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NHS
Leicestershire Partnership
NHS Trust

Public Trust Board – 28 July 2026
Declarations of Interest Report

Purpose of the Report

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

Board Member: Angela Hillery, Chief Executive Officer
Date of Annual Declaration: 2 April 2026

Current Declarations:	Declaration Reference	Date Interest Arose
Loyalty interests – Member and Chair of LLR MH Executive Board	6873	01.04.26
Loyalty interests – Member and Chair of Northamptonshire MHLDA Executive Board	6872	01.04.26
Loyalty interests – Mentorship role to various individuals within the NHS	6871	01.04.26
Loyalty interests – Member of Midlands & East CEO Forum	6808	11.02.26
Loyalty Interests - Member of Mental Health Supply Side Review Working Group	6713	17.12.25
Loyalty Interests - Son – Police Officer Northamptonshire Police	6712	17.12.25
Loyalty Interests – Nephew is Senior police officer at Northamptonshire Police	6711	17.12.25
Hospitality – NHS Providers - Two-day ticket to NHS Providers RECHARGE Conference 2025	6671	11.11.25
Hospitality – NHS Providers - Pre-conference dinner for NHS Providers RECHARGE Conference 2025, honouring Claire Murdoch	6670	10.11.25
Hospitality - Royal Society of Medicine Travel expenses	6436	22.07.25
Loyalty Interests - Executive Reviewer for Care Quality Commission	6435	21.07.25
Loyalty Interest - Member of Royal College of Speech & Language Therapists	6434	21.07.25
Loyalty Interest - Invited to be part of CQC/NHSP Trust Well Led Reference Group	6433	21.07.25
Loyalty Interest - Member of RCSLT Senior Leaders Network	6357	01.05.25
Loyalty Interest - Member of Advisory Group supporting NHSE- led by Sam Allen CEO (Management and leadership)	6046	30.10.24
Gifts – REACH Network	6006	31.10.24
Hospitality - UNAM-UK CIC	5754	13.07.24
Gifts – Proud2beOpsConference	4502	07.11.23
Hospitality – NHS Providers	4393	21.02.24
Loyalty Interests - Dale Hillery (husband) - property surveyor	4273	01.04.23
Loyalty Interests - Director of 3Sixty (On behalf of NHFT)	4108	01.04.23
Loyalty Interests - Member of NHS Employers Workforce Policy Board	4106	01.04.23
Loyalty Interests - Member of National Mental Health Programme Board	4105	01.04.23
Loyalty interests – Member of Midlands region CEO representative for national health working group	4104	01.04.23
Outside Employment – NHFT – Joint CEO	4068	14.11.23

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

Board Member: Jean Knight, Deputy Chief Executive Officer/Managing Director
Date of Annual Declaration: 11 May 2026

Current Declarations:	Declaration Reference:	Date Interest Arose:
Loyalty Interests – Daughter Detective Constable Northamptonshire Police	6595	01.09.25
Loyalty Interests – Age UK Northamptonshire	3663	01.04.23
Loyalty Interests – BLMK ICB	3662	01.04.23
Loyalty Interests – Ellis (formerly Berendsen)	3661	01.04.23

Board Member: Hetal Parmar, Non-Executive Director
Date of Annual Declaration: 17 April 2026

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

Board Member: Liz Anderson, Non-Executive Director
Date of Annual Declaration: 29 May 2026

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

Board Member: Josie Spencer, Non-Executive Director
Date of Annual Declaration: 11 May 2026

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

Board Member: Chris Skelton, Non-Executive Director
Date of Annual Declaration: 19 May 2026

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

Board Member: Tim Harrison, Non-Executive Director
Date of Annual Declaration: 25 May 2026

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

Board Member: Faisal Hussain, Chair of the Trust
Date of Annual Declaration: 8 June 2026

Current Declarations:	Declaration Reference:	Date Interest Arose:
Loyalty Interests – NHS Providers Shared Leadership Network	6950	08.06.26
Loyalty Interests – NHS Alliance Mental Health Chairs Network	6949	08.06.26
Loyalty Interests – Northamptonshire Healthcare NHS FT	6948	08.06.26
Loyalty Interests – Raising Health Charity	3200	01.07.22
Loyalty Interests – Spinal Injuries Association Enterprise	3146	25.08.22
Loyalty Interests – Spinal Injuries Association	912	24.02.22
Loyalty Interests – Seacole Group	911	24.02.22
Loyalty Interests – Disabled NHS Directors Network	910	24.02.22
Loyalty Interests – APNA NHS Network	909	24.02.22

Board Member: Melanie Hall, Non-Executive Director
Date of Annual Declaration: 12 May 2026

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

Board Member: Kate Dyer, Director of Governance and Risk
Date of Annual Declaration: 1 April 2026

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

Board Member: David Williams, Executive Director of Strategy and Partnerships
Date of Annual Declaration: 15 May 2026

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

Board Member: Sarah Willis, Group Chief People Officer
Date of Annual Declaration: 1 April 2026

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

Board Member: Sam Leak, Executive Director of Community Health Services, Families, Young People and Children's Services, Learning Disabilities and Autism
Date of Annual Declaration: 19 May 2026

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

Board Member: Tanya Hibbert, Executive Director of Mental Health
Date of Annual Declaration: 11 May 2026

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

Board Member: Sharon Murphy, Chief Finance Officer
Date of Annual Declaration: 7 May 2026

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

Board Member: Linda Chibuzor, Group Chief Nurse
Date of Annual Declaration: 12 May 2026

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

Board Member: Bhanu Chadalavada, Chief Medical Officer
Date of Annual Declaration: 22 May 2026

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

Board Member: Paul Sheldon, Group Chief Commissioning Officer
Date of Annual Declaration: 14 May 2026

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

Board Member: Anne Rackham, Group Chief Delivery and Integration Officer
Date of Annual Declaration: 29 April 2026

