deemed deleted. Any modification to or deletion of a provision or part-provision under this Clause shall not affect the validity and enforceability of the rest of this Agreement.

24.8. This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute a duplicate original, but all the counterparts shall together constitute the one agreement.

24.9. No one other than a party to this Agreement shall have any right to enforce any of its terms.

24.10. This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the law of England and Wales.

24.11. Each Trust irrevocably agrees that the courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim arising out of or in connection with this Agreement or its subject matter or formation (including non-contractual disputes or claims).

The Trusts have executed this Agreement as set out below on the date stated at the beginning of it.

Partnership Agreement PART D – SCHEDULES

Schedule 1 **Definitions and Interpretation**

In this Agreement capitalised words and expressions shall have the meanings given to them as follows:

Word or expression	Meaning
Agreement (PCA)	This collaboration agreement (including its Schedules) which sets out arrangements of the Trusts to exercise their Functions jointly. Partnership Collaboration Agreement.
Arrangements for delegation and joint exercise of statutory functions	NHS England Guidance *Arrangements for delegation and joint exercise of statutory functions – Guidance for integrated care boards, NHS trusts and foundation trusts* dated 27 March 2023 (Publication approval reference: PRN00346)
Audit Committee	A Committee that each of the Trusts must appoint in accordance with NHS England's *Code of governance for NHS provider trusts* (2022) to ensure that it operates effectively and meets its statutory and strategic objectives, and to provide it with assurance that this is the case
Auditor Panel	An auditor panel that LPT must appoint in compliance with the Local Audit and Accountability Act 2014 and Local Audit (Health Service Bodies Auditor Panel and Independence) Regulations 2015
CEO	A Voting ED who is the Chief Executive Officer of one or both of the Trusts
Chair	A Voting NED who is the Chair of one or both of the Trusts
Commencement Date	29 May 2025
Committee	A committee or subcommittee of one of the Trusts or a subcommittee of a Joint Committee (including the Group Board)
Committees in Common (CiC)	Arrangements between the Trusts to appoint like for like Committees with the same or equivalent terms of reference and memberships so that they may meet simultaneously with shared agenda and minutes
CQC	Care Quality Commission
Data Protection Legislation	all applicable data protection legislation in force from time to time in the UK including the UK GDPR; the Data Protection Act 2018 (DPA 2018) (and regulations made thereunder); and the Privacy and Electronic Communications Regulations 2003 (SI 2003 No. 2426) as amended which apply to a party relating to the use of personal data UK GDPR has the meaning given to it in section 3(10) (as supplemented by section 205(4)) of the Data Protection Act 2018.
Direction	A direction to an NHS trust that the Secretary of State or NHS England may issue in the exercise of their respective functions under Legislation
Director	A NED or an ED of one or both of the Trusts

Word or expression	Meaning
ED or Executive Director	An executive director who may be Voting ED or a Non-Voting ED
EIR	Environmental Information Regulations 204 (SI 204/3391)
Establishment Order	For LPT means the Leicestershire and Rutland Healthcare National Health Service Trust (Establishment) Order 1998 as amended.
Exit Plan	A plan for the transition of any affected services and required changes to the Trust Boards on the expiry or termination of this Agreement to include: (i) details of the affected services; (ii) details of service users and/or user groups affected; (iii) the joint working arrangements and jointly exercised functions that will need to continue to ensure continuity of services and how these will be transitioned into separate arrangements for each Trust; (iv) the intended timescales for the Exit Plan
FOIA	Freedom of Information Act 2000
Functions	All the duties and/or powers of the Trusts under the NHSA or LPT's Establishment Order or any other legislation or otherwise conferred by any other source whatsoever
Governance	For NHFT means NHFT's Constitution, Standing Orders and Schedule 7 For LPT means LPT's Establishment Order, Schedule 4 of the NHSA and the NHSM&P Regulations
Group Board	A Joint Committee that the Trusts have agreed to establish to exercise Joint Functions in accordance with the Group Board ToR
Group Board ToR	ToR of the Group Board
Group MoU	the Group Memorandum of Understanding that the Trusts agreed in 2021 and updated in 2025 for the purpose of setting out collaboration arrangements between them
Guidance	Any statutory guidance of the Secretary of State or NHS England to NHS bodies comprising or including NHS trusts (for example *Arrangements for delegation and joint exercise of statutory functions*) or other non-statutory guidance that the Trusts must have regard to in accordance with their NHS provider licence
Joint Committee	A joint committee that the Trusts agree to establish under section 65Z6 of the NHSA
Joint Functions	Any Functions set out in Schedule 2 which the Trusts agree are jointly exercisable by them
Legislation	An Act of Parliament (for example the NHSA) or statutory instrument (for example the NHSM&P Regulations)
Mandatory Reserved Functions	Those functions set out in Schedule 3
NED or Non-Executive Director	A non-executive director who may be Voting NED or a Non-Voting NED

Word or expression	Meaning
NHSA	National Health Service Act 2006
NHSM&P Regulations	National Health Service (Membership and Procedure) Regulations 1990
NHSR Schemes	The indemnity schemes known as the Clinical Negligence Scheme for Trusts, Liabilities to Third Parties Scheme and Property Expenses which the Secretary of State has established under the NHSA and which are managed on her behalf by NHS Resolution
Non-Voting ED	An Executive Director who is not a Voting Director
Non-Voting NED	A Non-Executive Director who is not a Voting Director
Notice of Termination	Notice in writing from one Trust to the other Trust to terminate this Agreement in accordance with Clause 18
People and Culture Committee	A Committee that each Trust chooses to appoint with responsibility for people matters on behalf of the Board
Pooled Fund	A fund to be made up of payments received in accordance with arrangements between the Parties that must be set out in a Pooled Fund Agreement and out of which payments may be made in accordance with the arrangements towards expenditure incurred in the exercise of Joint Functions
Pooled Fund Agreement	An agreement in writing between the Trusts for the establishment of a Pooled Fund in accordance with section 65Z6 of the NHSA
Relevant Personal Data	means the Personal Data transferred between the Trusts under this Agreement.
Remuneration Committee	A Committee that each Trust must appoint whose responsibilities include functions under regulations 17 and 18 of the NHSM&P Regulations in the case of LPT and paragraphs 17(3), 17(4) and 18(2) of Schedule 7 in the case of NHFT: • (The CEO not being a member of it) to appoint the Trust's CEO and advise the Board about their remuneration and terms of service and • (The CEO being a member of it) to appoint other executive directors and advise the Board about their remuneration and terms of service
Reserved Functions	Any Functions set out in Schedule 3 which the Trusts agree are not Joint Functions
Secretary of State	Secretary of State for Health and Social Care
Standing Orders	In the case of an NHS trust the standing orders that an NHS trust must adopt in accordance with paragraph 19 of the NHSM&P Regulations for the regulation of the its proceedings and business and in the case of an NHSFT means the standing orders of its board of directors and/or the standing orders of its CoG that the NHSFT is

Word or expression	Meaning
	required to adopt by its Constitution for the regulation of their proceedings and business.
ToR	Terms of reference
UK GDPR	Has the meaning given to it in section 3(10) (as supplemented by section 205(4)) of the Data Protection Act 2018.
Variation	A variation of this Agreement in accordance with Clause 17
Voting Director	A Voting ED or a Voting NED
Voting ED	In the case of an NHS trust means a Director who is an executive director within the meaning of paragraph 3 of Schedule 4 of the NHSA and appointed by a Trust (acting by its Remuneration Committee) in accordance with the NHSM&P Regulations In the case of an NHSFT means a Director who is an executive director within the meaning of paragraph 16 of Schedule 7 and has been appointed by the NEDs and (except for the CEO's appointment) the CEO in accordance with the NHSFT's Constitution
Voting NED	In the case of an NHS trust means a Director who is a non-executive director within the meaning of paragraph 3 of Schedule 4 of the NHSA and appointed by NHS England in accordance with the NHSM&P Regulations In the case of an NHSFT means a Director within the meaning of paragraph 16 of Schedule 7 and has been appointed by the NHSFT's CoG in accordance with its Constitution

Any reference to the exercise by the Trusts of Joint Functions shall be interpreted to include any exercise of Joint Functions by the Group Board or a Committee of it on behalf of the Trusts.

Schedule 2 **Joint Functions**

1. Joint Functions are any Functions of the Trusts which are not Reserved Functions
2. Joint Functions include but are not limited to:
   2.1. Each of the Trust's Functions to provide goods and services, namely hospital accommodation and services and community health services, for the purposes of the health service in accordance with its Governance
   2.2. All the Trusts' Functions that NHS England has categorised as 'Open to Joint Exercise of Functions' in *Arrangements for delegation and joint exercise of statutory functions* as reproduced in the table set out in Paragraph 3 below (excluding references to legislation that is applicable to or in force in Wales only).
3. The table referred to in paragraph 2(2) is as follows:

For LPT:

Statutory provision	Wording	Category of function	Open to joint exercise
Schedule 4, Paragraph 15, NHS Act 2006	(1) In addition to carrying out its other functions, an NHS trust may, as the provider, enter into NHS contracts.	ANCILLARY FUNCTION	Yes
Schedule 4, Paragraph 16, NHS Act 2006	An NHS trust may undertake and commission research and make available staff and provide facilities for research by other persons.	ANCILLARY FUNCTION	Yes
Schedule 4, Paragraph 17, NHS Act 2006	An NHS trust may– (a) provide training for persons employed or likely to be employed by the NHS trust or otherwise in the provision of services under this Act, and (b) make facilities and staff available in connection with training by a university or any other body providing training in connection with the health service.	ANCILLARY FUNCTION	Yes
Schedule 4, Paragraph 19, NHS Act 2006	(1) According to the nature of its functions, an NHS trust may make accommodation or services available for patients who give undertakings (or for whom undertakings are given) to pay any charges imposed by the NHS trust in respect of the accommodation or services.	ANCILLARY FUNCTION	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
Schedule 4, Paragraph 21, NHS Act 2006	An NHS Trust may arrange for the provision of accommodation and services outside England and Wales.	COMMISSIONING	Yes
Schedule 4, Paragraph 24, NHS Act 2006	An NHS trust may provide services under an agreement made under section 92 (primary medical services) or section 107 (primary dental services) and may do so as a member of a qualifying body (within the meaning given by section 93 or section 108).	COMMISSIONING	Yes
Equality Act 2010 c. 15	Refers to all functions under this Act.	REGULATORY	Yes
Health Act 2009 c. 21	Refers to all functions under this Act.	REGULATORY	Yes
Health and Social Care Act 2008 c. 14	Refers to all functions under this Act.	REGULATORY	Yes
Local Government and Public Involvement in Health Act 2007 c. 28	Refers to all functions under this Act.	REGULATORY	Yes
Health Act 2006 c. 28	Refers to entire Act.	REGULATORY	Yes
Health and Social Care (Community Health and Standards) Act 2003 c. 43	Refers to entire Act.	REGULATORY	Yes
Mental Capacity Act 2005 c. 9	Refers to entire Act.	REGULATORY	Yes
Health and Social Care Act 2008 c. 14	Refers to all functions under this Act.	REGULATORY	Yes
Local Audit and Accountability Act 2014 c. 2	(1) This paragraph applies to a relevant authority [includes an NHS Trust - see note to s4, above] if a local auditor has made a public interest report [see Schedule 7, para 1] relating to the authority or an entity connected with it. (2) As soon as is practicable after receiving the report, the relevant authority must publish the report and a notice [see ss(7) and (8)(d) in relation to publication requirements] that— (a) identifies the subject matter of the report, and (b) unless the authority is a health service body, states that any member of the public may inspect the report and make a copy of it or any part of it between the times and at the place or places specified in the notice.	REGULATORY	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
	(3) As soon as is practicable after receiving the report, the relevant authority must supply a copy of the report to— (a) each of its members (if it has members), and (b) its auditor panel (if it has one).		
National Health Service and Community Care Act 1990 c. 19	Refers to entire Act.	REGULATORY	Yes
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 6(1)	(1) Where an NHS trust or an NHS foundation trust supplies a drug or appliance to a patient for the purpose of treatment, the NHS trust or the NHS foundation trust (as the case may be) must, subject to paragraphs (3) to (6), make and recover from the patient for the supply of [continues as to charges to be made in respect of particular items] [See further reg 6 for exemptions]	COMMISSIONING	Yes
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 7(1)	(1) Where drugs or appliances are supplied to a patient, including during the out of hours period, for the purpose of treating that patient, by a prescriber at a walk-in centre, the NHS trust, NHS foundation trust or other person responsible for the management of the centre, must, subject to paragraphs (3) to (5), make and recover from that patient for the supply of [continues as to charges to be made in respect of particular items] [See further reg 7 for exemptions]	COMMISSIONING	Yes
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 10(1)	(9) Where a claim to an exemption has been made but is not substantiated, and in consequence of the claim a charge has not been recovered, if—[...] (b) the drugs or appliances were supplied by an NHS trust or an NHS foundation trust as mentioned in regulation 6, then that NHS trust or NHS foundation trust must recover that charge from the person concerned [...]	COMMISSIONING	Yes
National Health Service (Charges to Overseas Visitors) Regulations 2015	The Regulations place various duties (not set out in full here) on "relevant bodies" (which includes NHS Trusts, by	COMMISSIONING	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
	reg 2) to make and recover charges for the provision of relevant services to overseas visitors. Further, NHS Trusts, in meeting their obligations to make and recover charges from overseas visitors, must (by reg 3A) enter certain specified information against record against the overseas visitor's consistent identifier.		
National Health Service (Optical Charges and Payments) Regulations 2013, reg 2(2)	(2) Where a charge is payable by virtue of paragraph (1) [a charge for such amount for glasses and contact lenses as determined by the SoS], the NHS trust or NHS foundation trust, or other person on its behalf, that supplies or is to supply the glasses or contact lenses must– (a) on arranging to supply the glasses or contact lenses, make the charge, and (b) on supplying the glasses or contact lenses or having them available for supply, recover the charge from the person supplied or to be supplied (if the charge has not previously been paid).	COMMISSIONING	Yes
National Health Service (Optical Charges and Payments) Regulations 2013, reg 10(1)	(1) An NHS trust or NHS foundation trust which, following a sight test, issues a prescription for an optical appliance to a person who— (a) has indicated that they are an eligible person; or (b) is an eligible person by virtue of regulation 8(5), must issue to that person a voucher relating to the optical appliance prescribed. [See further reg 10(2) for requirements on issuing a voucher]	COMMISSIONING	Yes
NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012, reg 4	(1) This regulation applies where a clinical commissioning group, NHS trust or NHS foundation trust and a local authority propose to designate a body as a Care Trust under section 77(1) of the 2006 Act, or propose to revoke such designation. (2) Where this regulation applies, the body and the local	REGULATORY	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
	authority must, before designating or revoking the designation, as the case may be, consult jointly such persons as appear to them to be affected by the proposed designation or revocation.		
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, reg 4(1)	(1) Each public authority listed in Schedule 2 [which includes NHS Trusts] to these Regulations must publish information to demonstrate its compliance with the duty imposed by section 149(1) of the Act [i.e. the public sector equality duty of the Equality Act 2010]. [See further regs 4(2) onwards and reg 6 for requirements as to publication and exemption for authorities with fewer than 150 employees]	REGULATORY	Yes

For NHFT:

Statutory provision	Wording	Category of function	Open to joint exercise
Section 43 NHS Act 2006	(2) An NHS foundation trust may provide goods and services for any purposes related to— (a) the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and (b) the promotion and protection of public health. (2A) An NHS foundation trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes. (3) An NHS foundation trust may also carry on activities other than those mentioned in subsection (2) for the purpose of making additional income available in order better to carry on its principal purpose.	ANCILLARY FUNCTION	Yes
Section 44 NHS Act 2006	(6) According to the nature of its functions, an NHS foundation trust may, in the case of patients being	COMMISSIONING	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
	provided with goods and services for the purposes of the health service, make accommodation or further services available for patients who give undertakings (or for whom undertakings are given) to pay any charges imposed by the NHS foundation trust in respect of the accommodation or services. (7) An NHS foundation trust may exercise the power conferred by subsection (6) only to the extent that its exercise does not to any significant extent interfere with the performance by the NHS foundation trust of its functions.		
Section 47 NHS Act 2006	(1) An NHS foundation trust may do anything which appears to it to be necessary or expedient for the purpose of or in connection with its functions. (2) In particular it may– (a) acquire and dispose of property, (b) enter into contracts, (c) accept gifts of property (including property to be held on trust for the purposes of the NHS foundation trust or for any purposes relating to the health service), (d) employ staff. (3) Any power of the NHS foundation trust to pay remuneration and allowances to any person includes power to make arrangements for providing, or securing the provision of, pensions or gratuities (including those payable by way of compensation for loss of employment or loss or reduction of pay). (4) "The purposes of the NHS foundation trust" means the general or any specific purposes of the trust (including the purposes of any specific hospital at or from which services are provided by the trust).	ANCILLARY FUNCTION	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
Section 47A NHS Act 2006 as inserted by section 64 of the Health and Care Act 2022	Joint exercise of functions An NHS foundation trust may enter into arrangements for the carrying out, on such terms as the NHS foundation trust considers appropriate, of any of its functions jointly with any other person.	CORPORATE	Yes
Section 56 NHS Act 2006	(1) An application may be made jointly by– (a) an NHS foundation trust, and (b) another NHS foundation trust or an NHS trust established under section 25, to the regulator for the dissolution of the trusts and the establishment of a new NHS foundation trust. (1A) An application under this section may be made only with the approval of more than half of the members of the council of governors of each applicant (that is an NHS foundation trust). (2) The application must– (a) be supported by the Secretary of State if one of the parties to it is an NHS trust, (b) specify the property and liabilities proposed to be transferred to the new NHS foundation trust, and (d) be accompanied by a copy of the proposed constitution of the new trust (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the dissolution of the trusts and the establishment of the proposed new trust have been taken. (11) On the grant of the application, the proposed constitution of the NHS foundation trust has effect, but the directors of the applicants may exercise the functions of the trust on its behalf until a board of directors is appointed in accordance with the constitution.	CORPORATE	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
Section 56A NHS Act 2006	56A Acquisitions (1) An application may be made jointly by— (a) an NHS foundation trust (A), and (b) another NHS foundation trust or an NHS trust established under section 25 (B), to the regulator for the acquisition by A of B. (2) An application under this section may be made only with the approval of more than half of the members of the council of governors of each applicant (that is an NHS foundation trust). (3) The application must— (a) be supported by the Secretary of State if B is an NHS trust, and (b) be accompanied by a copy of the proposed constitution of A, amended on the assumption that A acquires B. (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the acquisition have been taken. (4A) Where the regulator proposes to grant the application, it may by order make provision for the transfer of employees of B to A on the grant of the application. (5) On the grant of the application, the proposed constitution has effect, but where a person who is specified as a director of A in the constitution has yet to be appointed as such, the directors of A may exercise that person's functions under the constitution.	CORPORATE	Yes
Section 63 NHS Act 2006	An NHS foundation trust must exercise its functions effectively, efficiently and economically.	ANCILLARY FUNCTION	Yes
Section 63A NHS Act 2006	(1) In making a decision about the exercise of its functions, an NHS foundation trust must have regard to all likely effects of the decision in relation to— (a) the health and well-being of the people of England;	ANCILLARY FUNCTION	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
	(b) the quality of services provided to individuals— (i) by relevant bodies, or (ii) in pursuance of arrangements made by relevant bodies, for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England; (c) efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.		
Section 65Z5 NHS Act 2006 as inserted by Section 71 of the Health and Care Act 2022	Joint working and delegation arrangements (1) A relevant body may arrange for any functions exercisable by it to be exercised by or jointly with any one or more of the following— (a) a relevant body (b) a local authority (within the meaning of section 2B); (c) a combined authority. (2) In this section "relevant body" means— (a) NHS England, (b) an integrated care board, (c) an NHS trust established under section 25, (d) an NHS foundation trust, or (e) such other body as may be prescribed.	CORPORATE	Yes
Section 65Z6 NHS Act 2006 as inserted by Section 71 of the Health and Care Act 2022	Joint committees and pooled funds (1) This section applies where a function is exercisable jointly (by virtue of section 65Z5 or otherwise) by a relevant body and any one or more of the following— (a) a relevant body; (b) a local authority (within the meaning of section 2B); (c) a combined authority. (2) The bodies by whom the function is exercisable jointly may— (a) arrange for the function to be exercised by a joint	CORPORATE	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
	committee of theirs; (b) arrange for one or more of the bodies, or a joint committee of the bodies, to establish and maintain a pooled fund.		
Section 72 NHS Act 2006	(1) It is the duty of NHS bodies to co-operate with each other in exercising their functions.	ANCILLARY FUNCTION	Yes
Section 82 NHS Act 2006	In exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) must co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.	ANCILLARY FUNCTION	Yes
Section 223L NHS Act 2006	(1) NHS England may set joint financial objectives for integrated care boards and their partner NHS trusts and NHS foundation trusts. (2) An integrated care board and its partner NHS trusts and NHS foundation trusts must seek to achieve any financial objectives set under this section.	CORPORATE	Yes
Section 223LA NHS Act 2006	(1) An integrated care board and its partner NHS trusts and NHS foundation trusts must exercise their functions with a view to ensuring that their expenditure in a financial year (taken together) does not exceed the aggregate of any sums received by them in the year.	CORPORATE/ ANCILLARY	Yes
Section 223M NHS Act 2006	(1) Each integrated care board and its partner NHS trusts and NHS foundation trusts must exercise their functions with a view to ensuring that, in respect of each financial year— (a) local capital resource use does not exceed the limit specified in a direction by NHS England; (b) local revenue resource use does not exceed the limit specified in a direction by NHS England.	CORPORATE/ ANCILLARY	Yes
Section 242 NHS Act 2006	(1B) Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly	ANCILLARY FUNCTION	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
	or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in– (a) the planning of the provision of those services, (b) the development and consideration of proposals for changes in the way those services are provided, and (c) decisions to be made by that body affecting the operation of those services.		
Section 249 NHS Act 2006	(1) In exercising their respective functions, NHS bodies (on the one hand) and the prison service (on the other) must co-operate with one another with a view to improving the way in which those functions are exercised in relation to securing and maintaining the health of prisoners.	ANCILLARY FUNCTION	Yes
Criminal Justice Act 2003, Section 325(3)	In establishing those arrangements for the purpose of assessing and managing risks posed by relevant sexual and violent offenders &c, the responsible authority i.e. the chief officer of police, the local probation board for that area or (if there is no local probation board for that area) a relevant provider of probation services and the Minister of the Crown exercising functions in relation to prisons, acting jointly must act in co-operation with the persons specified in subsection (6); and it is the duty of those persons to co-operate in the establishment by the responsible authority of those arrangements, to the extent that such co-operation is compatible with the exercise by those persons of their relevant functions. NHS trusts are included among persons in sub-s (6)(h).	ANCILLARY FUNCTION	Yes
Mental Health (Care and Treatment) (Scotland) Act 2003, Section 31	(1) Where it appears to a local authority that the assistance of a Health Board, a Special Health Board or a National Health Service trust– (a) is necessary to enable the authority to perform any of their duties under section 25 or 26 of this Act i.e. relating	ANCILLARY FUNCTION	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
	to provision of care and support services and services designed to promote well-being and independence; or (b) would help the authority to perform any of those duties, the authority may request the Health Board, Special Health Board or National Health Service trust to co-operate by providing the assistance specified in the request. (2) A Health Board, a Special Health Board or a National Health Service trust receiving a request under subsection (1) above shall, if complying with the request– (a) would be compatible with the discharge of its own functions (whether under any enactment or otherwise); and (b) would not prejudice unduly the discharge by it of any of those functions, comply with the request.		
National Health Service Trust (Scrutiny of Deaths) (England) Order 2021, article 3	(1) An NHS trust in England may scrutinise the death of any person who has died in England where— (a) a senior coroner is not under a duty to investigate the death under section 1 of the Coroners and Justice Act 2009, or (b) it is unclear whether the death is one which a registered medical practitioner would be required to notify to the relevant senior coroner under the Notification of Deaths Regulations 2019.	ANCILLARY FUNCTION	Yes
Social Workers Regulations 2018, reg 7	(1) The persons specified for the purposes of section 53(1)(d) of the Act i.e the Children and Social Work Act 2017, which requires Social Work England ("the regulator") to cooperate with, among others, any person specified in regulations made by the Secretary of State are— (d) any NHS trust established under section 25 of the National Health Service Act 2006,	ANCILLARY FUNCTION	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
Children Act 2014, s11(2); (4)	(2) Each person and body to whom this section applies which includes NHS Trusts by ss(1) must make arrangements for ensuring that– (a) their functions are discharged having regard to the need to safeguard and promote the welfare of children; and (b) any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need. (4) Each person and body to whom this section applies must in discharging their duty under this section have regard to any guidance given to them for the purpose by the Secretary of State.	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 25(5) [Applicable in Wales only]	(1) Each local authority in Wales must make arrangements to promote co-operation between– (a) the authority; (b) each of the authority's relevant partners which includes NHS Trusts by ss(4)(e); and (c) such other persons or bodies as the authority consider appropriate, being persons or bodies of any nature who exercise functions or are engaged in activities in relation to children in the authority's area. (2) The arrangements under subsections (1) and (1A) not reproduced here are to be made with a view to— (a) improving the well-being of children within the authority's area, in particular those with needs for care and support; (b) improving the quality of care and support for children provided in the authority's area (including the outcomes that are achieved from such provision); (c) protecting children who are experiencing, or are at risk of, abuse, neglect or other kinds of harm (within the	ANCILLARY FUNCTION	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
	meaning of the Children Act 1989). (5) The relevant partners of a local authority in Wales must co-operate with the authority in the making of arrangements under this section.		
Children Act 2014, Section 25(6) [Applicable in Wales only]	(6) A local authority in Wales and any of their relevant partners may for the purposes of arrangements under this section– (a) provide staff, goods, services, accommodation or other resources; (b) establish and maintain a pooled fund as defined by ss(7).	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 25(8) [Applicable in Wales only]	(8) A local authority in Wales and each of their relevant partners must in exercising their functions under this section have regard to any guidance given to them for the purpose by the Welsh Ministers.	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 27(3) [Applicable in Wales only]	(3) An NHS trust to which section 25 see lines above applies must– (a) appoint an executive director, to be known as the trust's "lead executive director for children and young people's services", for the purposes of the trust's functions under that section; and (b) designate one of the trust's non-executive directors as its "lead non-executive director for children and young people's services" to have the discharge of those functions as his special care.	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 28(2) [Applicable in Wales only]	(2) Each person and body to whom this section applies including an NHS trust all or most of whose hospitals, establishments and facilities are situated in Wales, by ss(1)(c) must make arrangements for ensuring that– (a) their functions are discharged having regard to the need to safeguard and promote the welfare of children; and	ANCILLARY FUNCTION	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
	(b) any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need.		
Children Act 2014, Section 28(4) [Applicable in Wales only]	(4) The persons and bodies referred to in subsection (1)(a) to (c) and (i) must in discharging their duty under this section have regard to any guidance given to them for the purpose by the Assembly.	ANCILLARY FUNCTION	Yes
Domestic Violence, Crime and Victims Act 2004, Section 9(2), (3)	(3) It is the duty of any person or body within subsection (4) establishing or participating in a domestic homicide review (whether or not held pursuant to a direction under subsection (2)) to have regard to any guidance issued by the Secretary of State as to the establishment and conduct of such reviews.	ANCILLARY FUNCTION	Yes
Mental Health Units (Use of Force) Act 2018, s2(1) [Not in force]	(1) A relevant health organisation which includes NHS trusts by s13 that operates a mental health unit must appoint a responsible person for that unit for the purposes of this Act.	ANCILLARY FUNCTION	Yes
Mental Health Units (Use of Force) Act 2018, s3(1) [Not in force]	(1) The responsible person for each mental health unit must publish a policy regarding the use of force by staff who work in that unit.	ANCILLARY FUNCTION	Yes
Mental Health Units (Use of Force) Act 2018, s11(2) [Not in force]	(2) In exercising functions under this Act, responsible persons and relevant health organisations which includes NHS Trusts by s13 must have regard to guidance published by the SoS by ss(1) under this section.	ANCILLARY FUNCTION	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s4(3) [In force in Wales only]	(3) The following persons must, when exercising functions under this Part, have regard to any relevant guidance contained in the code on additional learning needs issued by the Welsh Ministers by ss(1)]— (h) an NHS trust;	ANCILLARY FUNCTION	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s20 [In force in Wales only]	(4) If a matter is referred to an NHS body which includes an NHS Trust by s99(1) under this section, the NHS body must consider whether there is a relevant treatment or	COMMISSIONING	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
	service as defined by ss(6) that is likely to be of benefit in addressing the child's or young person's additional learning needs. (5) If the NHS body identifies such a treatment or service, it must— (a) secure the treatment or service for the child or young person, (b) decide whether the treatment or service should be provided to the child or young person in Welsh, and (c) if it decides that the treatment or service should be provided to the child or young person in Welsh, take all reasonable steps to secure that the treatment or service is provided in Welsh.		
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s21 [In force in Wales only]	Various duties (not set out in full here) consequent on the NHS body identifying (or not identifying) a relevant treatment or service per s20	COMMISSIONING	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s64 [In force in Wales only]	(1) This section applies where a health body mentioned in subsection (2) which includes an NHS Trust, in the course of exercising its functions in relation to a child who is under compulsory school age and for whom a local authority is responsible, forms the opinion that the child has, or probably has, additional learning needs. (3) The health body must inform the child's parent of its opinion and of its duty in subsection (4). (4) After giving the parent an opportunity to discuss the health body's opinion with an officer of the body, the health body must bring it to the attention of the local authority that is responsible for the child or, if the child is looked after, to the attention of the local authority that looks after the child, if the health body is satisfied that doing so would be in the best interests of the child. (5) If the health body is of the opinion that a particular	REGULATORY	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
	voluntary organisation is likely to be able to give the parent advice or other assistance in connection with any additional learning needs that the child may have, it must inform the parent accordingly.		
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s65 [In force in Wales only]	(1) Subsection (2) applies if a local authority requests a person mentioned in subsection (4) [which includes NHS Trusts] to exercise the person's functions to provide the authority with information or other help, which it requires for the purpose of exercising its functions under this Part. (2) The person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person that decides not to comply with a request under subsection (1) must give the local authority that made the request written reasons for the decision.	REGULATORY	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s76 [In force in Wales only]	(1) The Education Tribunal for Wales may, in relation to an appeal under this Part,— (a) exercise its functions to require an NHS body to give evidence about the exercise of the body's functions; (b) make recommendations to an NHS body about the exercise of the body's functions. (3) An NHS body to whom a recommendation has been made by the Tribunal must make a report to the Tribunal before the end of any prescribed period beginning with the date on which the recommendation is made. ss(4) specifies the contents of the report.	REGULATORY	Yes
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(2) A regulatory body i.e. the Welsh Ministers and SCW, by s176(1) must, in the exercise of its relevant functions, seek to co-operate with a relevant authority which includes, by s177(1)(e) an NHS Trust if the regulatory body thinks such	REGULATORY	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
	co-operation— (a) will have a positive effect on the manner in which the body exercises its functions, or (b) will assist the body in achieving its general objectives.		
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(3) Where a regulatory body requests the co-operation of a relevant authority under subsection (2) the authority must comply with the request unless the authority— (a) is prevented from co-operating in the manner requested by any enactment or other rule of law, (b) thinks that such co-operation would otherwise be incompatible with its own functions, or (c) thinks that such co-operation would have an adverse effect on its functions.	REGULATORY	Yes
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(4) If a relevant authority requests the co-operation of a regulatory body, the body must comply with that request unless the body— (a) is prevented from co-operating in the manner requested by any enactment (including this Act) or other rule of law, (b) thinks that such co-operation would otherwise be incompatible with the regulatory body's own functions, or (c) thinks that such co-operation would have an adverse effect— (i) on the body's functions, or (ii) on achieving the body's general objectives.	REGULATORY	Yes
Well-being of Future Generations (Wales) Act 2015, Parts 2 and 3	Not reproduced in full here, the Act confers various duties on public bodies to do things in pursuit of the economic, social, environmental and cultural well-being of Wales in a way that accords with the sustainable development principle and to require public bodies to report on such action. "Public bodies", by section 6, includes NHS Trusts.	REGULATORY	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
Counter-terrorism and Security Act 2016, s26	(1) A specified authority which includes, by Schedule 6, and NHS Trust must, in the exercise of its functions, have due regard to the need to prevent people from being drawn into terrorism.	ANCILLARY FUNCTION	Yes
Counter-terrorism and Security Act 2016, s38	(1) The partners which include NHS Trusts by Schedule 7 of a panel i.e. a panel established by a LA by s36 must, so far as appropriate and reasonably practicable, act in co-operation with— (a) the panel in the carrying out of its functions; (b) the police and local authorities in the carrying out of their functions in connection with section 36.	CORPORATE	Yes
Counter-terrorism and Security Act 2016, s38	By ss(3) the duty of a partner of a panel to act in co-operation with the panel includes the giving of information (subject to ss(4)) and extends only so far as the co-operation is compatible with the exercise of the partner's functions under any other enactment or rule of law.	CORPORATE	Yes
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, reg 4(1)	(1) Each public authority listed in Schedule 2 which includes NHS Trusts to these Regulations must publish information to demonstrate its compliance with the duty imposed by section 149(1) of the Act i.e. the public sector equality duty of the Equality Act 2010. See further regs 4(2) onwards and reg 6 for requirements as to publication and exemption for authorities with fewer than 150 employees	REGULATORY	Yes
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 6(1)	(1) Where an NHS trust or an NHS foundation trust supplies a drug or appliance to a patient for the purpose of treatment, the NHS trust or the NHS foundation trust (as the case may be) must, subject to paragraphs (3) to (6), make and recover from the patient for the supply of continues as to charges to be made in respect of particular items See further reg 6 for exemptions	COMMISSIONING	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 7(1)	(1) Where drugs or appliances are supplied to a patient, including during the out of hours period, for the purpose of treating that patient, by a prescriber at a walk-in centre, the NHS trust, NHS foundation trust or other person responsible for the management of the centre, must, subject to paragraphs (3) to (5), make and recover from that patient for the supply of continues as to charges to be made in respect of particular items See further reg 7 for exemptions	COMMISSIONING	Yes
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 10(1)	(9) Where a claim to an exemption has been made but is not substantiated, and in consequence of the claim a charge has not been recovered, if— (b) the drugs or appliances were supplied by an NHS trust or an NHS foundation trust as mentioned in regulation 6, then that NHS trust or NHS foundation trust must recover that charge from the person concerned	COMMISSIONING	Yes
National Health Service (Charges to Overseas Visitors) Regulations 2015	The Regulations place various duties (not set out in full here) on "relevant bodies" (which includes NHS Trusts, by reg 2) to make and recover charges for the provision of relevant services to overseas visitors. Further, NHS Trusts, in meeting their obligations to make and recover charges from overseas visitors, must (by reg 3A) enter certain specified information against record against the overseas visitor's consistent identifier.	COMMISSIONING	Yes
National Health Service (Optical Charges and Payments) Regulations 2013, reg 2(2)	(2) Where a charge is payable by virtue of paragraph (1) a charge for such amount for glasses and contact lenses as determined by the SoS, the NHS trust or NHS foundation trust, or other person on its behalf, that supplies or is to supply the glasses or contact lenses must– (a) on arranging to supply the glasses or contact lenses, make the charge, and (b) on supplying the glasses or contact lenses or having	COMMISSIONING	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
	them available for supply, recover the charge from the person supplied or to be supplied (if the charge has not previously been paid).		
National Health Service (Optical Charges and Payments) Regulations 2013, reg 10(1)	(1) An NHS trust or NHS foundation trust which, following a sight test, issues a prescription for an optical appliance to a person who— (a) has indicated that they are an eligible person; or (b) is an eligible person by virtue of regulation 8(5), must issue to that person a voucher relating to the optical appliance prescribed. See further reg 10(2) for requirements on issuing a voucher	COMMISSIONING	Yes
Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218, reg 23	This provision imposes consultation duties (not set out in full here) on a "responsible person" ("R") (which may be a "service provider", a definition which by reg 23(14) includes an NHS Trust) where R has under consideration any proposal for a substantial development of the health service. This is subject to reg 23(12) which sets out the circumstances in which the functions in reg 23 are to be carried out by a responsible commissioner in the place of a service provider.	ANCILLARY FUNCTIONS	Yes
NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012, reg 4	(1) This regulation applies where a clinical commissioning group, NHS trust or NHS foundation trust and a local authority propose to designate a body as a Care Trust under section 77(1) of the 2006 Act, or propose to revoke such designation. (2) Where this regulation applies, the body and the local authority must, before designating or revoking the designation, as the case may be, consult jointly such persons as appear to them to be affected by the proposed designation or revocation.	REGULATORY	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
Care Act 2014, s6	(1) A local authority must co-operate with each of its relevant partners which, by ss(7) includes each NHS body in the authority's area, defined in turn by ss(8) as NHS trust or NHS foundation trust which provides services in the authority's area, and each relevant partner must co-operate with the authority, in the exercise of— (a) their respective functions relating to adults with needs for care and support, (b) their respective functions relating to carers, and (c) functions of theirs the exercise of which is relevant to functions referred to in paragraph (a) or (b).	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s17	(5) A Local Health Board or an NHS Trust providing services in the area of a local authority must, for the purposes of this section which imposes a duty on Welsh LAs to secure the provision of information, advice and assistance, provide that local authority with information about the care and support it provides in the local authority's area.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s118	(2) Where a child who is accommodated in Wales— (g) in any accommodation provided by or on behalf of an NHS Trust or by or on behalf of an NHS Foundation Trust, ceases to be so accommodated after reaching the age of 16, the person by whom or on whose behalf the child was accommodated or who carries on or manages the home or hospital (as the case may be) must inform the local authority or local authority in England within whose area the child proposes to live. subject to ss(3) which provides that the duty if the accommodation has been provided for a consecutive period of at least three months.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s120	(1) Subsection (2) applies where a child is provided with accommodation in Wales by a Local Health Board, an NHS Trust or a local authority in the exercise of education	ANCILLARY FUNCTION	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
	functions ("the accommodating authority")— (a) for a consecutive period of at least 3 months, or (b) with the intention, on the part of that authority, of accommodating the child for such a period. (2) The accommodating authority must notify the appropriate officer as defined by ss(4) of the responsible authority as defined by ss(3)— (a) that it is accommodating the child, and (b) when it ceases to accommodate the child.		
Social Services and Well-being (Wales) Act 2014, s134	Not reproduced in full here, this section makes provision for "Safeguarding Boards" and regulations governing them. By ss(2)(d) an NHS Trust is designated as a partner of a Safeguarding Board.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s161B	(1) The Welsh Ministers may require a person falling within subsection (2) which includes an NHS Trust to provide them with— (a) any documents, records (including medical or other personal records) or other information— (i) which relate to the exercise of a social services function of a local authority, and (ii) which the Welsh Ministers consider it necessary or expedient to have for the purposes of a review under section 149A or 149B; (b) an explanation of the content of— (i) any documents, records or other information provided under paragraph (a), or (ii) any documents or records provided to an inspector conducting an inspection of premises under section 161 in connection with a review under section 149B. Subject to ss(3) which provides that a person is not required to provide documents, records or other information under subsection (1) if the person is prohibited	REGULATORY	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
	from providing them by any enactment or other rule of law.		
Social Services and Well-being (Wales) Act 2014, s162(6)	(1) A local authority must make arrangements with a view to promoting the matters specified in ss(3) to promote co-operation between— (a) the local authority, (b) each of the authority's relevant partners including, by ss(4)(f) an NHS Trust providing services in the area of the authority in the exercise of— (i) their functions relating to adults (ii) their other functions the exercise of which is relevant to the functions referred to in sub-paragraph (i), and (c) such other persons or bodies as the authority considers appropriate, being persons or bodies of any nature who or which exercise functions or are engaged in activities in relation to— (i) adults within the authority's area with needs for care and support, or (ii) adults within the authority's area who are carers. (6) The relevant partners of a local authority must co-operate with the authority in the making of arrangements under this section.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s162(7); (9)	(7) A local authority and any of its relevant partners may for the purposes of arrangements under this section— (a) provide staff, goods, services, accommodation or other resources; (b) establish and maintain a pooled fund defined at ss(7); (c) share information with each other.	COMMISSIONING	Yes
Social Services and Well-being (Wales) Act 2014, s162(7); (9)	(9) A local authority and each of its relevant partners including, by ss(4)(f) an NHS Trust providing services in the area of the authority must, in exercising their functions	ANCILLARY FUNCTION	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
	under this section, have regard to any guidance given to them for the purpose by the Welsh Ministers.		
Social Services and Well-being (Wales) Act 2014, s164(1), (3)	(1) If a local authority requests the co-operation of a person mentioned in subsection (4) includes an NHS Trust in the exercise of any of its social services functions, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.	REGULATORY	Yes
Social Services and Well-being (Wales) Act 2014, s164(2); (3)	(2) If a local authority requests that a person mentioned in subsection (4) includes an NHS Trust provides it with information it requires for the purpose of the exercise of any of its social services functions, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.	REGULATORY	Yes
Social Services and Well-being (Wales) Act 2014, s164(5)	(5) A local authority and each of those persons mentioned in subsection (4) includes an NHS Trust must in exercising their functions under this section have regard to any guidance given to them for the purpose by the Welsh Ministers.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s164A(1), (3)	(1) If a local authority requests the co-operation of a person mentioned in subsection (4) includes NHS Trusts in	REGULATORY	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
	the exercise of its functions mentioned in subsection (5) relating to functions under Children Act 1989 &c, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.		
Social Services and Well-being (Wales) Act 2014, s164A(2), (3)	(2) If a local authority requests that a person mentioned in subsection (4) includes NHS Trusts provides it with information it requires for the purpose of the exercise of any of its functions mentioned in subsection (5) relating to functions under Children Act 1989 &c, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.	REGULATORY	Yes
Children and Families Act 2014, s28	(1) A local authority in England must co-operate with each of its local partners which includes, by ss(2)(m), an NHS Trust or NHS Foundation Trust which provides services in the authority's area, or which exercises functions in relation to children or young people for whom the authority is responsible, and each local partner must co-operate with the authority, in the exercise of the authority's functions under this Part.	ANCILLARY FUNCTIONS	Yes