Current Declarations:	Declaration Reference:	Date Interest Arose:
Loyalty Interests – Member of leadership team at Grange Park Church	6954	01.04.26
Loyalty Interests – Personal friend works at NHFT (SALT)	6910	29.04.26
Loyalty Interests – Husband works at NHFT: LD Clinical Service Manager	6909	29.04.26

Decision Required

Briefing – no decision required

Governance Table

For Board and Board Committees:	Public Trust Board 28 July 2026
Paper sponsored by:	Kate Dyer, Director of Governance and Risk
Paper authored by:	Sonja Whelan, Corporate Governance Coordinator
Date submitted:	14 July 2026
Name and date of other committee / forum at which this report / issue was considered:	Not applicable
Level of assurance gained if considered elsewhere	☐Assured ☐ Partially assured ☐ Not assured
Date of next report:	July 2026
THRIVE strategic alignment:	☐ **T**echnology ☐ **H**ealthy communities ☐ **R**esponsive ☐ **I**ncluding everyone ☐ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	Not applicable
Is the decision required consistent with LPT's risk appetite:	Yes
False or Misleading Information (FOMI) considerations:	Considered
Positive confirmation that the content does not risk the safety of patients or the public:	Yes
Equality considerations:	Considered

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Unconfirmed

Leicestershire Partnership NHS Trust

LPT Trust Board

Minutes of the Public Trust Board meeting held 26 May 2026 at 9.30am via Microsoft Teams

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

In Attendance:
Tanya Hibbert, Executive Director of Mental Health
Sarah Willis, Group Chief People Officer
Kate Dyer, Director of Governance and Risk
Chris Skelton, Associate Non-Executive Director
Kamy Basra, Associate Director of Communications and Culture
Samantha Hamer, Deputy Chief Medical Officer
Zayad Saumtally, Head of Nursing, Allied Health Professionals and Quality
Sarah Morley, Deputy Director, Community Health Services

TB/26-7/001	**Apologies for Absence** Apologies for absence were received from Sam Leak, Anne Rackham, David Williams, Paul Sheldon, Bhanu Chadalavada and Liz Anderson. Deputies in attendance, and welcomed, were Sam Hamer, Zayad Saumtally and Sarah Morley. The Director of Nursing and Allied Health Professional Research Fellows and others observing via the livestream function were also welcomed.
TB/26-7/002	**Service Presentation: Perinatal and Maternal Mental Health Team (Directorate of Mental Health)** Tanya Hibbert introduced the service presentation which would focus on the Perinatal and Maternal Mental Health Team. The team presenting included Rosie Klair (Service Manager, Specialist Services), Natalie King (Team Manager), Dr Gillian O'Brady-Henry (Perinatal Consultant Psychiatrist and Medical Lead), Dr Joanne Herdman (Consultant Clinical Psychologist and Psychology Lead) and Dina Patel (Parent Infant Practitioner). Rosie Klair provided an overview of the service, which was established nationally by NHS England (NHSE) in recognition of the heightened vulnerability of women during the perinatal period (from conception to 24 months postnatally). It was noted that approximately 1 in 4 women experience mental health difficulties

during pregnancy or within the first 24 months of birth and, if left untreated, can have significant long term impacts on the individual, child and wider family; this is known as the 1001 critical days.

The service supports individuals experiencing moderate to severe mental illness including conditions such as antenatal and postnatal depression, anxiety, postpartum psychosis and PTSD. A whole family approach is central to service delivery, with collaboration across multiple partners including primary care, maternity services, health visiting, safeguarding, social care, secondary care, family hubs, inpatient mother and baby units, talking therapies and voluntary organisations. The service also provides signposting support for fathers and partners where required.

In addition to the core service, the Maternal Mental Health Service was outlined, which offered psychologically informed support for individuals experiencing tokophobia (fear of childbirth), birth trauma and perinatal loss.

Natalie King then provided an overview of the workforce and support arrangements and reported the service operated as a multidisciplinary team, including medical staff, psychological therapists, mental health practitioners and a social worker (social care perspective). A key feature was the inclusion of Parent Infant Practitioners, focusing on both parental mental health and the parent-infant relationship during the first 1001 days. Recently introduced Peer Support Worker and Lived Experience Partner roles had strengthened co-production and patient involvement.

The service was supported through partnership working including specialist midwife input, safeguarding support, and regular reflective practice for staff. In terms of activity, the service comprised 42 clinical staff (plus administration) who delivered approximately 900 appointments per month and received around 115 referrals per month. Response times ranged from 4 hours to 4 weeks depending on urgency. Caseloads included around 330 community patients and 220 outpatient cases. Service users were predominantly aged 20–45, with smaller numbers of younger patients supported jointly with the Child and Adolescent Mental Health Service (CAMHS). It was also noted that work to improve equality, diversity, and inclusion was ongoing, including collaboration with voluntary services and plans to establish an Equality, Diversity and Inclusion (EDI) group in order to raise awareness and improve access into the service.

Gillian O'Brady-Henry outlined the national perinatal mental health standards and the service's performance against access targets. The NHS Long Term Plan and National Perinatal Mental Health Strategy aimed to ensure that women experiencing moderate to severe perinatal mental health difficulties were able to access specialist services from pregnancy through to 12-24 months postpartum. Based on national projections, approximately 10% of women giving birth were expected to require support which equated to 1,259 women within the LLR population. It was reported that the service had previously struggled to meet the access target post-Covid, but following service improvements and organisational development, the target had been consistently achieved since the end of January.

Also summarised was the Perinatal Quality Network (PQN) standards, developed by the Royal College of Psychiatrists, which guided delivery of safe, high-quality, and compassionate care and these were structured around seven core domains:-

- Access and referral
- Assessment
- Discharge and transfer of care
- Care and treatment
- Rights, infant welfare and safeguarding
- Staffing and training
- Recording and audit

It was noted that the PQN accreditation process involved external review and peer assessment. The service underwent a PQN review in October 2023, which included feedback from staff, patients, families and partner agencies; feedback from patients was reported as highly positive. The service was preparing for its next PQN review in 2027, with plans to complete a self-assessment against the standards in advance.