Statutory provision	Wording	Category of function	Open to joint exercise
Children and Families Act 2014, s31	(1) This section applies where a local authority in England requests the cooperation of any of the following persons and bodies in the exercise of a function under this Part— (g) an NHS trust or NHS foundation trust. (2) The person or body must comply with the request, unless the person or body considers that doing so would— (a) be incompatible with the duties of the person or body, or (b) otherwise have an adverse effect on the exercise of the functions of the person or body. (3) A person or body that decides not to comply with a request under subsection (1) must give the authority that made the request written reasons for the decision.	ANCILLARY FUNCTIONS	Yes
Children and Families Act 2014, s77	(4) The persons listed in subsection (1) including at ss(1)(l) NHS Trusts must have regard to the Code of Practice issued by the SoS pursuant to ss(1) in exercising their functions under this Part.	ANCILLARY FUNCTIONS	Yes
Equality Act 2010 c. 15	Refers to all functions under this Act	CORPORATE	Yes
Health Act 2009 c. 21	Refers to entire Act.	REGULATORY	Yes
Health and Social Care Act 2008 c. 14	All duties of an NHS Trust under this Act	REGULATORY	Yes
Local Government and Public Involvement in Health Act 2007 c. 28	All duties of an NHS Trust under this Act	REGULATORY	Yes
Health Act 2006 c. 28	Refers to entire Act.	REGULATORY	Yes
Health and Social Care (Community Health and Standards) Act 2003 c. 43	Refers to entire Act.	REGULATORY	Yes
Mental Capacity Act 2005 c. 9	Refers to entire Act.	REGULATORY	Yes
Health and Social Care Act 2008 c. 14	All functions of a Trust under this Act.	REGULATORY	Yes
Local Audit and Accountability Act 2014 c. 2	Refers to entire Act.	REGULATORY	Yes

Schedule 3 **Mandatory Reserved Functions**

1. Reserved Functions are any Functions of the Trusts that they cannot lawfully delegate or jointly exercise or otherwise are Functions that NHS England has categorised as not 'Open to Joint Exercise of Functions' in *Arrangements for delegation and joint exercise of statutory functions* as reproduced in the table set out in paragraph 2 below.
2. The table referred to in paragraph 1 is as follows:

For LPT:

Statutory provision	Wording	Category of function	Open to joint exercise
Section 27C NHS Act 2006 as inserted by Section 56 of the Health and Care Act	Recommendations about restructuring (1) NHS England may— (a) make recommendations to NHS trusts for or in connection with the making of restructuring applications; (b) take such other steps as it considers appropriate to facilitate restructuring applications involving NHS trusts.	REGULATORY	No
Section 27D NHS Act 2006 as inserted by Section 57 of the Health and Care Act	Intervention in NHS trusts: recommendations etc by NHS England (1) If NHS England considers that Secretary of State ought to make an order under section 66(2) or 68(2) in relation to an NHS trust established under section 25, NHS England must— (a) make a recommendation to that effect, (b) set out its reasons for the recommendation, and (c) make any recommendations it considers appropriate as to the contents of the order. (2) NHS England must make any inquiries, and provide any other assistance, that the Secretary of State may require in connection with deciding whether to make an order under section 66(2) or 68(2) in relation to an NHS trust established under section 25 and, if so, on what terms.	REGULATORY	No
Section 33-39 NHS Act 2006	(1) An NHS trust may make an application to the regulator for authorisation to become an NHS foundation trust, if	CORPORATE	No

Statutory provision	Wording	Category of function	Open to joint exercise
	the application is supported by the Secretary of State. Applications by NHS trusts 34 Other applications 35 Authorisation of NHS foundation trusts 36 Effect of authorisation 37 Amendments of constitution 38 Variation of authorisation 39 Register of NHS foundation trusts.		
Chapter 5A NHS Act 2006	Trusts Special Administration.	REGULATORY	No
Section 77 NHS Act 2006	(1) Where– (a) [...] an NHS trust [or a clinical commissioning group or an NHS foundation trust] is, or will be, a party to any existing or proposed LA delegation arrangements, [...] (b) [the body and the local authority concerned consider] that designation of the body as a Care Trust would be likely to promote the effective exercise by the body of prescribed health-related functions of [the local authority] (in accordance with the arrangements) in conjunction with prescribed NHS functions of the body, [and] (c) the requirements in subsection (1A) are satisfied, [the body and the local authority may jointly] designate the body as a Care Trust.	COMMISSIONING	No
Schedule 4, Paragraph 11, NHS Act 2006	(1) An NHS trust must pay– (a) to the chairman and any non-executive director of the NHS trust remuneration of an amount determined by the Secretary of State, not exceeding such amount as may be approved by the Treasury, (b) to the chairman and any non-executive director of the NHS trust such travelling and other allowances as may be determined by the Secretary of State with the approval of the Treasury,	CORPORATE	No

Statutory provision	Wording	Category of function	Open to joint exercise
	(c) to any member of a committee or sub-committee of the NHS trust who is not also a director such travelling and other allowances as may be so determined.		
Schedule 4, Paragraph 11A, NHS Act 2006	(1) An NHS trust must keep proper accounts and proper records in relation to the accounts.	CORPORATE	No
Schedule 4, Paragraph 12, NHS Act 2006	(1) For each accounting year an NHS trust must prepare and send to the Secretary of State an annual report in such form as may be determined by the Secretary of State.	CORPORATE	No
Schedule 4, Paragraph 13, NHS Act 2006	An NHS trust must furnish to the Secretary of State such reports, returns and other information, including information as to its forward planning, as, and in such form as, he may require.	CORPORATE	No
Schedule 4, Paragraph 23, NHS Act 2006	(1) The powers of an NHS trust include power to enter into externally financed development agreements.	CORPORATE	No
Mental Health Act 1983	Refers to entire Act.	REGULATORY	No
Mental Capacity Act 2005	Refers to entire Act.	REGULATORY	No
Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008/1858	Refers to entire Regulations.	REGULATORY	No
Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008/1184	Refers to entire Regulations.	REGULATORY	No
Schedule 15 NHS Act 2006	Requirements for audit and accounts of NHS bodies	CORPORATE	No
Charities Act 2011, ss149; 152	Various provisions as to the audit/examination of the accounts of an "English NHS charity" (which would include a charitable trust, the trustees of which are an NHS Trust), including requirements as to the auditor/independent examiner and the giving of guidance by the Charities Commission	REGULATORY	No
Policing and Crime Act 2017, s1	(1) A collaboration agreement [as defined by ss(3)] may be made by—	CORPORATE	No

Statutory provision	Wording	Category of function	Open to joint exercise
	(a) one or more persons within a paragraph of subsection (2), and (b) one or more persons within another paragraph of that subsection. (2) Those persons are— (a) an ambulance trust in England, (b) a fire and rescue body in England, and (c) a police body in England. [See further sections 3 and 4 regarding collaboration agreements]		
Investigatory Powers Act 2016, Part 3	Not reproduced in full here, this part of the Act contains provision for applications by "relevant public authorities" to the Investigatory Powers Commissioner for authorisations to obtain communications, and the granting of authorisations by a designated officer in a relevant public authority in specific circumstances. "Relevant public authority" includes (by Schedule 4) ambulance trusts.	REGULATORY	No
Immigration Act 1999, s20A	Not reproduced in full here, this provision confers a duty on NHS Trusts to supply a "nationality document" at the direction of the SoS, if the SoS has reasonable grounds for believing is lawfully in the possession of an NHS Trust.	REGULATORY	No
Network and Information Systems Regulations 2018	Not reproduced in full here, the regulations make provision for the identification of "operators of essential services" (OES) (where they provide an essential service as specified in Schedule 2 of the regs and where they (a) rely on network and information systems; and (b) satisfy a threshold requirement described for that kind of essential service. NHS Trusts are specified in Schedule 2. An OES is subject to duties relating to notification of their status to a designated competent authority and take appropriate and proportionate technical and organisational measures to	CORPORATE	No

Statutory provision	Wording	Category of function	Open to joint exercise
	manage risks posed to the security of the network and information systems on which their essential service relies.		
Controlled Drugs (Supervision of Management and Use) Regulations 2013	The Regulations place various duties (not set out in full here) on "designated bodies" (which includes NHS Trusts, by reg 7) in relation to the supervision, management and use of controlled drugs	REGULATORY	No
Children and Families Act 2014, s23	(1) This section applies where, in the course of exercising functions in relation to a child who is under compulsory school age, a clinical commissioning group, NHS trust or NHS foundation trust form the opinion that the child has (or probably has) special educational needs or a disability. (2) The group or trust must— (a) inform the child's parent of their opinion and of their duty under subsection (3), and (b) give the child's parent an opportunity to discuss their opinion with an officer of the group or trust. (3) The group or trust must then bring their opinion to the attention of the appropriate local authority in England. (4) If the group or trust think a particular voluntary organisation is likely to be able to give the parent advice or assistance in connection with any special educational needs or disability the child may have, they must inform the parent of that.	ANCILLARY FUNCTIONS	No
Housing Act 1996, s213B	NHS Trusts are included among the public authorities specified by Homelessness (Review Procedure etc) Regulations 2018 (see reg 10 and Schedule) for the purposes of this provision: (1) This section applies if a specified public authority considers that a person in England in relation to whom the authority exercises functions is or may be homeless or threatened with homelessness.	REGULATORY	No

Statutory provision	Wording	Category of function	Open to joint exercise
	(2) The specified public authority must ask the person to agree to the authority notifying a local housing authority in England of— (a) the opinion mentioned in subsection (1), and (b) how the person may be contacted by the local housing authority. (3) If the person— (a) agrees to the specified public authority making the notification, and (b) identifies a local housing authority in England to which the person would like the notification to be made, the specified public authority must notify that local housing authority of the matters mentioned in subsection (2)(a) and (b).		
Local Audit and Accountability Act 2014, s4	(4) The persons listed in subsection (1) [including at ss(1)(l) NHS Trusts] must have regard to the [Code of Practice issued by the SoS pursuant to ss(1)] in exercising their functions under this Part.	CORPORATE	No
Local Audit and Accountability Act 2014, s8	(1) A relevant authority [which includes an NHS Trust - see note to s4, above] must consult and take into account the advice of its auditor panel on the selection and appointment of a local auditor under section 7. (2) The relevant authority must, within the period of 28 days beginning with the day on which the appointment is made, publish a notice that— (a) states that it has made the appointment, (b) identifies the local auditor that has been appointed, (c) specifies the period for which the local auditor has been appointed, (d) sets out the advice, or a summary of the advice, of its auditor panel about the selection and appointment of a local auditor, and	CORPORATE	No

Statutory provision	Wording	Category of function	Open to joint exercise
	(e) if it has not followed that advice, sets out the reasons why it has not done so. [See further ss(3) and (4) as to requirements as to publication of notices]		
Local Audit and Accountability Act 2014, s10(1) to (6)	(1) A relevant authority's [includes an NHS Trust - see note to s4, above] auditor panel must advise the authority on the maintenance of an independent relationship with the local auditor appointed to audit its accounts. (4) A relevant authority's auditor panel must advise the authority on the selection and appointment of a local auditor to audit its accounts [see further ss(5) as to this duty] (6) A relevant authority's auditor panel must advise the authority on any proposal by the authority to enter into a liability limitation agreement (see section 14) [see further ss(7) as to this duty]	CORPORATE	No
Local Audit and Accountability Act 2014, s10(9)	(9) A relevant authority must publish advice from its auditor panel in accordance with subsection (10) [NB there are specific provisions in ss(10) applicable to NHS Trusts.]	CORPORATE	No
Local Audit and Accountability Act 2014, Schedule 7	(1) This paragraph applies to a relevant authority [includes an NHS Trust - see note to s4, above] if a local auditor has made a public interest report [see Schedule 7, para 1] relating to the authority or an entity connected with it. (2) As soon as is practicable after receiving the report, the relevant authority must publish the report and a notice [see ss(7) and (8)(d) in relation to publication requirements] that— (a) identifies the subject matter of the report, and (b) unless the authority is a health service body, states that any member of the public may inspect the report and	REGULATORY	No

Statutory provision	Wording	Category of function	Open to joint exercise
	make a copy of it or any part of it between the times and at the place or places specified in the notice. (3) As soon as is practicable after receiving the report, the relevant authority must supply a copy of the report to— (a) each of its members (if it has members), and (b) its auditor panel (if it has one).		
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, reg 5(1)	(1) Each public authority listed in Schedule 2 [which includes NHS Trusts] to these Regulations must prepare and publish one or more objectives it thinks it should achieve to do any of the things mentioned in paragraphs (a) to (c) of section 149(1) of the Act. [See further regs 5(2) onwards and reg 6 for requirements as to publication.]	CORPORATE	No
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, Schedule 1(2)	Not reproduced in full here, a relevant public authority is subject to a duty to publish annual information relating to gender pay gap information relating to employees.	CORPORATE	No
Schedule 4, Paragraphs 28-29, NHS Act 2006	Powers to dissolve NHS trusts.	REGULATORY	No

For NHFT:

Statutory provision	Wording	Category of function	Open to joint exercise
Section 27A NHS Act 2006	(1) A public benefit corporation must hold an annual meeting of its members. (2) The meeting must be open to members of the public. (3) At least one member of the board of directors of the corporation must attend the meeting and present the following documents to the members at the meeting— (a) the annual accounts, (b) any report of the auditor on them, (c) the annual report. (4) Where an amendment is made to the constitution in relation to the powers or duties of the council of governors	CORPORATE	No

	of a public benefit corporation (or otherwise with respect to the role that the council has as part of the corporation)— (a) at least one member of the council of governors must attend the next meeting to be held under this paragraph and present the amendment, and (b) the corporation must give the members an opportunity to vote on whether they approve the amendment. (5) If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the corporation must take such steps as are necessary as a result.		
Section 37 NHS Act 2006	(1) An NHS foundation trust may make amendments of its constitution only if— (a) more than half of the members of the council of governors of the trust voting approve the amendments, and (b) more than half of the members of the board of directors of the trust voting approve the amendments.	CORPORATE	No
Section 42B (6) NHS Act 2006 as inserted by section 62 of the Health and Care Act 2022	Limits on capital expenditure (6) A trust that is the subject of an order under this section must not exceed the capital expenditure limit imposed by the order during the financial year to which it relates.	CORPORATE / REGULATORY	No
Section 43 NHS Act 2006	(1) The principal purpose of an NHS foundation trust is the provision of goods and services for the purposes of the health service in England.	CORPORATE	No
Section 43 NHS Act 2006	(3D) An NHS foundation trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the council of governors of the trust voting approve its implementation.	CORPORATE	No

Section 46 NHS Act 2006	(1) An NHS foundation trust may borrow money for the purposes of or in connection with its functions. (4) An NHS foundation trust may invest money (other than money held by it as trustee) for the purposes of or in connection with its functions. (5) The investment may include investment by– (a) forming, or participating in forming, bodies corporate, (b) otherwise acquiring membership of bodies corporate. (6) An NHS foundation trust may give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its functions.	CORPORATE / ANCILLARY	No
Section 50 NHS Act 2006	An NHS foundation trust must pay to the regulator such fee as the regulator may determine in respect of its exercise of functions under— (a) section 39; (b) section 39A.	REGULATORY	No
Section 51A NHS Act 2006	(1) An NHS foundation trust may enter into a significant transaction only if more than half of the members of the council of governors of the trust voting approve entering into the transaction. (2) "Significant transaction" means a transaction or arrangement of such description as may be specified in the trust's constitution. (3) If an NHS foundation trust does not wish to specify any descriptions of transaction or arrangement for the purposes of subsection (2), the constitution of the trust must specify that it contains no such descriptions.	CORPORATE	No
Section 56B NHS Act 2006	(1) An application may be made to the regulator by an NHS foundation trust for the dissolution of the trust and the establishment of two or more new NHS foundation trusts. (2) An application under this section may be made only with the approval of more than half of the members of the	CORPORATE	No

	council of governors of the applicant. (3) The application must, by reference to each of the proposed new trusts— (a) specify the property and liabilities proposed to be transferred to it; (b) be accompanied by a copy of its proposed constitution. (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the dissolution of the trust and the establishment of each of the proposed new trusts have been taken. (5) On the grant of the application, the proposed constitution of each of the new trusts has effect but, in the case of each of the new trusts, the proposed directors may exercise the functions of the trust on its behalf until a board of directors is appointed in accordance with the constitution.		
Section 57A NHS Act 2006	57A Dissolution (1) An application may be made by an NHS foundation trust to the regulator for dissolution. (2) An application under this section may be made only with the approval of more than half of the members of the council of governors of the applicant.	CORPORATE	No
Section 61 NHS Act 2006	(1) An NHS foundation trust must take steps to secure that (taken as a whole) the actual membership of any public constituency and (if there is one) of the patients' constituency is representative of those eligible for such membership.	CORPORATE	No
Chapter 5A NHS Act 2006	Trusts Special Administration.	REGULATORY	No
Domestic Violence, Crime and Victims Act 2004, Section 9(2), (3)	(2) The Secretary of State may in a particular case direct a specified person or body within subsection (4) including NHS trusts established under section 25 of the National Health Service Act 2006 or section 18 of the National Health Service (Wales) Act 2006 by ss(4)(a) to establish, or to	ANCILLARY FUNCTION	No

	participate in, a domestic homicide review as defined by ss(1).		
Charities Act 2011, ss149; 152	Various provisions as to the audit/examination of the accounts of an "English NHS charity" (which would include a charitable trust, the trustees of which are an NHS Trust), including requirements as to the auditor/independent examiner and the giving of guidance by the Charities Commission	REGULATORY	No
Policing and Crime Act 2017, s1	(1) A collaboration agreement as defined by ss(3) may be made by— (a) one or more persons within a paragraph of subsection (2), and (b) one or more persons within another paragraph of that subsection. (2) Those persons are— (a) an ambulance trust in England, (b) a fire and rescue body in England, and (c) a police body in England. See further sections 3 and 4 regarding collaboration agreements	CORPORATE	No
Investigatory Powers Act 2016, Part 3	Not reproduced in full here, this part of the Act contains provision for applications by "relevant public authorities" to the Investigatory Powers Commissioner for authorisations to obtain communications, and the granting of authorisations by a designated officer in a relevant public authority in specific circumstances. "Relevant public authority" includes (by Schedule 4) ambulance trusts.	REGULATORY	No
Immigration Act 1999, s20A	Not reproduced in full here, this provision confers a duty on NHS Trusts to supply a "nationality document" at the direction of the SoS, if the SoS has reasonable grounds for believing is lawfully in the possession of an NHS Trust.	REGULATORY	No
Network and Information Systems Regulations 2018	Not reproduced in full here, the regulations make provision for the identification of "operators of essential services"	CORPORATE	No

	(OES) (where they provide an essential service as specified in Schedule 2 of the regs and where they (a) rely on network and information systems; and (b) satisfy a threshold requirement described for that kind of essential service. NHS Trusts are specified in Schedule 2. An OES is subject to duties relating to notification of their status to a designated competent authority and take appropriate and proportionate technical and organisational measures to manage risks posed to the security of the network and information systems on which their essential service relies.		
Housing Act 1996, s213B	NHS Trusts are included among the public authorities specified by Homelessness (Review Procedure etc) Regulations 2018 (see reg 10 and Schedule) for the purposes of this provision: (1) This section applies if a specified public authority considers that a person in England in relation to whom the authority exercises functions is or may be homeless or threatened with homelessness. (2) The specified public authority must ask the person to agree to the authority notifying a local housing authority in England of— (a) the opinion mentioned in subsection (1), and (b) how the person may be contacted by the local housing authority. (3) If the person— (a) agrees to the specified public authority making the notification, and (b) identifies a local housing authority in England to which the person would like the notification to be made, the specified public authority must notify that local housing authority of the matters mentioned in subsection (2)(a) and (b).	REGULATORY	No

Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, reg 5(1)	(1) Each public authority listed in Schedule 2 which includes NHS Trusts to these Regulations must prepare and publish one or more objectives it thinks it should achieve to do any of the things mentioned in paragraphs (a) to (c) of section 149(1) of the Act. See further regs 5(2) onwards and reg 6 for requirements as to publication.	CORPORATE	No
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, Schedule 1(2)	Not reproduced in full here, a relevant public authority is subject to a duty to publish annual information relating to gender pay gap information relating to employees.	CORPORATE	No
Controlled Drugs (Supervision of Management and Use) Regulations 2013	The Regulations place various duties (not set out in full here) on "designated bodies" (which includes NHS Trusts, by reg 7) in relation to the supervision, management and use of controlled drugs	REGULATORY	No
Children and Families Act 2014, s23	(1) This section applies where, in the course of exercising functions in relation to a child who is under compulsory school age, a clinical commissioning group, NHS trust or NHS foundation trust form the opinion that the child has (or probably has) special educational needs or a disability. (2) The group or trust must— (a) inform the child's parent of their opinion and of their duty under subsection (3), and (b) give the child's parent an opportunity to discuss their opinion with an officer of the group or trust. (3) The group or trust must then bring their opinion to the attention of the appropriate local authority in England. (4) If the group or trust think a particular voluntary organisation is likely to be able to give the parent advice or assistance in connection with any special educational needs or disability the child may have, they must inform the parent of that.	ANCILLARY FUNCTIONS	No
Mental Health Act 1983	Refers to entire Act.	REGULATORY	No
Mental Capacity Act 2005	Refers to entire Act.	REGULATORY	No

Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008/1858	Refers to entire Regulations.	REGULATORY	No
Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008/1184	Refers to entire Regulations.	REGULATORY	No

Schedule 4 **Group Board ToR**

1. Introduction

1.1. The Group Board is a statutory joint committee of the boards of Leicestershire Partnership NHS Trust and Northamptonshire Healthcare NHS Foundation Trust, who have established it to exercise Joint Functions in accordance with the Partnership Agreement dated 29 May 2025.

1.2. In these terms of reference 'Joint Functions' mean all the Trusts' functions that the Trusts have agreed in this Partnership Collaboration Agreement (PCA) to exercise jointly subject to any variation of the PCA that the Trusts have agreed in accordance with it.

2. Authority and Accountabilities

2.1. The Group Board is authorised by the Boards to exercise the Joint Functions.

2.2. The Group Board shall be fully and equally accountable to both Trust Boards for the exercise of the Joint Functions and shall at all times comply with the PCA and NHS England guidance when exercising Joint Functions.

2.3. The Group Board may authorise one of the Trusts to contract with a third part on behalf of itself alone or both Trusts jointly and severally subject to compliance with the Trusts' Standing Orders and Standing Financial Instructions.

2.4. The Group Board is authorised by the Boards to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2.5. The Group Board shall transact all business in accordance with the policies of the Trusts on openness and conformity with the Nolan principles and values of Public Services.

3. Reporting arrangements

3.1. The minutes of the Group Board shall be formally recorded and submitted to each Trust's Board.

3.2. The Group Board shall provide to each Trust's Board an Annual Report of the activities of the Group Board.

4. Frequency of meetings

4.1. Meetings of the Group Board shall be held not less than six times a year.

4.2. Extraordinary meetings may be called for a specific purpose at the discretion of the Joint Chair. Where possible a minimum of seven working days' notice will be given when calling an extraordinary meeting.

5. Membership

5.1. The voting members of the Group Board shall include all the Voting Directors of both Trusts during their terms of office.

5.2. Additionally the Trusts may appoint Non-Voting Directors of the Trusts to be voting or non-voting members of the Group Board.

5.3. The proceedings of the Group Board shall not be invalidated by any vacancy in its membership or by any defect in the appointment of a member of the Group Board.

5.4. In line with both Trusts' Standing Orders, members of the Group Board must attend at least two thirds of meetings annually, subject to annual review and appraisal process.

6. Attendance

6.1. The Group Board will be supported by the respective Directors of Corporate Affairs (and Trusts' Secretariats) to ensure business is transacted as per this Terms of Reference, the Partnership Agreement and the relevant Standing Orders and any documents referred to in them.

6.2. In the absence of a member a nominated deputy may attend with the agreement of the Chair and will be formally nominated with the same rights and privileges.

7. Quorum

7.1. No business shall be transacted at a meeting of the Group Board unless:

7.1.1. The voting members present include (in addition to the Joint Chair) at least one Voting ED of LPT and one Voting ED of NHFT (who in the case of a joint director may be the same person) and at least one Voting NED of LPT and one Voting NED of NHFT (who in the case of a joint NED may be the same person).

8. Chair and Deputy Chair

8.1. The Joint Chair of the Trusts shall preside at any meetings of the Group Board.

8.2. If the Joint Chair is absent, one of the Deputy Chairs from one of the Trusts shall preside. If a Deputy Chair is presiding at a meeting instead of the Chair, then references in this Terms of Reference to the Joint Chair shall be construed as the Deputy Chair.

9. Decision Making

9.1. The Group Board will generally operate on the basis of forming consensus on all issues considered, taking account of views expressed by all members. The Joint Chair will seek to ensure that any lack of consensus is resolved amongst members.

9.1.1. If the Group Board is unable to reach a consensus on an issue, the Joint Chair may put the issue to a vote. The vote will be carried if:

9.1.2. A majority of voting members present and voting are in favour (and in the event of a tied vote the Joint Chair shall have a casting vote), and

9.1.3. The voting members in favour include not less than half the LPT Voting Directors present and not less than half the NHFT Voting Directors present.

10. Admission of the public to meetings

10.1. Meetings of the Group Board shall be held in public.

10.2. But the Group Board may, by resolution, exclude the public from a meeting (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings.

11. Conflict of Interest

11.1. Each member of the Group Board must abide by all policies of the Trust of which they are a Director or Officer in relation to conflicts of interest.

11.2. Where any member of Group Board has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Joint Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate in meetings (or parts of meetings) in which the relevant matter is discussed.

12. Administrative Arrangements

12.1. The LPT and NHFT corporate affairs offices shall jointly provide administrative support to the Group Board.

13. Annual Workplan

13.1. The Group Board will agree an annual workplan and cycle of business prior to the beginning of each financial year. The reporting cycle will form part of the agenda alongside the standing agenda items.

14. Frequency of Meetings

14.1. Meetings of the Group Board shall be held not more than six times a year.

14.2. Extraordinary meetings may be called for a specific purpose at the discretion of the Joint Chair. Where possible, a minimum of seven working days' notice will be given when calling any extraordinary meeting.

15. Papers Publication

15.1. All papers will be made available at least 3 days prior to the meeting. A progress report of outstanding/pending Group Board actions will be presented to each meeting of the Group Board.

16. Standards

16.1. The Group Board shall comply with the following standards:

- 16.1.1. NHSE Code of Governance for NHS provider trusts
- 16.1.2. NHSE Risk Assessment Framework
- 16.1.3. NHSE Annual Planning Guidance
- 16.1.4. The Healthy NHS Board – Principles of Good Governance
- 16.1.5. Corporate Governance – Principles of Public Life (GP01)

17. Standard Agenda

17.1. Agendas will be built around the Group Board annual workplan, and most of the following will appear on each agenda,

- 17.1.1. Declarations of interest,
- 17.1.2. Minutes of previous meeting,
- 17.1.3. Action list
- 17.1.4. Other items as per agreed cycle of business

18. Committees

18.1. For the purpose of assisting the exercise of Joint Functions, the Group Board may appoint one or more additional committees.

18.2. The voting members of a committee of the Group Board may only be individuals who are voting members of the Group Board.

18.3. The Group Board may authorise a committee to exercise joint functions that the Group Board expressly sub-delegates to the committee in its ToRs.

19. Review

19.1 These Terms of Reference will be reviewed on an annual basis, in line with the review of the Partnership Agreement. The Terms of Reference may only be amended by variation in accordance with Clause 17 of the Partnership Agreement.

Date approved: 29 May 2025

Date of review: May 2026

Schedule 5 **Data sharing and confidentiality**

Part A: Confidentiality

1. In this Schedule "Confidential Information" means: all information, whether written or oral (however recorded), provided by one Trust (the Disclosing Trust) to the other Trust (Receiving Trust) and which (i) is known by the Receiving Trust to be confidential; (ii) is marked as or stated to be confidential; or (iii) ought reasonably to be considered by the Receiving Trust to be confidential.

2. The Trusts may disclose Confidential Information:

   2.1. to their employees, agents or consultants who need to know such information for the purpose of discharging their obligations under this Agreement if they ensure that their employees, agents, or consultants to whom they disclose Confidential Information comply with this Schedule 6 and

   2.2. as may be required by law, a court of competent jurisdiction or any governmental or regulatory authority.

3. The Trusts will not use each other's Confidential Information for any purpose other than to comply with this Agreement.

4. The Trusts acknowledge that they are subject to legal duties under the FOIA and EIR which may require them to disclose, on request, information relating to this Agreement and that they are also subject to the Code of Practice on Openness in the NHS (4 August 2003).

5. If a Trust receives a Request for Information (as defined in FOIA) or a request under regulation 5(1) of EIR (each, a Request) about their collaboration arrangements or the Group Board, prior to any disclosure of information to which an exemption to FOIA or EIR (as the case may be) may apply (Potentially Exempt Information) and recognising fully that the decision whether and what to disclose is for the Trust receiving the Request:

   5.1. Notify the other Trust of such Request

   5.2. Consider any representations made by the other Trust in relation to the Request and any possible exemptions and

   5.3. Consult with the other Trust in relation to any proposed disclosure as to whether any further explanatory material or advice should also be disclosed with the information in question.

6. Each Trust agrees that it will promptly inform the other Trust of any media enquiries which it receives in relation to the collaboration arrangements. The Trusts will work co-operatively to agree a joint response to any media enquiries received in relation to the collaboration arrangements.

Part B: Independent Data Controllers

7. The Trusts shall, and shall procure that any of its staff and its other employees, agents and sub-contractors involved in the processing of Relevant Personal Data under this Agreement ("Personnel") shall, in connection with this Agreement and the transactions and activities contemplated by it, comply with their obligations under Data Protection Legislation and this Schedule 6.

8. For the purposes of the Data Protection Legislation each Trust shall be an independent Data Controller of any Relevant Personal Data created in connection with the conduct or performance of this Agreement.

9. Each Trust shall implement and maintain appropriate technical and organisational measures (including, but not limited to, [encryption and password protection]), when transferring and/or processing Relevant Personal Data, to preserve the confidentiality, integrity, availability and resilience of Relevant Personal Data and prevent any unlawful processing or disclosure or damage, taking into account the state of the art, the costs of implementation, the nature, scope, context and purposes of processing as well as the risk of varying likelihood and severity for the rights and freedoms of the Data Subjects.

10. Each Trust shall notify the other Trust without undue delay, and in any event within 48 hours of becoming aware of:

    10.1. a Personal Data Breach where the breach has affected or could have affected the Relevant Personal Data;

    10.2. a breach of technical and organisational security measures or any Data Protection Legislation where the breach has affected or could have affected the Relevant Personal Data;

    10.3. an enquiry from the Information Commissioner's Office about the Relevant Personal Data; or

    10.4. a request from a Data Subject exercising any of their rights under Chapter III UK GPDR in respect of the Relevant Personal Data (a "Data Subject Rights Request").

    10.5 Each Trust agrees to keep the other regularly updated as to how the handling of such breach, enquiry or request.

11. Each Trust shall provide reasonable assistance to the other Trust in ensuring compliance with its obligations under the Data Protection Legislation with respect of Personal Data Breach notifications and a Trust shall not make such notification without first consulting the other Trust wherever possible.

12. Each Trust shall, as soon as reasonably practicable taking into account the nature of the processing provide reasonable assistance to the other Trust, where that Trust has received:

    12.1. a Data Subject Rights Request;

    12.2. an enquiry from the Information Commissioner's Office about the Relevant Personal Data;

    12.3. a complaint or request relating obligations served under the Data Protection Legislation which relates to the processing of Relevant Personal Data by any Trust; or

    12.4. any other communication directly relating to the processing of any Relevant Personal Data created in connection with the conduct or performance of this Agreement in relation to such requests.

    12.5. Wherever possible, neither Trust shall not disclose, release, amend, delete or block any Relevant Personal Data in response to a Data Subject Rights Request or respond to such a request, complaint or communication without first consulting the other Trust. Each Trust will bear their own costs in complying with their respective obligations under this Schedule 6.

13. Each Trust shall:

13.1. ensure that only those Personnel who need to have access to the Relevant Personal Data are granted such access and only for the purposes of performing their respective obligations under this Agreement;

13.2. take all reasonable steps to ensure the reliability of its Personnel;

13.3. ensure that all Personnel have completed training in Data Protection Legislation and in the care and handling of the Relevant Personal Data;

13.4. ensure that all Personnel are informed of the confidential nature of the Relevant Personal Data and are subject to appropriate contractual obligations of confidentiality; and

13.5. ensure that all Personnel comply with the obligations set out in this Schedule 6.

14. During the term and upon the termination or expiry of this Agreement, each Trust shall ensure that all Relevant Personal Data held by it shall be up-to-date and accurate.

15. Where transferring the Relevant Personal Data to the other Trust or to a third party, each Trust shall:

15.1. ensure that such transfer is compliant with all applicable laws;

15.2. make such transfer in a secure manner; and

15.3. take all reasonable steps, at its own cost, to provide the Relevant Personal Data in a usable and compatible format.

16. Where transferring the Personal Data to a third party, each Trust shall enter into appropriate arrangements with all third parties containing written contractual obligations concerning the Relevant Personal Data (including obligations of confidentiality) which are no less onerous than those imposed by this Schedule 6 and where applicable, compliant with Article 26 or 28 UK GDPR.

17. Neither Trust shall transfer any Relevant Personal Data outside the UK unless the transferor ensures that:

17.1. the transfer is to a country approved under the applicable Data Protection Legislation as providing adequate protection;

17.2. there are appropriate safeguards in place, such as the Standard Contractual Clauses, pursuant to the applicable Data Protection Legislation; or

17.3. one of the derogations for specific situations in the applicable Data Protection Legislation applies to the transfer.

18. Each Trust shall retain Relevant Personal Data in a form which permits identification of Data Subjects for no longer than is necessary for the purposes for which it processes the Personal Data, as per its obligations under the Data Protection Legislation. Each Trust shall securely delete Relevant Personal Data which cannot be lawfully retained in accordance with Data Protection Legislation and good industry practice.

19. In this Schedule 6 the terms “Personal Data”, “Processing”, “Processor”, “Controller”, “Personal Data Breach” and “Data Subject” shall have the meanings ascribed to them under Data Protection Legislation, and the terms “Process” “Processes” and “Processed” shall be construed accordingly.

Part C: Joint Controller Status and Allocation of Responsibilities

20. With respect to personal data under Joint Control of the Trusts, as set out in Paragraph 25 below ("Shared Personal Data"), the Trusts envisage that they shall each be a Data Controller in respect of that Shared Personal Data in accordance with the terms of this Part C of Schedule 6 (Joint Controller Agreement) in replacement of Part B of Schedule 6. Accordingly, the Trusts each undertake to comply with the applicable Data Protection Legislation in respect of their Processing of such Shared Personal Data as Data Controllers.

21. The Trusts agree that the information governance team(s) of each Trust:

    21.1. are the exclusive point of contact for Data Subjects and is responsible for using best endeavours to comply with the UK GDPR regarding the exercise by Data Subjects of their rights under the UK GDPR;

    21.2. shall direct Data Subjects to the Data Protection Officer(s) or suitable alternative in connection with the exercise of their rights as Data Subjects and for any enquiries concerning their Shared Personal Data or privacy;

    21.3. are responsible for the Trusts' compliance with all duties to provide information to Data Subjects under Articles 13 and 14 of the UK GDPR;

    21.4. are responsible for ensuring the informed consent of Data Subjects, in accordance with the UK GDPR, for Processing in connection with the Joint Functions where consent is the relevant legal basis for that Processing; and

    21.5. shall make available to Data Subjects the essence of this Part C of Schedule 6 (and notify them of any changes to it) concerning the allocation of responsibilities as Joint Controller and its role as exclusive point of contact, the Trusts having used their best endeavours to agree the terms of that essence. This must be outlined relevant privacy policies (which must be readily available by hyperlink or otherwise on all of its public facing services and marketing).

22. Notwithstanding the terms of Paragraph 21, the Trusts acknowledge that a Data Subject has the right to exercise their legal rights under the Data Protection Legislation as against the relevant Trust as Controller.

Undertakings of both Trusts

23. The Trusts each undertake that they shall:

    23.1. report to the other Trust every quarter on:

        23.1.1. the volume of Data Subject Access Request (or purported Data Subject Access Requests) from Data Subjects (or third parties on their behalf);

        23.1.2. the volume of requests from Data Subjects (or third parties on their behalf) to rectify, block or erase any Shared Personal Data;

        23.1.3. any other requests, complaints or communications from Data Subjects (or third parties on their behalf) relating to the other Trust's obligations under applicable Data Protection Legislation;

        23.1.4. any communications from the Information Commissioner or any other regulatory authority in connection with Shared Personal Data; and

        23.1.5. any requests from any third-party for disclosure of Shared Personal Data where compliance with such request is required or purported to be required by Law, that it has received in relation to the exercise of the Joint Functions under this Agreement during that period;

23.2. notify each other immediately if it receives any Data Subject Request, complaint or communication made as referred to in Paragraphs 23.1.1 to 23.1.5. For the avoidance of doubt, this clause 23.2 does not apply to requests, complaints or communications made about the general operations of the Trusts as a whole;

23.3. provide the other Trust with full cooperation and assistance in relation to any request, complaint or communication made as referred to in Paragraphs 21 and 23.1.1 to 23.1.5 to enable the other Trust to comply with the relevant timescales set out in the Data Protection Legislation;

23.4. not disclose or transfer the Shared Personal Data to any third-party unless necessary for the provision of the Joint Functions and, for any disclosure or transfer of Shared Personal Data to any third-party, (save where such disclosure or transfer is specifically authorised under this Agreement or is required by Law) that disclosure or transfer of Shared Personal Data is otherwise considered to be lawful processing of that Shared Personal Data in accordance with Article 6 of the UK GDPR. For the avoidance of doubt, the third-party to which Shared Personal Data is transferred must be subject to equivalent obligations which are no less onerous than those set out in this Part C of Schedule 6

23.5. request from the Data Subject only the minimum information necessary to provide the Joint Functions and treat such extracted information as Confidential Information;

23.6. ensure that at all times it has in place appropriate technical and organisational measures to guard against unauthorised or unlawful Processing of the Shared Personal Data and/or accidental loss, destruction or damage to the Shared Personal Data and unauthorised or unlawful disclosure of or access to the Shared Personal Data;

23.7. use best endeavours to ensure the reliability and integrity of any of its Personnel who have access to the Shared Personal Data and ensure that its Personnel:

23.7.1. are aware of and comply with their duties under this Part C of Schedule 6 (Joint Controller Agreement) and those in respect of Confidential Information;

23.7.2. are informed of the confidential nature of the Shared Personal Data, are subject to appropriate obligations of confidentiality and do not publish, disclose or divulge any of the Shared Personal Data to any third-party where that Trust would not be permitted to do so;

23.7.3. have undergone adequate training in the use, care, protection and handling of Shared Personal Data as required by the applicable Data Protection Legislation;

23.8. ensure that it has in place appropriate technical and organisational measures as appropriate to protect against a personal data breach having taken account of the:

23.8.1. nature of the data to be protected;

23.8.2. harm that might result from a personal data breach;

23.8.3. state of technological development; and

23.8.4. cost of implementing any measures;

23.9. ensure that it has the capability (whether technological or otherwise), to the extent required by Data Protection Legislation, to provide or correct or delete at the request

of a Data Subject all the Shared Personal Data relating to that Data Subject that the party holds; and

23.10. ensure that it notifies the other Trust as soon as it becomes aware of a personal data breach.

24. Each Joint Controller shall use best endeavours to assist the other Controller to comply with any obligations under applicable Data Protection Legislation and shall not perform its obligations under this Part C of Schedule 6 in such a way as to cause the other Joint Controller to breach any of its obligations under applicable Data Protection Legislation to the extent it is aware, or ought reasonably to have been aware, that the same would be a breach of such obligations.

Shared Personal Data

25. Both Trusts shall document and keep a register of types of Shared Personal Data that will be shared between the Trusts during the Term. This register will be coordinated by the Information Governance team(s).

Data Protection Breach

26. Without prejudice to Paragraph 27, each Trust shall notify the other Trust without undue delay, and in any event within 48 hours, upon becoming aware of any personal data breach or circumstances that are likely to give rise to a personal data breach, providing the other Trust and their advisors with:

26.1. sufficient information and in a timescale which allows the other Trust to meet any obligations to report a personal data breach under the Data Protection Legislation;

26.2. all reasonable assistance, including:

26.2.1. co-operation with the other Trust and the Information Commissioner investigating the personal data breach and its cause, containing and recovering the compromised Shared Personal Data and compliance with the applicable guidance;

26.2.2. co-operation with the other Trust including using such best endeavours as are directed by the Trust to assist in the investigation, mitigation and remediation of a personal data breach;

26.2.3. co-ordination with the other Trust regarding the management of public relations and public statements relating to the personal data breach; and/or

26.2.4. providing the other Trust and to the extent instructed by the other Trust to do so, and/or the Information Commissioner investigating the personal data breach, with complete information relating to the personal data breach, including, without limitation, the information set out in Paragraph 27.

27. Each Trust shall use best endeavours to restore, re-constitute and/or reconstruct any Shared Personal Data where it has lost, damaged, destroyed, altered or corrupted as a result of a personal data breach which is the fault of that Trust as if it was that Trust's own data at its own cost with all possible speed and shall provide the other Trust with all reasonable assistance in respect of any such personal data breach, including providing the other Trust, as soon as possible and within 48 hours of the personal data breach relating to the personal data breach, in particular:

27.1.1. the nature of the personal data breach;

27.1.2. the nature of Shared Personal Data affected;

27.1.3. the categories and number of Data Subjects concerned;

27.1.4. the name and contact details of the joint Data Protection Officer or other relevant contact from whom more information may be obtained;

27.1.5. measures taken or proposed to be taken to address the personal data breach; and

27.1.6. describe the likely consequences of the personal data breach.

Impact Assessments

28. The Trusts shall:

28.1.1. provide all reasonable assistance to each other to prepare any Data Protection Impact Assessment as may be required (including provision of detailed information and assessments in relation to Processing operations, risks and measures); and

28.1.2. maintain full and complete records of all Processing carried out in respect of the Shared Personal Data in connection with this Agreement, in accordance with the terms of Article 30 UK GDPR.

Liabilities for Data Protection Breach

29. If financial penalties are imposed by the Information Commissioner on either Trust for a personal data breach ("Financial Penalties") then the following shall occur:

29.1.1. if in the view of the Information Commissioner, one Trust (Trust A) is responsible for the personal data breach, in that it is caused as a result of the actions or inaction of Trust A, its employees, agents, contractors (other than the other Trust) or systems and procedures controlled by Trust A, then Trust A shall be responsible for the payment of such Financial Penalties. In this case, Trust A will conduct an internal audit and engage at its reasonable cost when necessary, an independent third-party to conduct an audit of any such personal data breach. The other Trust shall provide to Trust A and its third-party investigators and auditors, on request and at Trust A's reasonable cost, full cooperation and access to conduct a thorough audit of such personal data breach;

29.1.2. if no view as to responsibility is expressed by the Information Commissioner, then the Trusts shall work together to investigate the relevant personal data breach and allocate responsibility for any Financial Penalties as outlined above, or by agreement to split any financial penalties equally if no responsibility for the personal data breach can be apportioned.