Joanne Herdman advised that rapid service growth and the impact of Covid-19 had led to challenges in staff morale, retention, and team cohesion, prompting a programme of organisational development. It was reported that this programme, supported by the Trust and external facilitation, had focused on leadership, team culture, training, staff wellbeing and roles and responsibilities. The outcomes included the development of a team canvas which was co-produced with staff and which set out shared values, behaviours, roles and expectations, and the introduction of team time out sessions to support reflection and team development.

Rosie Klair reported on the impact of the organisational development programme undertaken over the previous 12 months regarding improvements to team culture and staff support. To monitor cultural change and staff experience, the service had implemented an anonymous local staff survey, initially conducted monthly for six months and subsequently on a quarterly basis. The survey enabled staff to rate their experience against five consistent measures, supported by free-text feedback. The findings demonstrated a marked improvement in staff experience over time, with increased scores indicating that staff felt the team was functioning more effectively, there was greater psychological safety within the workplace and their feedback was being heard and acted upon. This remained an ongoing programme, with survey feedback continuing to inform service improvements. Rosie Klair then presented patient and staff experience accounts via pre-recorded videos, which illustrated the practical impact of these improvements on service delivery.

A service user described a highly positive experience of care, with access to psychiatric support, medication, and psychological therapy contributing to significant recovery. The individual reported feeling supported and listened to, with improved confidence, wellbeing, and the ability to engage positively in parenting and everyday life. The service user also reflected about limited awareness of the service during pregnancy and early engagement with primary

	care as well as initial fears about potential child removal and suggested the need for clearer reassurance about this particular anxiety. The staff experience feedback further reinforced the positive impact of the organisational development work. The value of clinical supervision and multidisciplinary working in supporting safe and holistic care, feeling well supported by colleagues and leadership, reducing isolation in decision-making and access to ongoing training and development opportunities was highlighted. Additional insight was provided into the Parent Infant Practitioner role, which supported the parent-infant relationship through antenatal preparation and transition to parenthood, postnatal support with bonding, play, and parenting confidence and guidance on infant care and development. The Chair thanked the team for a comprehensive and insightful presentation and noted the significant impact of the service within local communities and highlighted how the work clearly demonstrated delivery of the Trust's THRIVE Strategy, particularly in relation to supporting healthy communities and amplifying both patient and staff voice. He further commended the development of the Team Canvas – a tool to help improve team learning and development, and culture, through continuous improvement - and the focus on staff morale and organisational improvement. Questions and comments were then invited. Angela Hillery thanked the team for the presentation, commending the scale of transformation achieved, improvements in access, and the positive staff and patient experiences described and asked how decisions were made regarding which practitioners worked with individuals and families, given the breadth of the multidisciplinary team. In response, Gillian O'Brady-Henry explained that following initial assessment, cases were discussed at the multi-disciplinary team (MDT) meetings where input from different professional groups, including medical staff, was considered to determine the most appropriate support. Joanne Herdman added that a stepped care model was in place for psychological input; all staff were trained in core psychological skills, ensuring early intervention, with MDT discussions and psychology consultation used to determine when more specialist psychological support was required. Natalie King further clarified that care allocation was dynamic, with practitioners able to join or step back at different points in a patient's journey. This included flexibility to involve parent infant practitioners, peer support workers, occupational therapists, or nursing staff as needs evolved, with changes agreed through MDT discussions. Josie Spencer queried how the service was working with primary care to ensure equitable access, noting the service user account where referral had not occurred via a GP. In response, Rosie Klair advised that the service worked closely with primary care, including support from a named GP lead for perinatal mental health, delivery of training and awareness sessions, improvements to website information, and the introduction of an electronic referral process but acknowledged that awareness-raising was an ongoing activity to also involve the voluntary sector and community organisations. The Chair asked whether the service was engaging with wider informal networks,

	including community groups and schools, to further disseminate information. Rosie Klair confirmed that strong links existed with community groups, family hubs, neighbourhood leads and health visiting services but advised that work with schools was not currently in place; however this could be considered further including through the developing co-production group. Gillian O'Brady-Henry added that the service worked closely with University Hospitals of Leicester maternity services, including shared pathways and input into an antenatal mental health clinic, supporting a joined-up, holistic approach to care. Jean Knight commended the team on the significant transformation achieved within the perinatal mental health service, noting clear improvements in team cohesion and staff support since her visit 18 months earlier. Rosie Klair thanked her for her ongoing support throughout the improvement journey. Sharon Murphy thanked the team for the presentation and commented positively on the Team Canvas, particularly the focus on staff health and wellbeing, and asked whether progress had been made in relation to providing quiet spaces for staff to take breaks, recognising the importance of this for staff support. In response, Joanne Herdman confirmed that progress had been made despite limited estate and advised that office space had been reconfigured to create a dedicated conference and break space, with protected lunchtime access, enabling staff to step away from the main office environment. She reported that this had been clearly communicated to staff and was viewed positively. Linda Chibuzor congratulated the team on the scale of service delivery, highlighting the high volume of referrals and appointments as particularly impressive. Drawing on her previous experience with perinatal services and accreditation work, she emphasised the importance of community-based perinatal services in providing personalised and culturally responsive support to women and families. She noted the anxiety many mothers experience, particularly regarding separation from their babies, and commended the team for delivering compassionate, tailored care. Tanya Hibbert expressed strong pride in the team, highlighting their patient-focused approach, mutual support and effective teamwork and noted that the perinatal team was viewed as an example of good practice across the Directorate of Mental Health. The Chair endorsed these comments, highlighting the team's response to periods of low morale and challenge during and following Covid-19, and noted that there were clear learning opportunities for the wider organisation, particularly in relation to sharing and replicating good practice and on behalf of the Board, asked that thanks be conveyed to all staff within the service for their continued commitment and high-quality work.
TB/26-7/003	**Questions from the Public (verbal)** There were no public questions.
TB/26-7/004	**Declarations of Interest (Paper A)** There were no declarations of interest in respect of items on the agenda.

	The Board received this report and noted the declarations of interest contained within. **Resolved**: The Board received this report for information and assurance.
TB/26-7/005	**Minutes of the previous public meeting held 31 March 2026 (Paper B)** The minutes were approved as an accurate record of proceedings. **Resolved:** The Board approved the minutes.
TB/26-7/006	**Matters Arising (Paper C)** All items were confirmed as complete and presented for closure. **Resolved:** The Board approved the closure of all actions.
TB/26-7/007	**Trust Board Workplan 2026/27 (Paper D)** The Trust Board Workplan was presented for information. No questions or queries were received.
TB/26-7/008	**Chair's Report (Paper E)** The Chair presented this report which summarised Chair and Non-Executive Director (NED) activities and key events relating to the well-led framework for the period April to May 2026. Attention was drawn to the following key points: • A recent meeting with Nursing and Allied Health Professional Fellows – the breadth and quality of their research projects was noted and the anticipated positive impact on the communities served. • The NED membership including committee roles and responsibilities had been updated to reflect recent changes. • The success of a joint nursing conference where strong engagement, networking and knowledge-sharing demonstrated at the event emphasised the importance of such forums in supporting collaboration across organisations. • Congratulations were offered to Angela Hillery on her continued recognition in the Health Service Journal (HSJ) Top 50 NHS Chief Executives, noting her consistent placement within the Top 5, and Angela Hillery acknowledged the wider team's contribution to this achievement. **Resolved:** The Board received this report for information.
TB/26-7/009	**Managing Director's Report (Paper F)** Jean Knight presented this report which provided an update on current local developments since the last Board meeting. Key points highlighted were: • The CQC unannounced inspection of the Specialist Children and Young People's Mental Health Teams in November 2025 had resulted in an overall rating of Good, which was commended as a testament to the teams' hard work. • The Community Mental Health Teams had also been re-inspected in January 2026, with the outcome again rated Good, recognising the significant effort involved and the positive impact on the LLR population.

	• The Trust had achieved the Triangle of Care Star 2 Award, recognising sustained commitment to supporting unpaid carers and aligning strongly with the Trust's strategy and partnership approach to healthy communities. • The International Nurses Day celebration had been well received, with positive feedback received, and thanks were extended to Linda Chibuzor and her team. • During Mental Health Awareness Week, extensive community engagement activity had taken place, with over 1,000 people engaged, demonstrating strong outreach beyond internal promotion. Further detail would be shared at a future Board meeting. • The Group Talent Matters Programme had launched, supporting progress towards a fully inclusive workforce, with anticipated outcomes to be reported to the Board in due course. • Friends and Family Test results demonstrated that LPT continued to benchmark favourably. • The Trust had achieved notable success at the Health Service Journal Digital Awards, including: – A joint award for Improving Mental Health Through Digital (LPT's ChatHealth and NHFT's Crisis 24/7 service) – The Partnership Award for Driving Interoperability and Digital Standards for the LLR Shared Care Record – Recognition for the LLR Improving Out-of-Hospital Care Through Digital Jean Knight concluded by thanking all staff for their dedication and hard work in delivering high quality care, particularly in challenging conditions, and invited any questions from the Board. Melanie Hall shared a personal reflection based on her lived experience as a carer and commended services across the Trust for their delivery of the Triangle of Care. She reported consistently positive experiences over the previous six to eight months, noting that she had always felt included as part of the care process and that the impact on families was appropriately recognised. She described the quality of care provided to both carers and service users as outstanding. The Chair thanked Melanie for sharing her experience and noted that this feedback aligned with learning shared elsewhere within the organisation, including recent presentations on the Triangle of Care. Chris Skelton sought clarification regarding wording in the Medium-Term Plan and Five-Year Strategic Commissioning Plan, specifically in relation to compliance being assessed as conditional due to non-compliance and activity submissions. In response, Jean Knight explained that this related primarily to waiting times, particularly within children's neurodevelopmental services, and that work was underway to develop plans to reduce waiting times to acceptable standards within the agreed timeframe. The Chair thanked colleagues for their contributions. **Resolved**: The Board received this report for information.
TB/26-7/010	**Environmental Analysis (verbal)**

	Angela Hillery advised that the Rt Hon James Murray MP had been appointed as Secretary of State for Health and Social Care on 14 May 2026.
TB/26-7/011	**Audit and Risk Committee AAA Report: 17 April 2026 (Paper G)** Hetal Parmar presented this report and drew attention to the following key points:- • The advisory item relating to the annual accounts remained unchanged from the previous report as the accounts were still progressing through the audit process; this item had been retained for consistency. • Significant assurance had been received through the Interim Head of Internal Audit Opinion. • The draft annual accounts presented confirmed that the Trust had met its statutory duties and delivered a planned surplus and thanks were extended to the finance team for this achievement. • The Trust had achieved 100% completion of high and medium risk internal audit actions, which was benchmarked as outstanding when compared with other organisations. Kate Dyer added that the 100% follow-up rate demonstrated a strong organisational commitment to learning from internal audit and acting on third party assurance. She clarified that the Trust had not received any high risk internal audit actions during the year and that the timely completion of actions reflected a positive improvement culture across the organisation. **Resolved:** The Board received this report for information and assurance.
TB/26-7/012	**Quality and Safety Committee AAA Report: 21 April 2026 (Paper H)** Josie Spencer presented this report and highlighted the following key points:- • An ongoing alert remained in place in relation to neurodevelopmental waiting times. The committee discussed the potential adoption of the Portsmouth Model of Care. Further assurance was sought regarding quality, safety, and financial implications. A detailed discussion on the proposed model would be scheduled for a forthcoming Board Development Session. • The complaints improvement plan and target of achieving 90% compliance with complaint response times by the end of March had not been fully met. However, a 23% improvement had been achieved over the year, reflecting significant progress, and work continued to improve performance further. • A concern raised through the Health and Safety Committee regarding the use of personal safety equipment by staff was highlighted. This issue was being progressed through a task and finish group to ensure staff safety and appropriate use of provided equipment. • A draft Group Quality Framework had been received for information, with a fuller version expected in June, which was welcomed by the Committee. • Items closed by the Committee: – Audiology improvement work - the majority of immediate and short-term actions had been completed. The Committee was assured of progress and agreed that the remaining longer-term work could be managed through business as usual arrangements, with escalation if required.