29.1.3. If either Trust is the defendant in a legal claim brought before a court of competent jurisdiction ("Court") by a third-party in respect of a personal data breach, then unless the Trusts otherwise agree, the Trust that is determined by the final decision of the court to be responsible for the personal data breach shall be liable for the losses arising from such personal data breach. Where both Trusts are liable, the liability will be apportioned between the Trusts in accordance with the decision of the Court.

29.1.4. In respect of any losses, cost claims or expenses incurred by either Trust as a result of a personal data breach (the "Claim Losses"):

29.1.4.1. if a Trust is responsible for the relevant personal data breach, then that Trust shall be responsible for the Claim Losses;

29.1.4.2. if responsibility for the relevant personal data breach is unclear, then the Trusts shall be responsible for the Claim Losses equally.

30. Nothing in either Paragraph 28 or Paragraph 29 shall preclude the Trusts reaching any other agreement, including by way of compromise with a third-party complainant or claimant, as to the apportionment of financial responsibility for any Claim Losses as a result of a personal data breach, having regard to all the circumstances of the personal data breach and the legal and financial obligations of the Trusts.

Termination

31. The Trusts acknowledge and confirm that neither of them shall be entitled to terminate this Agreement in consequence of any breach, including of this Part C of Schedule 6 in accordance with Clause 18 (Termination).

Sub-Processing

32. In respect of any Processing of Shared Personal Data performed by a third-party on behalf of a Trust, that Trust shall:

    32.1. carry out adequate due diligence on such third-party to ensure that it is capable of providing the level of protection for the Shared Personal Data as is required by this Agreement, and provide evidence of such due diligence to the other Trust where reasonably requested; and

    32.2. ensure that a suitable agreement is in place with the third-party as required under applicable Data Protection Legislation.

Data Retention

33. The Trusts agree to erase Shared Personal Data from any computers, storage devices and storage media that are to be retained as soon as practicable after it has ceased to be necessary for them to retain such Shared Personal Data under applicable Data Protection Legislation and their privacy policy (save to the extent (and for the limited period) that such information needs to be retained by the Trust for statutory compliance purposes or as otherwise required by this Agreement), and taking all further actions as may be necessary to ensure its compliance with Data Protection Legislation and its privacy policy.

Part D: Controller to Processor Agreement

Allocation of responsibilities

34. With respect to personal data under Control of one of the Trusts, as set out in Paragraph 37 below ("Personal Data"), the Trusts envisage that for the purpose of the Data Protection Legislation that they shall, at times, each serve as the Controller and the other as the Processor in respect of that Personal Data in accordance with the terms of this Part D of Schedule 6 (Controller to Processer Agreement) in replacement of paragraphs Part B of Schedule 6 (Data Protection).

35. Accordingly, the Trusts each undertake to comply with the applicable Data Protection Legislation in respect of their Processing of such Personal Data in their respective roles as Controller and Processor.

36. The Controller retains control of the Personal Data and remains responsible for its compliance obligations under the Data Protection Legislation, including but not limited to, providing any required notices and obtaining any required consents, and for the written processing instructions it gives to the Processor.

37. A record will be maintained by both Trusts to detail the subject matter, duration, nature and purpose of the processing and the Personal Data categories and Data Subject types in respect of which a Trust will serve as the Processor and may process the Personal Data to fulfil the Joint Functions.

38. The Trusts acknowledge that a Data Subject has the right to exercise their legal rights under the Data Protection Legislation as against the relevant Trust as Controller.

Undertakings of both Trusts

39. The Processor will only process the Personal Data to the extent, and in such a manner, as is necessary for the exercise of the Joint Functions in accordance with the Controller's written instructions. The Processor will not process the Personal Data for any other purpose or in a way that does not comply with this Agreement or the Data Protection Legislation. The Processor must promptly notify the Controller if, in its opinion, the Controller's instructions do not comply with the Data Protection Legislation.

40. The Processor must comply promptly with any Controller written instructions requiring the Processor to amend, transfer, delete or otherwise process the Personal Data, or to stop, mitigate or remedy any unauthorised processing.

41. The Processor will maintain the confidentiality of the Personal Data and will not disclose the Personal Data to third-parties unless the Controller or this Agreement specifically authorises the disclosure, or as required by domestic law, court or regulator (including the Commissioner). If a domestic law, court or regulator (including the Commissioner) requires the Processor to process or disclose the Personal Data to a third-party, the Processor must first inform the Controller of such legal or regulatory requirement and give the Controller an opportunity to object or challenge the requirement, unless the domestic law prohibits the giving of such notice.

42. The Processor will reasonably assist the Controller, at no additional cost to the Controller, with meeting the Controller's compliance obligations under the Data Protection Legislation, taking into account the nature of the Processor's processing and the information available to the Processor, including in relation to Data Subject rights, data protection impact assessments and reporting to and consulting with the Commissioner under the Data Protection Legislation.

43. The Processor (and any subcontractor) must not transfer or otherwise process the Personal Data outside the UK without obtaining the Controller's prior written consent.

44. The Processor may not authorise any third party or subcontractor to process the Personal Data without the agreement of the Controller. The Trusts agree that the Processor will be deemed by them to control legally any Personal Data controlled practically by or in the possession of its subcontractors.

45. The Processor must, at no additional cost to the Controller, take such technical and organisational measures as may be appropriate, and promptly provide such information to the Controller as the Controller may reasonably require, to enable the Controller to comply with:

    45.1. the rights of Data Subjects under the Data Protection Legislation, including, but not limited to, subject access rights, the rights to rectify, port and erase personal data, object to the processing and automated processing of personal data, and restrict the processing of personal data; and

    45.2. information or assessment notices served on the Controller by the Commissioner under the Data Protection Legislation.

46. The Processor must notify the Controller immediately in writing if it receives any complaint, notice or communication that relates directly or indirectly to the processing of the Personal Data or to either party's compliance with the Data Protection Legislation.

47. The Processor must notify the Controller within 7 days if it receives a request from a Data Subject for access to their Personal Data or to exercise any of their other rights under the Data Protection Legislation.

48. The Processor will give the Controller, at no additional cost to the Controller, its full co-operation and assistance in responding to any complaint, notice, communication or Data Subject request.

49. The Processor must not disclose the Personal Data to any Data Subject or to a third-party other than in accordance with the Controller's written instructions, or as required by domestic law.

50. The Processor must at all times implement appropriate technical and organisational measures against accidental, unauthorised or unlawful processing, access, copying, modification, reproduction, display or distribution of the Personal Data, and against accidental or unlawful loss, destruction, alteration, disclosure or damage of Personal Data.

51. The Processor must implement such measures to ensure a level of security appropriate to the risk involved, including as appropriate:

    51.1. the pseudonymisation and encryption of personal data;

    51.2. the ability to ensure the ongoing confidentiality, integrity, availability and resilience of processing systems and services;

    51.3. the ability to restore the availability and access to personal data in a timely manner in the event of a physical or technical incident; and

    51.4. a process for regularly testing, assessing and evaluating the effectiveness of the security measures.

52. The Processor will ensure that all of its employees:

    52.1. are informed of the confidential nature of the Personal Data and are bound by written confidentiality obligations and use restrictions in respect of the Personal Data;

    52.2. have undertaken training on the Data Protection Legislation and how it relates to their handling of the Personal Data and how it applies to their particular duties; and

    52.3. are aware both of the Processor's duties and their personal duties and obligations under the Data Protection Legislation and this Agreement.

Breaches

53. The Processor will within 48 hours and in any event without undue delay notify the Controller in writing if it becomes aware of:

    53.1. the loss, unintended destruction or damage, corruption, or unusability of part or all of the Personal Data. The Processor will restore such Personal Data at its own expense as soon as possible.

    53.2. any accidental, unauthorised or unlawful processing of the Personal Data; or

    53.3. any Personal Data Breach.

54. Where the Processor becomes aware of the matters set out in Paragraph 53 above, it will, without undue delay, also provide the Controller with the following written information:

54.1. description of the nature of the matters set out in Paragraph 53, including the categories of in-scope Personal Data and approximate number of both Data Subjects and the Personal Data records concerned;

54.2. the likely consequences; and

54.3. a description of the measures taken or proposed to be taken to address the matters set out in Paragraph 53, including measures to mitigate its possible adverse effects.

55. Immediately following any accidental, unauthorised or unlawful Personal Data processing or Personal Data Breach, the Trusts will co-ordinate with each other to investigate the matter. Further, the Processor will reasonably co-operate with the Controller at no additional cost to the Controller, in the Controller's handling of the matter, including but not limited to:

55.1. assisting with any investigation;

55.2. providing the Controller with physical access to any facilities and operations affected;

55.3. facilitating interviews with the Processor's employees, former employees and others involved in the matter including, but not limited to, its officers and directors;

55.4. making available all relevant records, logs, files, data reporting and other materials required to comply with all Data Protection Legislation or as otherwise reasonably required by the Controller; and

55.5. taking reasonable and prompt steps to mitigate the effects and to minimise any damage resulting from the Personal Data Breach or accidental, unauthorised or unlawful Personal Data processing.

56. The Processor will not inform any third-party of any accidental, unauthorised or unlawful processing of all or part of the Personal Data and/or a Personal Data Breach without first obtaining the Controller's written consent, except when required to do so by domestic law.

57. The Processor agrees that the Controller has the sole right to determine:

57.1. whether to provide notice of the accidental, unauthorised or unlawful processing and/or the Personal Data Breach to any Data Subjects, the Commissioner, other in-scope regulators, law enforcement agencies or others, as required by law or regulation or in the Controller's discretion, including the contents and delivery method of the notice; and

57.2. whether to offer any type of remedy to affected Data Subjects, including the nature and extent of such remedy.

58. The Processor will cover all reasonable expenses associated with the performance of the obligations under Paragraphs 53 to 55 unless the matter arose from the Controller's specific written instructions, negligence, wilful default or breach of this Agreement, in which case the Controller will cover all reasonable expenses.

59. The Processor will also reimburse the Controller for actual reasonable expenses that the Controller incurs when responding to an incident of accidental, unauthorised or unlawful processing and/or a Personal Data Breach to the extent that the Processor caused such, including all costs of notice and any remedy as set out in Paragraph 57.

Warranties

60. Each Trust warrants and represents that, in acting as Processor:

60.1. its employees, subcontractors, agents and any other person or persons accessing the Personal Data on its behalf are reliable and trustworthy and have received the required training on the Data Protection Legislation;

60.2. it and anyone operating on its behalf will process the Personal Data in compliance with the Data Protection Legislation and other laws, enactments, regulations, orders, standards and other similar instruments;

60.3. it has no reason to believe that the Data Protection Legislation prevents it from providing any of the Joint Functions; and

60.4. considering the current technology environment and implementation costs, it will take appropriate technical and organisational measures to prevent the accidental, unauthorised or unlawful processing of Personal Data and the loss or damage to, the Personal Data, and ensure a level of security appropriate to:

60.4.1. the harm that might result from such accidental, unauthorised or unlawful processing and loss or damage;

60.4.2. the nature of the Personal Data protected; and

60.4.3. comply with all applicable Data Protection Legislation and its information and security policies.

61. Each Trust warrants and represents that in acting as Controller, the Processor's expected use of the Personal Data for the Joint Functions and as specifically instructed by the Controller will comply with the Data Protection Legislation.

Impact assessment

62. The Trusts shall:

62.1. provide all reasonable assistance to each other to prepare any Data Protection Impact Assessment as may be required (including provision of detailed information and assessments in relation to Processing operations, risks and measures); and

62.2. maintain full and complete records of all Processing carried out in respect of the Personal Data in connection with this Agreement, in accordance with the terms of Article 30 UK GDPR.

Termination

63. The Trusts acknowledge and confirm that neither of them shall be entitled to terminate this Agreement in consequence of any breach, including of this Part D of Schedule 6 in accordance with Clause 18 (Termination).

Data retention

64. At the Controller's request, the Processor will give the Controller, or a third-party nominated in writing by the Controller, a copy of or access to all or part of the Personal Data in its possession or control in the format and on the media reasonably specified by the Controller.

65. On termination of this Agreement for any reason or expiry of its term, the Processor will securely delete or destroy or, if directed in writing by the Controller, return and not retain, all or any of the Personal Data related to this Agreement in its possession or control, only.

66. If any law, regulation, or government or regulatory body requires the Processor to retain any documents, materials or Personal Data that the Processor would otherwise be required to return or destroy, it will notify the Controller in writing of that retention requirement, giving details of the documents, materials or Personal Data that it must retain, the legal basis for such

retention, and establishing a specific timeline for deletion or destruction once the retention requirement ends.

67. The Processor will certify in writing to the Controller that it has deleted or destroyed the Personal Data within 28 days after it completes the deletion or destruction.

Schedule 6 **Scheme for Trust Board Appointments**

Membership & expected attendance
Trust Board Members (voting and non-voting) Required to be in attendance
Board Directors (non-voting) including the Trust Secretary Required to be in attendance
Directors and others Invited to attend for specific items

Governance Table

For Board and Board Committees:	Group Trust Board 28 May 2026	
Paper sponsored by:	Kate Dyer Director of Governance and Risk LPT Richard Smith Director of Corporate Governance NHFT	
Paper authored by:	Kate Dyer Director of Governance and Risk	
Date submitted:	18 May 2026	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	--	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	NA	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Annual	
LPT strategic alignment:	T - Technology	All
	H – Healthy Communities	
	R - Responsive	
	I – Including Everyone	
	V – Valuing our People	
	E – Efficient & Effective	
CRR/BAF considerations *(list risk number and title of risk):*	All areas of the BAF and CRR	
Is the decision required consistent with the Group's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed	
Equality considerations:	None	

Leicestershire Partnership and
Northamptonshire Healthcare
Associate University Group

H

Group Board of Directors Meeting – 28 May 2026

Group Board Terms of Reference

Purpose of the Report

The terms of reference for the Group Board are subject to an annual review cycle. Having been reviewed by the Directors responsible for Governance, the revised terms of reference are presented to the Group Board for consideration and approval.

Analysis of the Issue

The Group Board was established in conjunction with the Partnership Agreement between LPT and NHFT Boards as a 'special purpose joint committee' focussed on priorities in common across the Group. At inception, it was agreed that the terms of reference for the Group Board would be reviewed on an annual basis in conjunction with an annual review of the Partnership Agreement itself. Since the terms of reference were last reviewed in May 2025, they are due for review this month.

Proposal

The Directors responsible for Governance in both Trusts have reviewed the terms of reference for the Group Board. No material changes are proposed. References to job titles and certain documents have been amended to reflect current terminology. No further changes are proposed to the terms of reference. The revised terms of reference is appended to this report for consideration by the Group Board.

Decision Required

The Group Board is asked to receive and approve the revised Terms of Reference for the Group Board.

Governance Table

For Board and Board Committees:	Group Board Meeting in Public – 28 May 2026
Paper sponsored by:	Kate Dyer, Director of Governance and Risk

DRAFT

Leicestershire Partnership and
Northamptonshire Healthcare
Associate University Group

	Richard Smith, Director of Corporate Governance
Paper authored by:	Richard Smith, Director of Corporate Governance
Date submitted:	20 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:	May 2027
THRIVE strategic alignment:	☒ Technology ☒ Healthy communities ☒ Responsive ☒ Including everyone ☒ Valuing our people ☒ Efficient and effective
Board Assurance Framework considerations:	All
Is the decision required consistent with NHFT's risk appetite:	Yes
False or Misleading Information (FOMI) considerations:	None believed to apply
Positive confirmation that the content does not risk the safety of patients or the public:	There are no risks to the safety of patients or the public from this report
Equality considerations:	None believed to apply

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Appendix – Group Board Terms of Reference (revised)

Group Trust Board Terms of Reference 2026/27

Version	2026/27 v2
Date Approved	[Approval pending]
Review Date	Group Trust Board May 2027

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1. Introduction

1.1. The Group Board is a statutory joint committee of the boards of Leicestershire Partnership NHS Trust and Northamptonshire Healthcare NHS Foundation Trust, established to exercise Joint Functions in accordance with the Partnership Agreement dated 29 May 2025.

1.2. In these terms of reference 'Joint Functions' mean all the Trusts' functions that the Trusts have agreed in this Partnership Agreement (PA) to exercise jointly subject to any variation of the PA that the Trusts have agreed in accordance with it.

2. Authority and Accountabilities

2.1. The Group Board is authorised by the Boards to exercise the Joint Functions.

2.2. The Group Board shall be fully and equally accountable to both Trust Boards for the exercise of the Joint Functions and shall at all times comply with the PA and NHS England guidance when exercising Joint Functions.

2.3. The Group Board may authorise one of the Trusts to contract with a third part on behalf of itself alone or both Trusts jointly and severally subject to compliance with the Trusts' Standing Orders and Standing Financial Instructions.

2.4. The Group Board is authorised by the Boards to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2.5. The Group Board shall transact all business in accordance with the policies of the Trusts on openness and conformity with the Nolan principles and values of Public Services.

3. Reporting arrangements

3.1. The minutes of the Group Board shall be formally recorded and submitted to each Trust's Board.

4. Frequency of meetings

4.1. Meetings of the Group Board shall be held at a frequency annually agreed by both Trust Boards in setting their corporate calendar(s).

4.2. Extraordinary meetings may be called for a specific purpose at the discretion of the Group Chair. Where possible a minimum of seven working days' notice will be given when calling an extraordinary meeting.

5. Membership

5.1. The voting members of the Group Board shall include all the Voting Directors of both Trusts during their terms of office.

5.2. Additionally, the Trusts may appoint Non-Voting Directors of the Trusts to be voting or non-voting members of the Group Board.

5.3. The proceedings of the Group Board shall not be invalidated by any vacancy in its membership or by any defect in the appointment of a member of the Group Board.

5.4. In line with both Trusts' Standing Orders, members of the Group Board must attend at least two thirds of meetings annually, subject to annual review and appraisal process.

6. Attendance

6.1. The Group Board will be supported by the respective Directors responsible for Corporate Governance (and Trusts' Secretariats) to ensure business is transacted as per this Terms of Reference, the Partnership Agreement and the relevant Standing Orders and any documents referred to therein.

6.2. In the absence of a member, a nominated deputy may attend with the agreement of the Chair and will be formally nominated with the same rights and privileges.

7. Quorum

7.1. No business shall be transacted at a meeting of the Group Board unless:

7.1.1. The voting members present include (in addition to the Group Chair) at least one Voting Executive Director of LPT and one Voting Executive Director of NHFT (who in the case of a group or joint director may be the same person) and at least one Voting Non-Executive Director of LPT and one Voting Non-Executive Director of NHFT (who in the case of a Group or Joint Non-Executive Director may be the same person).

8. Chair and Deputy Chair

8.1. The Group Chair of the Trusts shall preside at any meetings of the Group Board.

8.2. If the Group Chair is absent, one of the Deputy Trust Chairs shall preside. If a Deputy Trust Chair is presiding at a meeting instead of the Group Chair, then references in this Terms of Reference to the Group Chair shall be construed as the Deputy Chair.

9. Decision Making

9.1. The Group Board will generally operate on the basis of forming consensus on all issues considered, taking account of views expressed by all members. The Group Chair will seek to ensure that any lack of consensus is resolved amongst members.

9.2. If the Group Board is unable to reach a consensus on an issue, the Group Chair may put the issue to a vote. The vote will be carried if:

9.2.1. A majority of voting members present, and voting are in favour (and in the event of a tied vote the Group Chair shall have a casting vote), and

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9.2.2. The voting members in favour include not less than half the LPT Voting Directors present and not less than half the NHFT Voting Directors present.

10. Admission of the public to meetings

10.1. Meetings of the Group Board shall be held in public.

10.2. The Group Board may, by resolution, exclude the public from a meeting (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings.

11. Conflict of Interest

11.1. Each member of the Group Board must abide by all policies of the Trust of which they are a Director or Officer in relation to conflicts of interest.

11.2. Where any member of Group Board has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Group Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate in meetings (or parts of meetings) in which the relevant matter is discussed.

12. Administrative Arrangements

12.1. The LPT and NHFT corporate governance offices shall jointly provide administrative support to the Group Board.

13. Annual Workplan

13.1. The Group Board will agree an annual workplan and cycle of business prior to the beginning of each financial year. The reporting cycle will form part of the agenda alongside the standing agenda items.

14. Frequency of Meetings

14.1. Ordinary meetings of the Group Board shall be held at a frequency agreed annually by Trust Boards and in any case not more than six times a year.

14.2. Extraordinary meetings may be called for a specific purpose at the discretion of the Group Chair. Where possible, a minimum of seven working days' notice will be given when calling any extraordinary meeting.

15. Papers Publication

15.1. All papers will be made available at least 3 days prior to the meeting. A progress report of outstanding/pending Group Board actions will be presented to each meeting of the Group Board.

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16. Standard Agenda

16.1. Agendas will be built around the Group Board annual workplan, and will include:

16.1.1. Declarations of interest,

16.1.2. Minutes of previous meeting,

16.1.3. Action list

16.1.4. Other items as per agreed cycle of business

17. Committees

17.1. For the purpose of assisting the exercise of Joint Functions, the Group Board may appoint one or more additional committees.

17.2. The voting members of a committee of the Group Board may only be individuals who are voting members of the Group Board.

17.3. The Group Board may authorise a committee to exercise joint functions that the Group Board expressly sub-delegates to the committee in its Terms of Reference.

18. Review

18.1 These Terms of Reference will be reviewed on an annual basis, in line with the review of the Partnership Agreement. The Terms of Reference may only be amended by variation in accordance with Clause 17 of the Partnership Agreement.