	– Safeguarding improvement plan - all remaining actions linked to the previously agreed plan with the former ICB had been completed and the item was closed, to be monitored through routine processes. • Celebratory items included the Integrated Crisis Response Service (hosted by the Local Authority with significant LPT input) which had received an Outstanding rating from the CQC and the Clozapine patient improvement work which was highlighted as good practice. Following the update, Angela Hillery emphasised the importance of retaining the Board alert on 52-week neurodevelopmental waiting times as it remained a significant challenge both locally and nationally. It was acknowledged that this was a longstanding issue across the NHS but encouragement from the innovative models of care being explored was highlighted. Also noted was the importance of ensuring that pathways were clearly embedded across the wider NHS system and it was confirmed that Jean Knight was engaging with regional colleagues across the East Midlands and Midlands and East to support shared learning and collective approaches. Josie Spencer advised that the QSC had explicitly considered whether to remove the alert and had agreed to retain it, recognising both the historical nature of the challenge and the scale of improvement work underway. She expressed encouragement at the progress being made, despite the complexity of the issue. Melanie Hall added that, from the perspective of the Finance and Performance Committee (FPC), the focus was on how waiting times were being addressed, alongside assurance that people were being supported while waiting. She advised that, given the strength of the improvement activity observed, the committee had not designated waiting times as an alert within its remit. Kate Dyer informed the Board that a pilot of an enhanced AAA reporting approach was being rolled out to better track previously alerted items, providing improved visibility of progress and assurance over whether issues should be re-alerted or monitored through ongoing oversight. The Chair welcomed the pilot, noting that it strengthened assurance by clearly tracking progress against previously identified risks. **Resolved:** The Board received this report for information and assurance.
TB/26-7/013	**Safe Staffing Monthly Report (Paper I)** Linda Chibuzor presented this report which provided a full overview of nursing safe staffing during the month of March 2026. The key points were highlighted as:- • The Trust continued to report staffing and activity data on a monthly basis to include inpatient activity • Nurse-sensitive indicators were routinely reviewed to assure staffing safety • A summary position on vacancy rates was included within the report, based on data for March 2026, noting that reporting was not presented ahead of the reporting period.

	• There was an ongoing reduction in the use of temporary staffing, with reassurance provided that temporary staff were only used where required to maintain patient safety, such as during periods of enhanced observations. • Biannual establishment reviews were underway, with data collection and review in progress, and outcomes to be reported once finalised. • The report had also been considered by the Executive Management Board, providing additional oversight and assurance. Linda Chibuzor concluded by assuring the Board that, while there remained areas under active management, the Trust was compliant with safe staffing requirements and continued to prioritise patient and staff safety. **Resolved:** The Board received this report for information and assurance.
TB/26-7/014	**Patient Safety and Learning Assurance Report (Paper J)** Linda Chibuzor presented this report which provided assurance of the efficacy of the incident management and Duty of Candour compliance processes. Incident reporting supporting this paper had been reviewed and refreshed to assure that systems of control continued to be robust, effective, and reliable thus underlining the commitment to continuous improvement of incident and harm minimisation. Key areas were highlighted as:- • The report set out the top five reported patient safety incidents for the period March and April, alongside analysis of the degree of harm associated with incidents. • It was noted that the Trust continued to demonstrate a strong reporting culture, with the majority of incidents reported as no-harm, and far fewer incidents resulting in moderate or severe harm. • Although suicide did not feature within the top five reported incident themes, all suicides were reviewed for themes, trends, and learning, with actions taken forward as appropriate. • Benchmarking of incident reporting had been explored; however, it was highlighted that NHS England did not recommend benchmarking through the Learning Improvement Tool, due to variation in reporting themes and population groups across organisations. • Increased levels of reporting were not indicative of poor care but instead reflected the inclusion of near miss reporting, which supported prevention and organisational learning. • The report included specific information on no-harm incidents, reinforcing the Trust's proactive approach to safety. • Updates were provided on patient sexual safety, complementing previous discussions on staff safety, alongside information on learning from deaths. • Progress updates were included on clinical investigations and the status of incident reviews. Sharon Murphy noted the reference within the report to the medicines amnesty undertaken in March and asked whether the planned evaluation would include consideration of the potential benefits of running the amnesty more frequently that once a year. Linda Chibuzor confirmed this suggestion would be considered as part of the evaluation.