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Group Board of Directors Meeting – 28 May 2026

Group Board Development Programme 2026/27

Purpose of the Report

The Board's development programme is designed to support members of the Board individually and collectively to improve their effectiveness through a series of interactive learning and development workshops throughout the year. Since both Leicestershire Partnership NHS Trust (LPT) and Northamptonshire Healthcare NHS Foundation Trust (NHFT) Boards decided to pursue board development in common in 2026/27, this report sets out the group development programme for the year.

Analysis of the Issue

Background to Board Development

A high performing Board of Directors is one that has a clear vision and knows how that vision will be achieved. It also understands how well the organisation is performing and where there is risk. It is comprised of individuals who understand their duties as individual executive and non-executive directors and also as a unitary board, whose operating principles are trust, constructive challenge, and effective scrutiny.

A high performing Board develops and maintains good relations with its stakeholders and, where possible, involves them in decision-making.

The behaviour and culture of the Board of Directors are key determinants of its, and therefore the organisation's, performance. The Board of Directors is responsible for building a culture that drives curiosity and continuous improvement. How the Board exercises stewardship and accountability, and seeks assurance, sets the standard and tone for the rest of the organisation.

Building a High Performing Board

At the core of a high performing Board is a clear framework which sets out the skills, competencies, knowledge, and behaviours required to:

1. **Ensure the effectiveness of the Board collectively and Board members individually in meeting core duties of the Board:**
    - fulfilling legal duties;
    - thinking and operating strategically;
    - formulating policy and understanding risk;
    - scrutinising and supervising management actions to gain assurance;
    - exercising stewardship and accountability to all stakeholders;

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- building a culture that drives continuous improvement; and
- effectively chairing, scrutinising and challenging.

2. **Deliver good governance in the Board's operations, giving Board members a clear sense of how to:**
    - formulate and drive the agenda of the Board/its committees;
    - ask the right questions for effective Board level scrutiny and challenge;
    - use data intelligently and develop clear insights from the data;
    - understand and ensure improvement in patient and staff experience;
    - listen and respond to the voice of patients, staff and other partners and stakeholders;
    - capitalise on strategic engagement and alignment with partners;
    - manage meetings effectively;
    - use risk assessments and performance data to drive the agenda; and
    - regular reflection.

The Board Development Plan

Every year, the Board schedules time within its annual programme to consider its own performance and effectiveness, and engage in thematic learning, discussion, and reflection. This programme constitutes its Board Development Plan. Delivered via workshops, it provides a broad spectrum of development activity drawing on both 'behavioural' and 'skills-based' material.

The Board Development Plan builds on the induction and annual appraisal process which focuses both on each director's contribution as a member of the Board (in the case of executive directors, this is distinct from their functional leadership role) as well as the overall performance of the Board and its committees. The outputs from this process inform the development needs of individual directors as well as those for the whole Board and may be supplemented with views obtained from internal/external stakeholders who do not sit on the Board but nonetheless experience its impact, or from external experts.

The Board Development Plan is developed with regard to the NHS Leadership Competency Framework for Board Members, Assessing provider capability: guidance for NHS trust boards, The insightful provider board, and Well-led framework.

Evaluating Board Development

As part of its annual effectiveness review, the Board considers Board member participation in:

- The Board Development Plan;
- Relevant internal or external training;
- Stakeholder events;
- Service visits; and
- Appraisal.

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Proposal

The 2026/2027 development programme

The proposed development plan for the board in the 2026/2027 financial year is shown in the table below.

The board has six scheduled workshops for the year, all of which are expected to be group development workshops. These workshops are full-day, in-person events in either Leicestershire or Northamptonshire. NB Trust-specific development activity can be factored into the agenda of one or more of the planned workshops if and as required.

	Date	Topics to be covered
1	9 April 2026	▪ Cyber security and preparedness ▪ Group Board Assurance Framework and risk appetite ▪ THRIVE milestones ▪ Quality account priorities and quality framework
2	30 June 2026	▪ Driving research and innovation across the Group ▪ Developing an inclusive culture with active bystanders ▪ Creating a thriving culture ▪ Learning from elsewhere through benchmarking
3	6 August 2026	▪ Commissioning and contracting for population health ▪ Assessing our leadership and governance arrangements (incl. board and committee effectiveness) ▪ Reviewing our speaking up culture and governance arrangements ▪ Understanding the implications of The Health Bill 2026
4	27 October 2026	▪ Refreshing our understanding of health and safety duties ▪ Reviewing our Emergency Preparedness, Resilience, and Response arrangements ▪ Learning from complaints, concerns, claims, and compliments ▪ Safeguarding our patients and staff from harm
5	15 December 2026	▪ Refreshing our understanding of infection prevention and control ▪ Revisiting our sustainability and social value plans ▪ Harnessing social value to reduce health inequalities ▪ Considering our group value programme and priorities
6	23 February 2027	▪ Finalising our annual operational plan 2027/28 ▪ Refreshing our Group Board Assurance Framework ▪ Setting our Group risk appetite

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Leicestershire Partnership and
Northamptonshire Healthcare
Associate University Group

	Date	Topics to be covered
		▪ Considering our staff survey results

Decision Required

The Group Board is asked to consider and endorse the proposed board development programme for 2026/27.

Governance Table

For Board and Board Committees:	Group Board Meeting in Public – 28 May 2026
Paper sponsored by:	Kate Dyer, Director of Governance and Risk Richard Smith, Director of Corporate Governance
Paper authored by:	Richard Smith, Director of Corporate Governance
Date submitted:	20 May 2026
Name and date of other committee / forum at which this report / issue was considered:	Board of Directors Workshops / Strategic Executive Board Meeting – April 2026
Level of assurance gained if considered elsewhere	☒ Assured ☐ Partially assured ☐ Not assured
Date of next report:	May 2027
THRIVE strategic alignment:	☒ Technology ☒ Healthy communities ☒ Responsive ☒ Including everyone ☒ Valuing our people ☒ Efficient and effective
Board Assurance Framework considerations:	All
Is the decision required consistent with NHFT's risk appetite:	Yes

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False or Misleading Information (FOMI) considerations:	None believed to apply
Positive confirmation that the content does not risk the safety of patients or the public:	There are no risks to the safety of patients or the public from this report
Equality considerations:	None believed to apply

Leicestershire Partnership and
Northamptonshire Healthcare
Associate University Group

Alert, Advise and Assure Report

Joint People and Culture Committee in Common 11 February 2026

Key discussion points and matters to be escalated from the meeting

ALERT: Alert the Board to matters that need its attention or action, e.g. an area of non-compliance, safety or a threat to the Trust's strategy
None

ADVISE: Advise the Board of areas subject to on-going monitoring or development or where there is negative assurance
NHFT Valuing Our People Management Group Triple A: The Committee discussed increasing sickness absence, recent spikes in formal grievances and complex employee relations cases, recognising the interrelationship between these indicators and wider organisational change. A deep dive into sickness is planned, alongside continued delivery of the cultural competency programme and strengthened change support for leaders and staff. There is a clear focus on triangulating workforce data, including Freedom to Speak Up and staff survey insights, to identify hotspots and root causes. The Committee advised that this remains an area of ongoing monitoring and development. **LPT /NHFT Staff Sickness Hotspots / Areas of Concern by Trust and Directorates / Care Pathway SPC Charts:** Both Trusts reported sustained sickness challenges, with NHFT's rolling average at 5.6% and LPT entering a new phase of structured improvement work. The Committee explored the rising impact of stress, anxiety and burnout, and the need for clearer epidemiological understanding of drivers, including post-COVID and societal pressures. While access to wellbeing support was positively reflected in staff survey results, members emphasised the importance of evaluating impact and ensuring managers are equipped to respond effectively. Sickness absence will remain a central focus for the Committee. **Safe Staffing Combined LPT / NHFT report:** The first combined safe staffing report provided detailed triangulation of staffing levels, sickness and incident data across both organisations. No new escalations were required, although pressures remain in specific areas such as 136 suites and the management of flexible working requests. The Committee welcomed the transparency of the new format and requested further alignment of appendices across both Trusts. The paper was rated advise, reflecting continued mitigation in place but recognising ongoing workforce pressures.

ASSURE: Inform the Board where positive assurance has been received
LPT Workforce Development Group Triple A: The Committee received assurance on workforce planning deep dives, including emerging vacancy risks within AHP services such as podiatry and occupational therapy. Targeted actions are being developed to address recruitment pipeline constraints and sponsorship-related workforce experience issues. Although sickness absence is rising, a structured programme of work is in place for 2026/27. The Committee was assured that risks are being actively managed and escalated appropriately. **Joint People Dashboard**: Members noted continued refinement of the joint dashboard to improve like-for-like comparison, clarity of definitions and transparency of RAG ratings. Time-to-hire measures have been separated to reflect recruitment and onboarding delays, including prison clearance challenges. Agency spend remains within plan overall, with contextual explanation provided for prison service transfers. The Committee was assured that the dashboard provides a strong and evolving basis for oversight. **LPT Our People Data:** LPT remains above plan for substantive staff in post, with both bank and agency usage below plan and a projected 50% reduction in agency usage this year. Deep dives continue into known structural hotspots including nursing, medical and AHP roles, with escalation via AAA where required. The Committee requested vacancy oversight where risks trigger alert or advise. Overall, assurance was provided that workforce performance is stable and closely monitored. **NHFT Our People Data:** NHFT's substantive workforce sits approximately 5% above plan, largely due to the transfer of 157 staff from Nottinghamshire and Lincolnshire prisons. Despite increased agency usage within prison services, the Trust remains within its planned WTE and agency spend trajectory. Turnover remains low at around 7%, placing NHFT in the lowest national quartile. The Committee was assured by the strengthened People Pack format and improving rostering compliance, currently at 63% six-week rostering. **LPT / NHFT Medium-term Workforce Operational Plans:** Both Trusts presented three-year workforce plans aligned to financial, bank, agency and sickness reduction targets. NHFT has profiled a near 25% bank reduction in year one and a 30% agency reduction, supported by deep dives and executive oversight; LPT's plan incorporates known TUPE transfers, service changes and break-even assumptions. Members emphasised the importance of responsiveness to system changes and clear early warning mechanisms. The Committee was assured that robust governance arrangements are in place to monitor delivery against plan. **LPT People Plan:** The Committee formally approved LPT's People Plan, developed using NHFT's plan as a structural foundation but tailored to LPT's context. Both Trusts share aligned strategic workforce priorities, with local operational nuances reflected appropriately. The plan has been reviewed through the Workforce Development Group and aligns with overarching group ambitions. The Committee was assured of strategic coherence across the Group. **LPT Accountability Framework Meeting report:** The monthly accountability framework continues to provide oversight across quality, performance, finance and workforce pillars. While sickness and employee relations volumes remain under advisory review, no alerts were reported. Positive developments include improved medical job planning compliance (75%) and recognition of outstanding clinical leadership. The Committee was assured that governance and escalation routes are functioning effectively.

ASSURE: Inform the Board where positive assurance has been received
LPT / NHFT Freedom to Speak Up Quarterly Updates: Both Trusts reported increased Freedom to Speak Up activity in Q3, partly linked to Speak Up Month engagement, with themes including staff wellbeing and patient safety. Cases are being appropriately triaged and escalated, and champion visibility has increased. Members highlighted the importance of triangulating Speak Up data with sickness, grievances and survey results, and monitoring wellbeing impacts on those raising concerns. The Committee was assured that both functions remain robust and responsive. **NHFT Gender and Ethnicity Pay Gap report:** NHFT has reduced its overall gender pay gap since 2017, though progress has plateaued, with the mean gap around 13%. The distribution of males within the upper pay quartile continues to influence the gap. Ongoing actions include strengthened family-friendly policies, debiasing recruitment processes and senior recruitment ambassador roles. The Committee was assured that appropriate actions remain in place and reporting will move to a combined Group format. The report is attached as an appendix as per the NHS Employers gender pay gap reporting requirement that the action plan should be reported to, discussed and endorsed by the Board. **Joint Risk Report and BAF Summary:** The Committee reviewed workforce and EDI risks aligned to the Group BAF, particularly under the "Including Everyone" ambition. Differences in corporate risk escalation between the two Trusts were discussed, with commitment to greater alignment through the new group leadership structure. Assurance was provided that escalation processes are effective and that workforce risks are embedded within Level 2 governance structures. The next BAF iteration will reflect the discussion. **Joint Policy Framework:** The Committee noted continued alignment of Trust-wide policies within its remit and confirmed that no new policies required approval since the previous meeting. The framework provides transparency and oversight of harmonisation progress across the Group. Assurance was given that policy alignment remains on track.

RISK: Advise the Board which risks were discussed and any new risks identified
None

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding
The LPT Accountability Framework meeting report highlighted some outstanding contributions including three CAMHS consultants who were recently awarded fellowships by the Royal College of Psychiatrists. NHS Employers has published an LPT case study on the "Supporting Our Staff to Thrive" cultural leadership and inclusion programme following the organisation's recognition as a finalist in the Healthcare Journal Awards.

Author: Tim Harrison

Appendix

Joint People Committee in Common – 11 February 2026

NHFT Annual Gender Pay Gap Reporting

Purpose of the Report

The Trust is required by law to publish information on its gender pay gap at 31 March each year. Data is submitted via a government website and published on the NHFT site.

This report provides the 2025 gender pay gap data, in comparison to 2023 & 2024 data, across the six mandatory reporting metrics,

1. Gender pay gap (mean average)
2. Gender pay gap (median average)
3. Proportion of males and females in each quartile of the organisation's pay structure
4. Proportion of males and females receiving bonuses
5. Gender bonus gap (mean average)
6. Gender bonus gap (median average)

A gender pay gap is the difference between the average hourly earnings of males and females with the figure expressed as a proportion of male earnings. Information is extracted from ESR by a nationally built Business Intelligence reporting tool. It is important to note that gender pay gap reporting is separate from equal pay. The Trust can be assured that pay rates for females and males performing 'equal work of equal value' is delivered by use of the NHS nationally agreed pay scales and the NHS Job Evaluation Scheme.

The report also shares actions taken to reduce gender pay gaps at NHFT.

In future it is proposed NHFT and LPT Gender Pay Gap information will be shared together in a consistent format with the Joint People Committee in Common.

Analysis of the issue

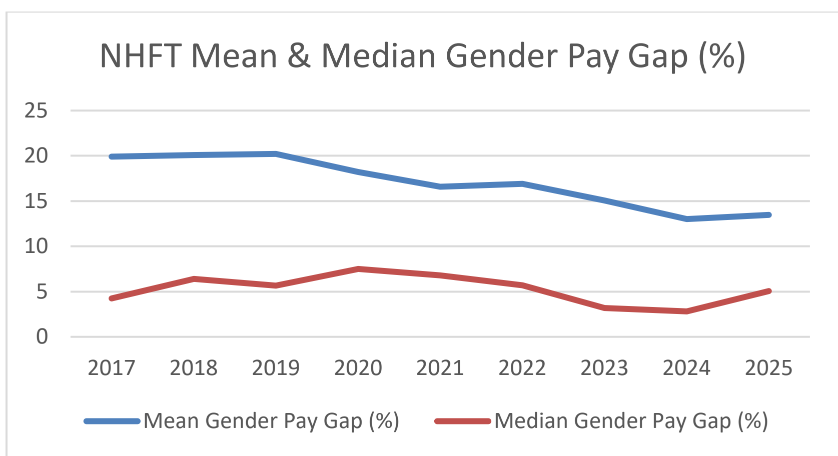
Reporting Metric 1 & 2 - Gender Pay Gap (mean and median averages)

	31 March 2023		31 March 2024		31 March 2025	
Gender	Avg. Hourly Rate	Median Hourly Rate	Avg. Hourly Rate	Median Hourly Rate	Avg. Hourly Rate	Median Hourly Rate
Male	£21.05	£17.40	£21.66	£18.20	£23.30	£20.04
Female	£17.88	£16.85	£18.82	£17.58	£20.16	£19.02
Difference	£3.16	£0.55	£2.83	£0.51	£3.14	£1.02
Pay Gap	**15.05%**	**3.18%**	**13.01%**	**2.81%**	**13.48%**	**5.05%**

NHFTs gender pay gap, calculated by mean average hourly rate, has increased slightly from 13.01% to 13.48%. This represents a held position over the past 2 years following a reduction in the pay gap since analysis was first completed in 2017. Median pay analysis is considered as a more accurate indicator of inequality in gender pay. NHFT median pay gap has unfortunately raised from 2.81% to 5.05% in 2024. The Office of National Statistics reported the UK 2024 UK gender pay gap to be 7%. The Trusts aims to work to remove all pay gaps.

The Governments Gender Pay reporting website allows for comparisons between organisations. By way of a benchmark, Leicester Partnership NHS Trust, Kettering General Hospital and Northampton General Hospital reported mean average pay gaps ranging from 10.4% to 26% and median average pay gaps ranging from 1.6% to 10.3%.

Narrowing of the NHFT Gender Pay Gap



The chart above illustrates the steady reduction in the Trusts mean and median gender pay gaps since reporting commenced in 2017.

Reporting Metric 3 - Proportion of men and women in each quartile of NHFTs pay structure *(Q1 is the lowest pay quartile and Q4 is the highest pay quartile).*

	31 March 2023					31 March 2024					31 March 2025			
Quartile	No. of Female	No. of Male	Female %	Male %		No. of Female	No. of Male	Female %	Male %		No. of Female	No. of Male	Female %	Male %
1	1143	147	89%	11%		1154	176	87%	13%		1165	193	86%	14%
2	1072	220	83%	17%		1086	246	82%	18%		1082	242	82%	18%
3	1097	195	85%	15%		1114	218	84%	16%		1163	236	83%	17%
4	999	293	77%	23%		1029	303	77%	23%		1053	308	77%	23%

Analysis by pay quartiles allows for consideration of any imbalance between males and females in comparison with the overall workforce. The Trusts gender split at 31 March 2025 was 82% female and 18% male. Over the past 5 years this represents an increase of 3% of males in the workforce. If total equality was to prevail then each quartile of the NHFT pay structure would report as 82% female and 18% male.

From the information reported above males at NHFT are disproportionally overrepresented in the highest pay quartile (Quartile 4). In the organisation women occupy 77% of the highest paid jobs (Quartile 4) and 86% of the lowest paid jobs (Quartile 1). Focus should be given to the recruitment to roles in the highest paid posts.

Reporting Metric 4 - Proportion of males & females receiving a bonus

	31 March 2023				31 March 2024				31 March 2025		
Gender	Employees Paid Bonus	Total Relevant Employees	%		Employees Paid Bonus	Total Relevant Employees	%		Employees Paid Bonus	Total Relevant Employees	%
Female	1412	4311	33%		793	4383	18%		241	4463	5%
Male	314	855	37%		260	943	27%		110	979	11%

NHFTs bonus payments include Clinical Excellence Awards for doctors, bonuses awarded to Directors via the Trusts Remuneration Committee, attraction and retention incentives and incentive payments to Bank Workers who cover additional shifts at times of high demand.

Reporting Metric 5 & 6 – Bonus Pay Gap (mean & median average)

	31 March 2023			31 March 2024			31 March 2025	
Gender	Avg. Bonus Pay	Median Bonus Pay		Avg. Bonus Pay	Median Bonus Pay		Avg. Bonus Pay	Median Bonus Pay
Male	£932	£100		£1261	£250		£2,610	£2,000
Female	£294	£100		£683	£100		£1,690	£1,200
Difference	£637	0		£578	£150		£920	£800
Pay Gap	**68%**	**0%**		**46%**	**60%**		**35%**	**£40%**

The data reports a reduction in the mean average bonus pay gap to 40% in 2025 from 60% in 2024. The Trusts bonus pay gap figures are widened by historical Clinical Excellence Awards and the over representation of male doctors in the highest value awards. In 2025, more females than males received a bonus payment (241 females v 110 males) which included bank incentives and bonuses for working additional shifts at times of high demand. These lower value bonuses for an increased number of people, reduce the female mean average bonus when compared to males. Males are over represented in the Clinical Excellence Awards and Director bonuses which increases the mean and median bonuses.

NHFT Actions taken to Narrow the Gender Pay Gap

Increased Family Friendly Policy Provision

The Trust launched a new Flexible Working Procedure at the start of 2025 after extensive engagement with colleagues, managers, Trade Unions and Staff Networks. The policy launch included workshops for managers to support a flexible working culture, a catalogue of positive stories shared via weekly communications campaigns and a HR on demand video to support the flexible working application process. Enhancing a flexible working culture is a key driver to reducing the gender pay gap and improving access to senior roles for females.

Changes have been made to increase the provision of Carers Leave and Special Leave available to colleagues. These have been promoted throughout the Trust. Family friendly policies help support colleagues at work and foster a commitment to balance work and life commitments. This culture helps open up roles in the Trust to females who typically hold more caring responsibilities than males.

Improvements have been reported in the NHS Staff Survey of colleagues feeling their line manager treats them with compassion and is responsive to their individual needs. Creating a more compassionate and inclusive culture helps foster good relations for women and advances equality of opportunity.

Implemented NHFT Recruitment Ambassadors

Recruitment Ambassadors are trained to support recruitment panels at Band 8a and above. All recruitment to Director and Deputy Director posts have allocated Recruitment Ambassadors as a check and balance on the appointment process. Ambassadors are equipped with expertise and resources to help de-bias selection and improve the experience for all candidates. The Trust currently has circa 75 Recruitment Ambassadors actively working to improve our recruitment outcomes and give equality of opportunity for all in posts at senor levels of the Trust.

Inclusive Recruitment Interviews Course

At the start of 2024 a new course was co-produced with NHFT Staff Networks to train recruiting managers on inclusive practice. The course was designed to address the feedback shared on NHFT recruitment processes from our Staff Networks, Trade Unions and Freedom to Speak Up Guardian. The course has been delivered to all Executive Directors and has been rolled out to over 300 recruiting managers. Training attendance is recorded on the TRAC recruitment system allowing an analysis of compliance at Lead Recruiter and panel level.

De-biasing Recruitment Practices

Throughout the delivery of the Inclusive Recruitment Interviews course feedback has been taken from recruiting managers on areas of process which required review. Members of the People Team met to review best practice, access gaps and take action to de-bias NHFT policy and processes. Overseen by the Director of HR & OD a task and finish group was established, and a new recruitment policy with more inclusive processes was launched at the start of 2025.

Management Development

The NHFT Excellence in Leadership programme equips managers with the skills to lead their teams and progress their careers. Delivered over 4 days the programmes effectiveness is regularly monitored with post session reviews and follow up analysis at 6 months post completion.

In early 2025, the Trust launched the ‘Leading with Confidence & Compassion’ course for line manager. The one day course equips managers with the necessary people skills to effectively manage their team covering key HR policies included supporting appraisals, pay progression and career development. Active support for career progression and development is a key strategy in reducing the gender pay gap.

Ongoing Data Analysis

We regularly monitor data to assess metrics linked to the gender pay gap. Experience of work metrics feed into our engagement and inclusion plans. For example, we analysed the NHS Staff Survey results for 2024 for the NHS People Promise element of ‘We Work Flexibly.’ The results reported a Trust wide score of 7.04 which is above the benchmark average 6.83.

Female representation in senior positions in reported annually to NHS England. Representation on the Executive Board is currently at 50% (4 out of 8), 53% on the Foundation Trust Board of Directors (9 out of 17).

Proposal

NHFT are committed to reducing the gender pay gap within the Trust and implementing evidenced based actions to drive forward gender equality. The focus on growing our workforce and delivery of the NHFT people plan demonstrates the strategic intent to put people first in the Trust. The gender pay gap data is a metric by which we can measure success.

Decision Required

The Joint People Committee in Common and asked to review the NHFT Gender Pay Gap information and give a level of assurance on the actions taken to reduce the gap.

The committee are asked to note the change in reporting, to a joint LPT and NHFT report. This will commence in 2026 to report the gender pay gap as at 31 March 2026.

Governance Table

For Board and Board Committees:	Joint People in Committee in Common
Paper sponsored by:	Sarah Willis (Group Chief People Officer) Deborah Callaghan (Director of Workforce)
Paper authored by:	David Ledger (Senior People Specialist)
Date submitted:	11th February 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:	Report by 31st March 2027 to be received by the Joint People Committee in Common combining LPT and NHFT Gender Pay Gap information in one consistent reporting format
Link to Strategic Theme	Valuing Our People
Board Assurance Framework considerations:	None
Is the decision required consistent with NHFT'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:	The content of the report does not risk the safety of patients or the public
Equality considerations:	Advancing gender equality in relation to pay at NHFT

Leicestershire Partnership and
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J2

Alert, Advise and Assure Report

Joint People and Culture Committee in Common 9 April 2026

Key discussion points and matters to be escalated from the meeting

ALERT: Alert the Board to matters that need its attention or action, e.g. an area of non-compliance, safety or a threat to the Trust's strategy
None

ADVISE: Advise the Board of areas subject to on-going monitoring or development or where there is negative assurance
NHFT Valuing Our People Management Group Triple A: The committee discussed a marked increase in employee relations activity, particularly grievances and disciplinary cases. There was acknowledgement of the ongoing pressure that more activity is putting on the People Teams. This is being monitored and managed.

ASSURE: Inform the Board where positive assurance has been received
LPT Workforce Development Group Triple A: Substantive staffing remains stronger than planned, driven in part by good retention. Temporary staffing reflects the decision to open an additional ward outside the original plan despite this, agency usage is below plan and bank usage is slightly above. The sickness absence continues to be an area of focus for the team to try and get back to target. **Joint People Dashboard**: The committee highlighted their support for the dashboard that is improving each time we review it. There is now opportunity to look at meaningful comparisons and benchmarking for many of the metrics. Where there are differences these were explained. The additional "alignment" column has been introduced to the dashboard to show progress, with most metrics now assessed as aligned and rated green. This report is giving us all increased assurance across a growing number of People metrics. **LPT / NHFT Our People Data:** The LPT people pack introduced strengthened assurance on HR policy compliance, with selected metrics now clearly identified as directly linked to HR policies via a green shield indicator, supporting oversight of both compliance and effectiveness. Committee discussion focused on workforce plan delivery, particularly the gap between the planned 3% reduction and the actual 0.2% reduction achieved. Committee members requested clearer narrative and more consistent RAG ratings in future reports to explain variances, articulate mitigations and better link workforce decisions to the wider financial and operational context.

ASSURE: Inform the Board where positive assurance has been received
The NHFT people report highlighted the impact of the Notts and Lincs prison transfer, which increased headcount and temporary staffing requirements and is now transparently separated in reporting to allow comparison against the original workforce plan. NHFT continues to demonstrate strong performance on turnover, which remains in the lowest quartile and significant progress on agency price-cap compliance, with remaining breaches largely confined to transferred services. The high bank spend and the high employee relation data were discussed and explained. **LPT / NHFT Employee Relations Update:** For LPT the committee welcomed the strengthened transparency and analysis and requested continued development of the narrative, including clearer explanation of learning from cases, triage decisions into formal processes and mitigations in place, to support assurance and future external scrutiny. The Committee agreed it was assured by the report, subject to this continued refinement. For NHFT a significant rise in grievances was noted, particularly within corporate services and secured services following the Notts and Lincs transfer. The predominant themes relate to organisational change and process issues, including workforce changes associated with the value programme. This was recognised as an expected consequence of increased transformation activity and changes to established ways of working. Grievance activity is overseen through a monthly director-led employee relations case review meeting, providing active monitoring of volume, themes and progress. **LPT / NHFT Staff Survey Findings and Staff Survey Action Plans:** In LPT Overall, the Committee welcomed the strength of the results, the transparency around areas for improvement and the clear evidence that survey findings are being actively used to inform organisational priorities and wider wellbeing and culture initiatives. In NHFT the Committee welcomed the constructive narrative, strong response rates and clear linkage between staff survey findings and wider culture, leadership and wellbeing programmes across the group. Members requested that future reports include clearer contextual framing, consistent presentation across organisations and deeper analysis of specific staff groups and services with persistently lower scores, such as estates, medical and dental staff and students. Overall, the Committee recognised the progress made, the transparency around challenges and the clear organisational response underway and took assurance from the report. **Joint OD Culture and Leadership Update:** The Committee noted the paper as read and received assurance on progress toward establishing a single group Organisational Development and Staff Engagement function. The Committee endorsed the proposed direction of travel, supported the move to a single group OD and staff engagement function and acknowledged the importance of developing shared leadership capability, clarity of roles and accountability, in line with emerging national leadership frameworks and legal expectations. **LPT / NHFT Health and Wellbeing Updates:** The Committee received and took assurance from the joint Health and Wellbeing paper, noting it as the first consolidated report across the group in response to a previous request. The Committee commended the collaborative approach taken in producing the paper, noted the quality and coherence of the joint offer and agreed it provided appropriate assurance. It was recommended that future iterations further

ASSURE: Inform the Board where positive assurance has been received
strengthen insight on relative risk areas, managerial impact on wellbeing and access to and uptake of wellbeing support, as part of the continued maturation of group-level reporting. **LPT Accountability Framework Meeting Triple A:** The paper provides appropriate assurance that the detailed and granular matters are being reviewed and managed through the AFM forum. Members were particularly invited to note the Celebrating Outstanding section, recognising that organisational culture extends beyond formal programmes and is reflected in co-production, staff engagement and a clear focus on the wellbeing of the wider population. **LPT / NHFT Freedom to Speak Up Quarterly Updates:** In LPT: The Committee was advised that the number of Freedom to Speak Up cases has increased again this quarter, reflecting positively on staff confidence in the process and the effectiveness and visibility of the FTSU Guardians. Overall, no significant additional risks were identified, and the update was noted. In NHFT A total of 48 concerns were raised in quarter four, bringing the annual total to 182, the highest recorded for NHFT and consistent with levels seen across quarters one to three in 2025/26. This reflects increasing awareness and confidence in speaking up. Members noted leadership actions to strengthen communications around the value programme, staffing and financial change, recognising these as drivers of FTSU themes. With the full complement of NHFT Guardians now in post, there is an opportunity to further integrate and benchmark FTSU data across the group to compare themes and learning with LPT. The Committee recorded assurance overall and thanked the FTSU teams across both organisations for their work. **NHFT Revalidation Report Annual Sign Off:** The paper was endorsed by the Committee **NHFT Medical Staff Budget and Payment Audit:** The Committee received the paper for information and assurance, noting that it was produced in response to an internal audit presented to the Audit Committee on medical staffing budgets. Members welcomed the clarity of the response, recognised the value of independent audit in identifying system and process weaknesses, and were reassured that appropriate corrective actions are being progressed through the Audit Committee. **LPT Equality Delivery System (EDS) Domains 2 and 3 Grading Report 2025/26**: The Committee received the update on the Equality Delivery System (EDS), noting its statutory requirement and the grading exercise undertaken for LPT Domains 2 and 3 (workforce health and wellbeing and inclusive leadership). The grading was completed in January with engagement from 60 stakeholders and is based on 2024/25 data. NHFT’s EDS position was noted as already approved and published earlier in the year, with LPT slightly behind due to Domain 1 (services) not yet being completed. The Committee approved the findings of the grading exercise and noted that a full EDS rating will be published once Domain 1 is completed. **Joint Risk Report and BAF Summary:** The Committee noted this update as a holding position following the transition to a fully group Board Assurance Framework (BAF) from 1 April. The Committee acknowledged the learning from early application of the group BAF, including the need for clearer exposure of underlying organisational risks and noted that

ASSURE: Inform the Board where positive assurance has been received
further development and discussion will continue through upcoming workshops and future reports. **Joint Policy Framework:** The Committee noted the update on policy compliance as a business-as-usual assurance report. All Trust policies are currently in date, with clear visibility of those due for review in the next three months and those approved since the last meeting.

RISK: Advise the Board which risks were discussed and any new risks identified
None

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding
The committee highlighted the development of the Joint People Dashboard as a real benefit of the new Governance structure.

Author: Tim Harrison

Leicestershire Partnership and
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Group Trust Board in Public

28 May 2026

Together we thrive: Refreshing our Strategic Reporting and Assurance Framework.

Purpose of the Report

To seek Group Trust Board approval for our Together we thrive reporting framework, including the proposed strategic indicators, governance arrangements, assurance routes, and reporting approach.

The framework has been developed following the April Trust Board workshop, engagement through Executive Management Boards (EMBs), and discussions with Non-Executive Directors (NEDs), and has been refined through engagement prior to submission to Group Trust Board.

The paper also seeks endorsement of the proposed Committee-led assurance model to support consistent and transparent oversight of delivery against THRIVE.

Analysis of the Issue

During April's Group Trust Board workshop, we discussed the reporting for Together We THRIVE to strengthen alignment between strategic ambition, operational delivery, and Board assurance.

The revised approach has been designed to:

1. Strengthen assurance that delivery is aligned to strategic priorities;
2. Demonstrate measurable progress at the required pace of change;
3. Translate strategic ambition into clear, measurable indicators with defined trajectories and impact; and
4. Support concise reporting that strengthens strategic oversight while reducing duplication and excessive narrative.

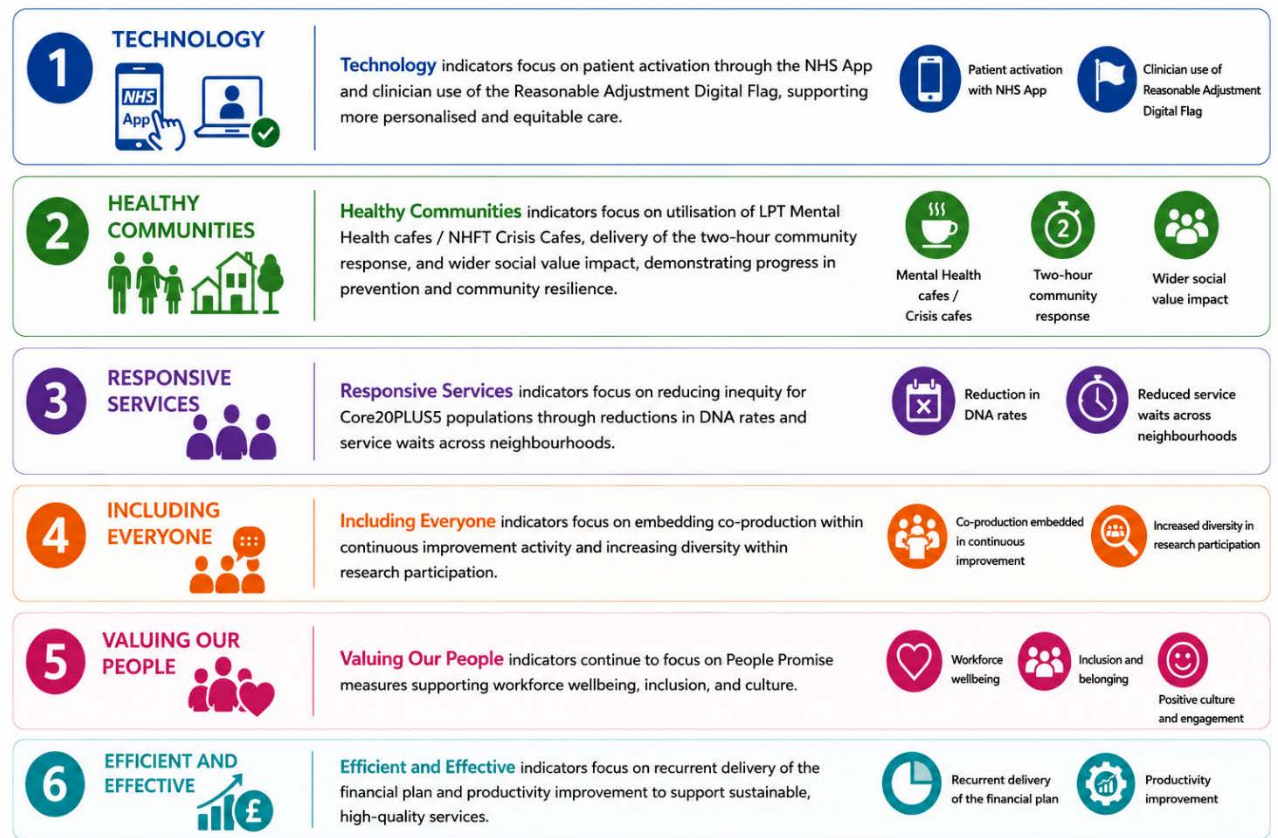
A concise suite of strategic indicators has been developed and engaged upon (attached).

The focus has been to maintain a small number of indicators that act as proxy measures for progress across THRIVE. This ensures reporting remains strategic, proportionate, and impactful, avoiding lengthy narrative reports that can become difficult to interpret when read in isolation and

involve many people and a lot of time to write and edit. The intention is to enable Group Trust Board to focus on strategic movement and organisational impact, rather than operational detail.

The indicators have been developed following discussions through EMBs and engagement with NEDs, ensuring the proposed framework reflects both operational deliverability and Board assurance requirements.

Collectively, the indicators provide a strong narrative demonstrating progress across all six **THRIVE** domains:



Importantly, the breadth of these measures demonstrates that THRIVE is not a standalone programme, but a whole-organisation strategic framework embedded across operational delivery, workforce, quality improvement, digital transformation, research, population health, and financial sustainability.

Committee ownership of indicators is proposed to strengthen governance, scrutiny, and confidence in reporting. This will enable detailed triangulation and due diligence through relevant Committees ahead of Trust Board reporting, ensuring discussions remain strategic and assurance-led.

The proposed approach will:

1. Strengthen alignment between strategy, delivery, and governance;
2. Improve transparency, accountability, and confidence in reporting;

3. Embed Committee-level scrutiny and ownership of indicators;
4. Provide clearer oversight of trajectories, risks, and delivery confidence; and
5. Support a consistent organisational narrative for Together We THRIVE.

Proposal

Group Trust Board is asked to:

1. Approve the final indicator set;
2. Support the proposed Committee-led assurance model, ensuring reporting timelines align with Board cycles and enable timely THRIVE updates.

Subject to approval, we will implement Together We THRIVE reporting from the next reporting cycle, subject to Committee reporting timelines.

Decision Required

The Group Trust Board is requested to:

1. Approve the refreshed Together We THRIVE indicator framework;
2. Endorse targets, data sources, and reporting routes;
3. Approve the Committee-led assurance and governance model; and
4. Support implementation of the refreshed reporting approach from the next reporting cycle.

Governance Table

For Board and Board Committees:	Group Trust Board in Public
Paper sponsored by:	Presented by Jean Knight Managing Director and Deputy CEO for LPT David Williams, Group Director of Strategy and Partnerships
Paper authored by:	Glyn Edwards, Group Head of Strategy and Partnerships
Date submitted:	20 May 2026
Name and date of other committee / forum at which this report / issue was considered:	Discussed in board workshops and in LPT & NHFT EMBs
Level of assurance gained if considered elsewhere	☒ Assured ☐ Partially assured ☐ Not assured

Date of next report:	Next Group Public Board
THRIVE strategic alignment:	☒ Technology ☒ Healthy communities ☒ Responsive ☒ Including everyone ☒ Valuing our people ☒ Efficient and effective
Board Assurance Framework considerations:	
Is the decision required consistent with the Group's risk appetite:	Yes
False or Misleading Information (FOMI) considerations:	Nothing identified
Positive confirmation that the content does not risk the safety of patients or the public:	Confirmed
Equality considerations:	Clear measures for the success of our THRIVE strategy ensure a focus on our organisational objectives including; healthy communities, valuing our people and including everyone.

Draft THRIVE Board indicators

Leicestershire Partnership and Northamptonshire Healthcare Associate University Group

Technology

T1 Increase the proportion of patients and carers supported to use digital tools to access records and manage care, where clinically appropriate and aligned to individual need, reaching 60% by 2030.

T2 Increase the consistent use of the Reasonable Adjustment Digital Flag to enable equitable, personalised access. (The improvement trajectory will be identified following the first report in September 2026)

Healthy Communities

H1 Increase the total numbers of people accessing our Mental Health cafes//Crisis cafes and increase our 2hour urgent community response to achieve and remain in the top quartile.

H2 Deliver year-on-year improvement in social value score, demonstrating increased prevention, independence and community impact.

Responsive

R1 Reduce inequalities in outpatient access (including Do Not Attend (DNA & Was Not Brought (WNB) rates) for Core20PLUS5 cohorts year-on-year, sustaining this rate to below 5% by 2030.

R2 Reduce average access waiting times year-on-year, sustaining national standard(s) by 2030.

Including everyone

I1 Monitor Continuous Improvement and Transformation programmes to ensure Co-production Charter principles are consistently embedded across all Group work areas.

I2 Increase participation from diverse and underserved communities in integrated mental and physical healthcare research year on year.

Valuing our people

V1 Achieve upper quartile performance across all 7 People Promise indicators, (compassion, inclusion, recognition, voice, safety, learning, flexibility, and teamwork),with year-on-year improvement in staff experience by 2030.

Efficient and Effective

E1 Deliver the financial plan with year-on-year improvement in recurrent efficiency and productivity, achieving a sustainable balanced position by 2030.

E2 Deliver year-on-year productivity growth, with activity increasing faster than cost, sustaining national upper quartile by 2030.

Committee report alignment

Leicestershire Partnership and Northamptonshire Healthcare Associate University Group

Indicator used for 2030 Ambitions	Committee	Source of data	Exec. Lead(s)
T1: Increase the proportion of patients and carers supported to use digital tools to access records and manage care, where clinically appropriate and aligned to individual need, reaching 60% by 2030.	Digital, Data & Technology Committee	Collated from Digital	Paul Sheldon
T2: Increase the consistent use of the Reasonable Adjustment Digital Flag to enable equitable, personalised access. (The improvement trajectory will be identified following the first report in September 2026)		SystmOne and BI teams	Linda Chibuzor
H1: Increase the total numbers of people accessing our Mental Health/Crisis cafes and increase our 2hour urgent community response to achieve and remain in the top quartile.	LPT: Finance Performance Committee NHFT: Performance Committee	MH service data and Model Hospital	LPT: Sam Leak LPT: Tanya Hibbert NHFT: Anne Rackham
H2: Deliver year-on-year improvement in social value score, demonstrating increased prevention, independence and community impact.		Rowntree Social Value score	David Williams
R1: Reduce inequalities in outpatient access (including DNA rates) for Core20PLUS5 cohorts year-on-year, sustaining this DNA/WNB rate to below 5% by 2030.	LPT: Quality and Safety Committee NHFT: Quality and Safety Committee	LPT: Thinking AHEAD app NHFT: Health Inequality Dashboard	LPT: Sam Leak, Tanya Hibbert NHFT: Anne Rackham
R2: Reduce average access waiting times year-on-year, sustaining national standard(s) by 2030.		Model Hospital	
I1: Monitor Continuous Improvement and Transformation programmes to ensure Co-production Charter principles are consistently embedded across all Group work areas.	LPT: Quality and Safety Committee NHFT: Quality and Safety Committee	Collated from CI programme	Linda Chibuzor
I2: "Increase participation from diverse and underserved communities in integrated mental and physical healthcare research year on year."		Collated from Research teams	LPT: Bhanu Chadalavada NHFT: Itai Matumbike
V1: Achieve upper quartile performance across all 7 People Promise indicators, (compassion, inclusion, recognition, voice, safety, learning, flexibility, and teamwork),with year-on-year improvement in staff experience by 2030.	Joint People Committee	People Promise survey	Sarah Willis
E1: Deliver the financial plan with year-on-year improvement in recurrent efficiency and productivity, achieving a sustainable balanced position by 2030.	LPT: Finance Performance Committee NHFT: Performance Committee	Financial Plan	LPT: Sharon Murphy NHFT: Paul Sheldon
E2: Deliver year-on-year productivity growth, with activity increasing faster than cost, sustaining national upper quartile by 2030.		Model Hospital.	