	Resolved: The Board received this report for information and assurance.
TB/26-7/015	**Thriving through Transformation: A year in review 2025/26 (Paper K)** Kate Dyer presented this report as an opportunity for Board to reflect on delivery of the Trust's transformation programme over the previous year. The report provided a comprehensive overview of good-news stories and spotlight reports, highlighting delivery across clinical directorates and priority workstreams, including digital transformation, people, estates and infrastructure programmes, waiting list initiatives, central access point developments and peer support worker programmes. This demonstrated the scale and reach of transformation activity delivered during the year and its relevance across portfolios. Josie Spencer commented positively on the report and raised a specific question regarding the space utilisation project, recalling previous Board Development discussions on reducing the Trust's estate footprint, and asked for an update on whether similar space utilisation initiatives were being rolled our more widely beyond localised management and individual teams. In response, Jean Knight confirmed that space utilisation was a regular area of discussion at the Executive Management Board (EMB) and that a range of initiatives were already underway to maximise estate usage while ensuring appropriate and confidential space for staff, particularly clinical teams. Jean Knight also commented on the report, welcoming its inclusion within the Board pack and explained that the content was drawn from the annual review undertaken by the Transformation and Quality Improvement Group of which she was Chair. Future work would place greater emphasis on measuring impact and outcomes, with clearer evidence of the benefits delivered through transformation initiatives. Melanie Hall added that FPC also received updates on estates, space utilisation and related initiatives, which aligned with the transformation work outlined and commented that the report clearly reflected progress across strategic priorities. Tim Harrison commented on the breadth and scale of activity described in the report noting the strong sense of momentum conveyed and suggested there may be opportunities to present the information in a more visual format to support wider communication and impact. **Resolved:** The Board received this report for information.
TB/26-7/016	**Finance and Performance Committee AAA Report: 23 April 2026 (Paper L)** Melanie Hall presented this report and highlighted the following key points:- • The Committee had considered three alerts from the Collaborative Commissioning and Contracting Group, all relating to changes and challenges within the partnership landscape. The Committee had been assured by the actions in place to mitigate the associated risks. • The previously reported SDF funding alert was confirmed as fully resolved and no longer an issue. • The Committee had advised the Board on matters relating to ADHD pathways, noting alignment with discussions already held at the Quality and

	Safety Committee and the agreed approach to consider this further at a Board Development Session. • Under the assure section, the Committee had undertaken a review of the draft annual accounts, including a focused discussion on loss making services. It was agreed that a further update on actions taken would be brought to a future Board meeting. • A detailed deep dive into neighbourhood working had provided strong assurance, with evidence of extensive engagement, a clear focus on inequalities, and significant progress being driven across multiple teams. • The Committee had retrospectively reviewed Exercise Echo One, a cyber security desktop exercise undertaken last autumn. Assurance was received on the lessons learned, the associated action plan, and the Trust's approach to cyber resilience, including alignment with the wider LLR and Northamptonshire system response. • The Committee reviewed the Board Assurance Framework (BAF), with particular focus on BAF01 (cyber security) and agreed that in addition to routine AAA reporting, bi-annual deep dives into cyber risk and mitigation would be undertaken to strengthen oversight. • A further deep dive into the strategic estates project was undertaken, covering space utilisation and estates management from a whole-system perspective, highlighting the complexity of the programme alongside the ambition and progress being made. • Celebratory items included the transformation report and the successful award of NHS England funding for a digital medicines consultation service. Tim Harrison welcomed the update on neighbourhood working but raised a point regarding feedback he had recently received from GP colleagues, including those in Leicestershire. He reported that there was anxiety within primary care about neighbourhood models potentially transferring complex, hospital level workload into general practice. He asked how the Trust was ensuring that primary care voices were being heard and meaningfully involved, given the size and importance of the primary care workforce as a gateway into healthcare. In response, Melanie Hall provided the FPC's perspective, confirming that engagement with GPs and primary care had been discussed. She acknowledged that while there were examples of strong and progressive engagement in some areas, this was not yet consistent everywhere and advised this remained work in progress Jean Knight advised that neighbourhood development was being progressed as a system led initiative, rather than being driven solely by LPT. She emphasised that models were being shaped around population health needs at neighbourhood level and confirmed that primary care would be integral to this approach. She highlighted engagement with Leicestershire County colleagues, including GPs, and noted that similar approaches were being taken across Leicester City and Rutland. She further advised that an ICB Board member, was closely involved in this work and expressed confidence that neighbourhood development would continue collaboratively to deliver the best outcomes for local populations. The Chair added further reassurance, noting that neighbourhood working had been discussed at recent Chairs and Chief Executives system meetings across

	Leicestershire and Northamptonshire. He confirmed that these discussions had placed strong emphasis on ensuring that primary care was actively involved and not subject to decisions being imposed upon it. He stated that system wide ways of working were becoming increasingly collaborative. Angela Hillery added that regular engagement also took place through clinical system leadership meetings, which included primary care representation. She noted increasing recognition of the importance of primary care within regional discussions, particularly where it had previously been under represented, and described this as an encouraging development likely to influence local delivery positively. Josie Spencer referred to an item within the report concerning the Collaborative Commissioning and Contracting Group, which noted quality matters relating to a community provider for people with learning disabilities and autism across LLR, and sought clarification on whether these matters were being managed through an established partnership level quality governance mechanism and whether they required any additional consideration through the Trust's internal QSC. In response, Jean Knight explained that learning disability and autism services were overseen through the LLR Collaborative, which included multi-agency representation and provided oversight across quality, finance and performance. She confirmed that there was a robust governance structure in place, comparable to Executive Management Board oversight, ensuring comprehensive review of issues. Linda Chibuzor confirmed there were multiple workstreams covering mental health, learning disabilities, and autism, each with embedded quality and safety representation. She advised that she attended the Joint Collaborative Commissioning Group to provide a Trust wide quality and safety perspective, alongside Medical Director representation. She confirmed that any significant issues were reported by exception to the Quality and Safety Committee, ensuring appropriate escalation where required. Hetal Parmar then commented on Exercise Echo One noting that both the paper and the exercise itself had been of a high standard. The exercise had identified valuable learning opportunities while also demonstrating that many elements had worked well and highlighted the importance of tabletop exercises in preparing the organisations for specific scenarios. **Resolved:** The Board received this report for information and assurance.
TB/26-7/017	**Finance Report – Month 1 (Paper M)** Sharon Murphy presented this Month 1 Finance Report, noting that, as is typical at this stage of the financial year, the report was presented at a higher level summary due to the ongoing external audit of the accounts. As a result, the report focused primarily on the pay position which represented over 80% of the Trust's costs. The following key points were highlighted:- • As at Month 1, the Trust was reporting delivery of its planned financial position, reflecting a £522k deficit, in line with plan. • Some directorate overspends were evident, largely attributable to the phasing of Cost Improvement Plans (CIPs) against actual delivery early in the year. It