Current benchmarks

Leicestershire Partnership and Northamptonshire Healthcare Associate University Group

Indicator used for 2030 Ambitions	Current benchmark	Notes	Exec. Lead(s)
T1: Increase the proportion of patients and carers supported to use digital tools to access records and manage care, where clinically appropriate and aligned to individual need, reaching 60% by 2030.	New measurement.	Ambition of 60% by 2030	Paul Sheldon
T2: Increase the consistent use of the Reasonable Adjustment Digital Flag to enable equitable, personalised access.	The improvement trajectory will be identified following the first report in September 2026		Linda Chibuzor
H1: Increase the total numbers of people accessing our Mental Health/Crisis cafes and increase our 2hour urgent community response to achieve and remain in the top quartile.	NHFT: Score 4 LPT: Score 2.04	Crisis café data based on local data. UCR best in country score 1. Worst score 4.	LPT: Sam Leak LPT: Tanya Hibbert NHFT: Anne Rackham
H2: Deliver year-on-year improvement in social value score, demonstrating increased prevention, independence and community impact.	New measurement.	Adoption of Rowntree Dashboard	David Williams
R1: Reduce inequalities in outpatient access (including DNA rates) for Core20PLUS5 cohorts year-on-year, sustaining this DNA/WNB rate to below 5% by 2030.	NHFT: 6.8% (2025/26) LPT: 7.4% (2025/26)	NHFT: non Core 20 = 4.8% (25/26) LPT non Core20 = 5.1% (25/26)	LPT: Sam Leak, Tanya Hibbert NHFT: Anne Rackham
R2: Reduce average access waiting times year-on-year, sustaining national standard(s) by 2030.	NHFT: Score 3.33 LPT: Score 3.85	NOF - 52 wk Comm Services. Best in country score 1. Worst score 4.	
I1: Monitor Continuous Improvement and Transformation programmes to ensure Co-production Charter principles are consistently embedded across all Group work areas.	New measurement – to be collated from Continuous Improvement programme		Linda Chibuzor
I2: "Increase participation from diverse and underserved communities in integrated mental and physical healthcare research year on year."		Family and Friends Test	LPT: Bhanu Chadalavada NHFT: Itai Matumbike
V1: Achieve upper quartile performance across all 7 People Promise indicators, (compassion, inclusion, recognition, voice, safety, learning, flexibility, and teamwork),with year-on-year improvement in staff experience by 2030.	People Promise outcomes have been shared with Board	People Promise survey	Sarah Willis
E1: Deliver the financial plan with year-on-year improvement in recurrent efficiency and productivity, achieving a sustainable balanced position by 2030.	Agreed financial plan confirmed by board	Financial Plan	LPT: Sharon Murphy NHFT: Paul Sheldon
E2: Deliver year-on-year productivity growth, with activity increasing faster than cost, sustaining national upper quartile by 2030.	NHFT: 10.5% (Quartile 1) LPT:4.5 % (Quartile 2)	Model Hospital data. Non-peer average 4.8%. Peer average 4.5%	

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Group Trust Board of Directors – Public Meeting 28th May 2026

Group Value Programme update

Purpose of the Report

To update Group Board on progress towards a Group Corporate and Enabling Service across LPT and NHFT against the changing national and local financial context.

Analysis of the Issue

Context – Local and National
LPT and NHFT have savings targets of 6.5% for 2025/26 which was difficult to deliver and both trusts face a savings target of over 6% again in 2026/27.

Corporate and enabling services are a critical part of the team within both NHFT and LPT and are fundamental to delivering the Group strategy THRIVE and to support frontline staff to deliver safe and compassionate clinical services efficiently.

The total expenditure on Corporate Services is £23m in LPT and £24.8m in NHFT. The Corporate Services benchmarking return has again indicated opportunities to reduce costs by £15.9m across both trusts when compared to the lowest quartile. Key areas of opportunities are in Digital (£4.5m), People (£4.6m) and Corporate Nursing, Governance & Risk (£5.5m).

NHS England (NHSE) wrote to trusts in March 2025 to highlight growth in Corporate Service expenditure and the message was to reduce growth in Corporate Services by 50%.

It should be noted that admin teams directly supporting clinical teams remain outside of the scope of this programme.

Proposal

Progress to Date
The inception of the Group Value Programme in spring 2024 the programme delivered an initial rapid assessment by executive leads to ascertain what savings could be delivered. This included a subsequent detailed scope for each workstream to move to a joint team for their lead areas. These plans were assessed by executive teams with input from an external consultant and Non-Executive Directors from both trusts.

Steadily the programme has subsequently overseen changes which are summarised in appendix 1. The latest changes are in the following areas;

- Executive portfolio changes that have saved an additional £148k per year
- Corporate Governance

- Contracting

With full year effects from 2025/26 and new changes implemented across both trusts in 2026/27 the full year recurrent savings is estimated at £3.5m. This will be reduced as some changes being implemented in year and timescales are being finalised to refine the forecast savings.

Some of the recent changes have been enabled by the Mutually Agreed Resignation schemes run in both trusts. These changes have added resilience and stability as well as improving the overall service delivered but crucially made recurrent savings.

<u>Planned changes</u>

Further changes are in the pipeline with work near completion in the following areas;

- People directorates
- Procurement
- Project Management Office
- Corporate Nursing, AHP and Quality
- Business Intelligence
- Research & Innovation
- Learning & Development

It should be noted that changes the People Directorate are numerous with the timing of changes not all being at once.

<u>Transition Group</u>

In addition to the Transition Group meetings Group SEB has been meeting weekly on this topic to generate ideas and drive quick decision making.

The Transition Group meets monthly and is focused on considering and agreeing proposed changes and the identification and review of risks associated with the programme. Any proposed changes to teams are ultimately considered by Group SEB.

The key risks identified to date include;

- the lack of access to redundancy funding to enable change
- differences in approach from staff side
- management of change management policies
- overlap with trust's Value Programmes
- access to redundancy funding.

A key aspect of group changes is how current policies across the trusts differ. The Chief People Officer is developing a plan to set out the options to harmonise policies across the group. Any plan to bring policies closer together will be co-produced with staff side and other staff groups.

The process for to ensuring consistency when appointing to joint roles is in place and for the moment it remains that when a joint role is to go to panel it will be reconsidered by the evaluation panel for the employing trust will carry out the evaluation.

Keeping staff side informed of the direction of the programme along with key developments will remain a key feature of this work. The Chief Executive Officer, Chief Finance Officer and Chief People Officer have spoken on numerous occasions to Staff Side colleagues at both trusts to keep them up to date with progress of the programme and next steps of which they are broadly supportive. The Chief Finance Officer and Chief People Officer will continue to meet with staff side colleagues monthly.

Overall, the programme estimates recurrent full year savings of c.£3.5m. These savings are those which have been validated so far and are in addition to those delivered in previous years.

Decision Required

Group Board is asked to note the progress made in the Group Value Programme.

Governance Table

For Board and Board Committees:	Group Trust Board of Directors - Public Meeting
Paper sponsored by:	Paul Sheldon, Chief Finance Officer
Paper authored by:	Paul Sheldon, Chief Finance Officer
Date submitted:	07/05/2026
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:	
THRIVE strategic alignment:	☐ Technology ☐ Healthy communities ☐ Responsive ☐ Including everyone ☐ Valuing our people ☒ Efficient and effective
Board Assurance Framework considerations:	BAF04
Is the decision required consistent with the Group's risk appetite:	Yes
False or Misleading Information (FOMI) considerations:	None believed to apply
Positive confirmation that the content does not risk the safety of patients or the public:	There are no risks to the safety of patients or the public from this report
Equality considerations:	None believed to apply

Leicestershire Partnership and Northamptonshire Healthcare Associate University Group

NHS

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Headline Performance Report

May 2026

NHS Oversight Framework (2025-26)

Trust Overall Segmentation

Leicestershire Partnership and
Northamptonshire Healthcare
Associate University Group

Northamptonshire Healthcare FT		Leicestershire Partnership Trust	
Overall Trust Segmentation		Overall Trust Segmentation	
Adjusted segment Provider value Q3 2025/26 2 NOF Score		Adjusted segment Provider value Q3 2025/26 2 NOF Score	
NOF Segment awarded:	Two	**NOF Segment awarded:**	Two
Assessment Period:	Quarter Three; 2025-26	**Assessment Period:**	Quarter Three; 2025-26
Financial Override applied:	No	**Financial Override applied:**	No
Subject to Provider Improvement Programme:	No	**Subject to Provider Improvement Programme:**	No

NHS Oversight Framework (2025-26)

Organisational Scores – Overall Domain Scores

Leicestershire Partnership and Northamptonshire Healthcare Associate University Group

Domain Name	Northamptonshire Healthcare FT			Leicestershire Partnership Trust		
	Spectrum Bar	Direction of Travel (against Q2)	Organisational Scores		Direction of Travel (against Q2)	Spectrum Bar
Access to Services		⇧	3.54	2.94	⇩	
Effectiveness & Experience of Care		⇩	2.67	2.25	⇧	
Patient Safety		⇧	1.38	2.47	⇩	
People & Workforce		⇧	2.01	2.47	⇩	
Finance & Productivity		⇨	1	1	⇧	

NHS Oversight Framework (2025-26)
Organisational Scores – Sub Domain Scores

Leicestershire Partnership and Northamptonshire Healthcare Associate University Group

	Northamptonshire Healthcare FT					Leicestershire Partnership Trust
Access to Services	Spectrum Bar	Direction of Travel (against Q2)	Organisational Score		Direction of Travel (against Q2)	Spectrum Bar
% of people waiting over 52 weeks for community services		⇧	3.33	3.85	⇩	
Annual change in the number of CYP accessing NHS-funded MH services		⇧	3.74	2.04	⇩	
Effectiveness & Experience of Care						
CQC Community Mental Health Survey Satisfaction Rate		⇨	2	2	⇨	
% of inpatients with a length of stay exceeding 60 days (at point of discharge)		⇧	2.02	2.72	⇧	
% of Urgent Community Response patients seen within 2 hours		⇩	4.00	2.04	⇧	
Finance & Productivity						
Planned Surplus / Deficit		⇨	1	1	⇨	
Relative difference in cost		⇨	1	2	⇨	

NHS Oversight Framework (2025-26)
Organisational Scores – Sub Domain Scores

Leicestershire Partnership and
Northamptonshire Healthcare
Associate University Group

	Northamptonshire Healthcare FT					Leicestershire Partnership Trust
Patient Safety	**Spectrum Bar**	**Direction (against Q2)**	**Organisational Score**		**Direction (against Q2)**	**Spectrum Bar**
NHS Staff Survey – Raising concerns sub-score		⇨	1.5	1.75	⇨	
CQC Safe Inspection Score (if awarded within previous 2 years)	No Data (not awarded in previous 2 years)	**N/A**			**N/A**	No Data (not awarded in previous 2 years)
% of patients in crisis to receive face-to-face contact within 24 hours		⇧	1.25	3.19	⇩	
People & Workforce						
Sickness Absence Rate		⇧	2.72	2.9	⇩	
NHS Staff Survey – Engagement theme sub-score		⇨	1.3	2.05	⇨	

NB Direction arrows are as reported on the Model Hospital platform

NOF Narrative

Leicestershire Partnership and
Northamptonshire Healthcare
Associate University Group

NHFT

NHFT's NOF score in Q3 remains at Segment 2.

The Trust saw an improvement in its scores for:

- Access to Services
- Patient Safety, and,
- People & Workforce

There was a slight deterioration in:

- Effectiveness & Experience of Care (related specifically to UCR 2-Hour response – see below)

Specific areas of were related to low scores in the following areas

- Number of over 52 week waits in community services – these are predominantly related to dietetics services, community paediatrics, and speech and language therapy services. Forecasts to reduce these to zero by March 2029 are in place. Proactive work with system partners (in relation to Community Paediatrics and Dietetics) is underway, as forecasts are aligned to strategic ambitions for CYP Lead Provider models and LLNR's Obesity Prevention & Innovation Programme.
- Chance in CYP Access – this is showing an increasing trend as Mental Health Support Teams (Wave 11) come online. Colleagues are aware that this NOF indicator is due to be retired in 2026-27, but internal monitoring will continue.
- Urgent Community Response (2-Hour RTT) – Decline in performance was related to a change in reporting methodology in Q3, which has now been resolved. Performance in April was 84% (higher than previous levels and close to national average. Colleagues are aware that this NOF indicator is also due to be retired in 2026-27, but internal monitoring will continue.

LPT

LPT's NoF score in Q3 remained at Segment 2.

The Trust saw an improvement in its score in:

- Finance and Productivity
- Effectiveness & Experience of Care

And a slight deterioration in:

- Access
- Patient Safety
- People & Workforce

Specific areas of concern related to low scores in the following areas:

- Numbers of over 52 week waits in community services – these are exclusively children and young people awaiting a neurodevelopmental assessment. Plans are in place to deliver a reduction in these numbers, brining them down to zero by the end of March 2029.
- % of inpatients with a length of stay exceeding 60 days (at point of discharge) – this indicator covers mental health inpatient beds. An improvement plan is in place to support timely discharge, and this indicator is now showing an improving trajectory

Trust Performance Data
Workforce

Leicestershire Partnership and
Northamptonshire Healthcare
Associate University Group

Workforce		**NHFT**			**LPT**		
Indicator	*Period*	*Target / Ceiling*	*Current*	*Trend*	*Target/ Ceiling*	*Current*	*Trend*
Vacancy rate	Apr-26	**< 10%**	**10.2%**	⇧	**< 10%**	**9.4%**	⇩
Sickness Overall	Apr-26	**< 4.6%**	**6.0%**	⇩	**< 5%**	**5.2%**	⇩
Turnover (Rolling 12 Month)	Apr-26	**< 12%**	**7.1%**	⇩	**< 10%**	**6.3%**	⇩
Staff Appraisals % in last 12 months	Apr-26	**>= 90%**	**90.2%**	⇩	**>= 80%**	**94.5%**	⇩
Mandatory Training	Apr-26	**>= 85%**	**94.3%**	⇨	**>= 85%**	**98.5%**	⇩
Agency Spend (£000's) - In Month	Apr-26	**<= 464**	**465**	⇩	**<= 922**	**551**	⇩

Source: Trust Internal Board Reporting

Trust Performance Data
Mental Health

Leicestershire Partnership and Northamptonshire Healthcare Associate University Group

MH LT Plan & National Objectives*		NHFT			LPT			Regional Benchmark	National Benchmark	Benchmark Period
Indicator (Trust Level Ambition/ Trust Level Target)	*Period*	*Target / Ceiling*	*Current*	*Trend*	*Target/ Ceiling*	*Current*	*Trend*	*Midlands*	*England*	*Period*
CYP ED Waiting Times - Urgent	Mar-26	**>= 95%**	**92%**	↑	**>= 95%**	**93%**	↑	**82%**	**76.9%**	Mar-26
CYP ED Waiting Time - Routine	Mar-26	**>= 95%**	**55%**	↓	**>= 95%**	**90%**	↓	**77%**	**80.4%**	Mar-26
Number of people accessing Perinatal treatment (rolling 12 months)	Mar-26	**971**	**1,075**	↑	**1,259**	**1,275**	↑			
EIP 2-week RTT Performance	Mar-26	**>= 60%**	**75%**	↑	**>= 60%**	**75%**	↑	**67%**	**72.3%**	Mar-26
Out of Area Bed Days (rolling quarter)	Mar-26	**0**	**295**	↑	**0**	**15**	↑			
Patients discharged receiving follow up in 3 days	Mar-26	**>= 80%**	**97%**	↑	**>= 80%**	**96%**	↑	**74%**	**77.4%**	Mar-26
Data Quality - DQMI score**	Jan-26	**>= 95%**	**91%**	↓	**>= 95%**	**93.0%**	→	**73.5%**	**66.9%**	Jan-26
Data Quality - SNOMED CT	Mar-26	**100%**	**71%**	↑	**100%**	**100.0%**	→	**83%**	**69.5%**	Mar-26
Accessing Individual Placement & Support (IPS) (12-Month rolling)	Mar-26	**641**	**485**	↑	**798**	**775**	↓			
Mean Length of Stay at Discharge (Adult & PICU Inpatients) (Days)	Mar-26	**<=42**	**42**	↓	**<=42**	**45**	↓	**49**	**48**	Mar-26
Mean Length of Stay at Discharge (Older Adult Inpatients) (Days)	Mar-26	**<=63**	**74**	↑	**<=63**	**70**	↓	**84**	**96**	
Restrictive interventions per 1,000 bed days	Mar-26		**50**	Null		**45**	Null	**40**	**31**	Mar-26
Indicator (System Level Ambition/ System Level Target)										
CYP Access (12-month rolling) (MHSDS published)	Feb-26	**9,835**	**12,640**	↑	**17,745**	**18,525**	↓			
CYP Self-Rated Measurable Improvement (MHSDS)	Feb-26		**22%**			**44%**		**50%**	**50.8%**	**Nov-25**
Community Mental Health Access (2+ contacts) (12-month rolling)	Feb-26	**8,375**	**10,420**	↑	**6,802**	**16,140**	↑			
Adult Inpatients with Learning Disability and/or autism	Apr-26	**17**	**33**	↑	**32**	**24**	↓			
CYP Inpatients with Learning Disability and/or autism	Apr-26	**2**	**3**	↑	**4**	**3**	↑			

Points of note:

Data is provided from Mental Health Core Data Pack (NHS Futures) - Filtered by Org Type: Provider. Latest benchmarkable data is to February 2026.
Exception being Inpatient with Learning Disability and/or autism – this is taken from internal Trust Data latest April 2026.

Trust Performance Data
Community & Family

Leicestershire Partnership and Northamptonshire Healthcare Associate University Group

Community National Objectives		NHFT			LPT			Regional Benchmark	National Benchmark	Benchmark Period
Indicator	*Period*	*Target / Ceiling*	*Current*	*Trend*	*Target/ Ceiling*	*Current*	*Trend*	*Midlands*	*England*	*Period*
52+ Week Total Waiters	Feb-26		**1,526**	⇧		**7158**	⇧			
% of overall waits waiting over 52 weeks	Feb-26	**1.5%**	**9.8%**	⇧	**1.5%**	**35.1%**	⇧		**8.1%**	**Feb-26**
52+ Week Adult Waiters	Feb-26		**817**	⇧		**0**	⇨			
% of overall Adult waits waiting over 52 weeks	Feb-26		**6.8%**	⇧		**0.0%**	⇨		**1.2%**	**Feb-26**
52+ Week Children’s Waiters	Feb-26		**709**	⇧		**7158**	⇧			
% of overall Children waits waiting over 52 weeks	Feb-26		**20.0%**	⇧		**36%**	⇧		**26.1%**	**Feb-26**
2-hr Urgent Care Response	Feb-26	**>= 70%**	**81%**	⇧	**>= 70%**	**84.6%**	⇩		**85.0%**	**Feb-26**
Community Beds Length of Stay (LOS) (Days)	Apr-26	**38**	**35**	⇧	**23.5**	**23.5**	⇧			
Attended Community Care Contacts	Apr-26	**113,350**	**123,288**	⇩	**89,901**	**84,196**	⇩			

Points of note:
Data is provided from Community Health Services SitRep. Latest benchmarkable data is to February 2026.
Exception being with LOS and Care Contacts – this is taken from internal Trust Data latest April 2026.

Performance Narrative

Leicestershire Partnership and
Northamptonshire Healthcare
Associate University Group

NHFT

NHFT's sickness rate has improved for the third consecutive month to 6.0% and continues to be a Trust focus area (with target to reduce to 4.6% by March 2029). Vacancy rates will continue to fluctuate over the next quarter, as budget setting changes and new investments are finalised and applied to ESR for the new financial year.

Focus areas for mental health are concentrated on reducing out-of-area bed days, CYP eating disorder wait times, access to IPS and transforming care (LDA) inpatient numbers. Improvement plans are aligned to medium-term plan forecasts, and underpinned by a range of support mechanism, such as Productivity & Efficiency plans, system-level programmes (e.g. UEC) and national, ring-fenced funding (e.g. Individual Placement & Support).

52-week waits are a primary focus, with adult metrics tracking above national average. The largest proportion are waiting for Weight Management services, with business cases submitted to ICB and readiness to engage in the system's Obesity Prevention Innovation Programme in 2026-27.

LPT

LPT's workforce performance continues to be strong with only sickness absence above target. However, appraisal and mandatory training compliance whilst above target have shown some deterioration. A focus will continue in these areas to sustain / improve performance.

There is variable performance against mental health plan / national objectives. CAMHS eating disorder, IPS, Length of Stay and perinatal targets continue to be challenging with all three areas below target – all have improvement plans in place to support performance.

Waiting times and numbers waiting for children and young people remain the biggest challenge in community services. The driver for these long waits are children and young people waiting for ND interventions. Plans are in place to deliver a reduction in these numbers, brining them down to zero by the end of March 2029.

The Trust continues to perform well for the 2-hr Urgent Care Response and community length of stay.

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