	was expected that over-delivery later in the year would offset early under-delivery. • Work to finalise specific CIP schemes for 2026/27 was ongoing, with identified values continuing to increase; the forecast outturn shown in Appendix B had improved by over £1m since the paper was prepared. • Consistent with previous years, the Trust planned to deliver a deficit in the first half of the financial year, peaking at £2m in Month 6, before improving month-by-month to achieve break-even at year end, which remained the forecast position. • Agency spend was slightly above plan in Month 1, driven by registered nursing and community teams covering long-term sickness and vacancies. Recruitment plans were in place, and agency usage was expected to reduce in future months. • Performance against the Better Payment Practice Code (BPPC) had continued to improve, with all targets achieved in Month 1 and performance exceeding the 95% threshold, building on improvements made in the previous financial year. • Capital expenditure was identified as a significant risk area for 2026/27 due to the late approval of NHS England funding allocations, including those relating to constitutional standards and left-shift programmes. Although allocations had now been approved, further processes were required to release cash, creating potential challenges in spending the full allocation within the financial year. This issue was shared across the system and had been discussed at the first meeting of the expanded Leicester, Northamptonshire and Rutland Capital Committee, with the intention of monitoring and, if necessary, escalating concerns collectively to NHS England. • Capital spend was reported as lower than plan in Month 1; however, this reflected the original plan submitted to NHS England in February, which assumed earlier receipt of capital funding. A revised capital spend trajectory would be included in the next report to provide clearer internal tracking against updated expectations. **Resolved:** The Board received this report for information and assurance.
TB/26-7/018	**Integrated Performance Report – Month 1 (Paper N)** Jean Knight presented this newly format integrated performance report which provided an overview of the Trust's performance against Key Performance Indicators (KPIs) for April 2026. The report was designed to bring all elements of Trust performance together in a single, comprehensive view, providing clearer oversight. The report would continue to evolve and would include the incorporation of new National Oversight Framework (NOF) metrics. Key areas highlighted included:- • Improved performance within community stroke and neurology services, cognitive behavioural therapy (CBT) and children's physiotherapy. These improvements reflected reductions in waiting times and aligned with internal governance oversight. • Waiting times for memory services and all-age neurodevelopmental services remained an area of concern, reflecting earlier Board discussions. Additional information on memory services and trajectories had previously been considered by FPC.

	• Workforce metrics remained positive overall, with sickness absence slightly above target. Benchmarking information indicated that performance compared favourably with other organisations, although continued focus on staff health and wellbeing was required. • The number of patients clinically ready for discharge in both mental health and community services was highlighted as a concern due to its impact on patient flow. It was noted that some community metrics required refinement and that external factors, including Ministry of Justice and Court of Protection delays, were contributing to discharge challenges. • Ongoing work with local authorities was underway to address discharge delays, with benchmarking data available through the accountability framework to contextualise performance nationally. • Discussions with NHS England were ongoing regarding NOF metrics and future expectations Tanya Hibbert advised that in terms of the discussion on clinically ready for discharge, a robust programme of work was in place, involving regular liaison with system partners to address and unblock challenges associated with discharge delays. She added that the report now included, for the first time, a breakdown of length of stay for adult and older adult service users, reflecting a new National Oversight Framework metric. Despite current pressures associated with clinically ready for discharge, it was noted that performance had remained within the target range, which was welcomed. This improvement reflected a significant programme of transformation within the Directorate of Mental Health over the preceding 12 months. **Resolved:** The Board received and approved this report.
TB/26-7/019	**Review of risk – any further risks as a result of board discussion?** No further risks were identified as a result of the discussions in today's meeting.
TB/26-7/020	**Any Other Urgent Business** 1. Sam Hamer clarified that the system around ADHD pathways, to be discussed at a future board development session, involved two main models; the Portsmouth model (children's services), and the North West Coast model (adults). 2. Board noted an emerging reduction in sickness absence in line with seasonal trends. A 360 degree audit of sickness process was underway, with findings to be reported to the Joint People and Culture Committee in due course.
TB/26-7/021	**Papers/updates not received in line with the work plan** All papers and updates were received in accordance with the workplan.
	Close - date of next public meeting: Tuesday, 28 July 2026 at 9.30am

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NHS
Leicestershire Partnership
NHS Trust

Public Trust Board 28 July 2026

Matters arising from the Public Trust Board meeting held 26 May 2026

Action sheet

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

T H R I V E

D

Leicestershire Partnership NHS Trust

LPT Trust Board Workplan 2026/27

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

T H R I V E

		26- May-26	24-June-26	28-July-26	29-Sep-26	24-Nov-26	26-Jan-27	30-Mar-27
Item/Theme		DMH	EGM	FYPCLDA	Enabling / Medical	CHS	DMH	FYPCLDA
Chief Executive's Verbal Update ***(Confidential Agenda)***	Every meeting Group CEO	X		X	X	X	X	X
Environmental Analysis ***(Confidential Agenda)***	Every meeting Group CEO/ Managing Dir	X		X	X	X	X	X
Governance and Assurance:								
Group BAF	Dir Gov & Risk			X	X	X	X	X
Audit and Risk Committee AAA Highlight Report	As required Chair, ARC	X (17.4.26)		X (12.06.26	X (11.09.25)		X (04.12.26)	X (05.03.26)
Audit and Risk Committee Annual Effectiveness Review, ToR and Workplan	Annual Chair, ARC				X			
Trust Board Annual Effectiveness Review, Terms of Reference	Annual Dir Gov & Risk				X			
Quality, Safety and Compliance:								
Quality and Safety Committee AAA Highlight Report *(Annual Reports to be appended following the June QSC)*	Every meeting Chair, QSC	X *(21.04.26)*		X *(19.05.26 & 16.06.26)*	X *(18.08.26)*	X *(20.10.25)*	X *(22.12.26)*	X *(16.02.27)*
Safe Staffing Monthly Report	Every meeting Group Chief Nurse	X		X	X	X	X	X
Patient Safety and Learning Assurance Report	Every meeting Group Chief Nurse	X		X	X	X	X	X
Freedom to Speak Up Annual Report *(FTSU Guardian to attend to present)*	Annual Managing Dir			X				

		26- May-26	24-June-26	28-July-26	29-Sep-26	24-Nov-26	26-Jan-27	30-Mar-27
Item/Theme		DMH	EGM	FYPCLDA	Enabling / Medical	CHS	DMH	FYPCLDA
Emergency Preparedness, Resilience and Response (EPRR) Annual Report	Annual Managing Dir			~~X~~ Deferred to Sept	X			
Confidential Patient Safety Report ***(Confidential Agenda)***	Every meeting Group Chief Nurse	X		X	X	X	X	X
Finance and Performance:								
Finance and Performance Committee AAA Highlight Report	Every meeting Chair, FPC	X *(23.04.26)*		X *(18.06.26)*	X *(20.08.26)*	X *(29.10.26)*	X *(21.12.26)*	X *(18.02.27)*
Finance Report	Every meeting Chief Fin Officer	X		X	X	X	X	X
Integrated Performance Report	Every meeting Managing Director	X		X	X	X	X	X
Charitable Funds Committee AAA Highlight Report	Quarterly Chair, CFC			X *(23.06.26)*		X *(23.09.26)*	X *(14.12.26)*	
Annual Operational Plan	Annual Group Exec Dir. Strat & Part							X
Risk Based Items When Required:								
Outline/Full Business Cases	As required							
CQC Inspection Reports	As required							
National/Local Reports	As Required							
Externally Commissioned Reports	As required							
System-wide Winter Planning	As required							
Award of legal contracts	As required							

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

E

Leicestershire Partnership NHS Trust

Public Trust Board 28th July 2026

Chair's Report

Purpose of the Report

This is a regular report for information and accountability, summarising Chair and Non-Executive Director (NED) activities and key events relating to the Well-Led framework for the period June 26 – July 26. Activities relating to formal Committees of the Board are reported through custom reports.

Analysis of the Issue

This period has been a great opportunity for networking both locally and nationally, these are a few highlights

It was good to see so many colleagues at this years NHS Confederation and hear updates on:

- Digital innovation being used to improve patient and user experiences of NHS services and assist clinicians in improving patient records whilst saving time to free up for more face to face clinics
- The benefit of focused research and development programmes in NHS organisations to help improve health outcomes and address health inequalities
- The benefits of IHO designation and holding a contract for a defined population to improve health outcomes for that cohort.

On 13 May, we held our Group International Nurses Day 2026 conference, themed "Our Future. Empowered Nurses Save Lives." The event brought together nursing colleagues from across the Group to celebrate the contribution of nurses and reflect on the future of the profession. It was great to hear and be involved in some of the conversations around shared learning, journeys and services across the Group.

On 9 July, I spent a fantastic afternoon celebrating our staff and volunteers who have received their long service awards. The total number of years worked in the NHS by the 728 eligible staff during 2025/26 is an amazing 13105 years' service between them. Congratulations to all of those who have reached these special milestones, and it was lovely to celebrate with you

It was a pleasure to open and attend our recent joint South Asian Heritage Month event, which brought colleagues together to reflect on this year's theme, Unity in Diversity. The event provided an opportunity to hear powerful personal stories from staff, celebrating the richness of South Asian heritage, and recognise the importance of inclusion, belonging and cultural understanding across our organisations.

Fit and Proper Person Test

The required Fit & Proper Persons checks for Board members have now been completed and taken through the appropriate internal governance channels in the Trust. Our submission to NHSE was made by 30 June deadline.

Chair/NED Appraisals, Recruitment and Succession Planning

The Chair appraisal discussion is now complete and a submission regarding the Chairs appraisal was made to NHSE ahead of 30 June deadline. NED appraisals are currently taking place and will be shared with NHSE in line with their reporting requirements.

We note the release of the national NHS Staff Standards and will be working to understand and embed these standards for all of our staff, including our Board.

Joint Board Development Workshop

On 30th June 2026, Board colleagues came together for a Joint Board Development Workshop which provided a valuable opportunity for us to collectively reflect on the culture, capability and strategic ambition needed to support delivery of our Together we Thrive strategy, encompassing joint values and leadership values.

Members of our EDI team and wider system colleagues joined the workshop to build on the work already undertaken to develop an inclusive culture. The session focused on active bystander approaches and on creating the conditions for staff, patients and communities to thrive. The Board recognises the important role it has in driving this change and remains committed to leading by example.

We also took the opportunity to review and discuss how our risks to the Group Research Delivery Plan are being managed and our contribution to system/regional innovation and research plans.

Mental Health Chairs Network

At June's Mental Health Chairs Network, David Williams, Deputy Director of Policy at The NHS Alliance provided an update on the Health Bill, including its terms of passage through parliament, and what it will mean for leaders when it lands. The session focused on the proposed abolition of Foundation Trust Councils of Governors as part of forthcoming NHS legislation. While LPT does not have a Council of Governors, the discussion reinforced the importance of maintaining strong mechanisms for patient, public and staff engagement, ensuring that community voices continue to inform decision-making and service improvement.

Working with Partners and Stakeholders

At a recent LNR health system Chairs and Chief Executives session, we met to discuss a range of topics relevant to systemwide partnerships and collaborative working including UEC pressures and responses, Neighbourhood services, Frailty initiatives and interventions, IHO opportunities for Northamptonshire communities (if NHFT is approved by NHSE and awarded designation to hold contract for a defined population).

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

- NHS Confederation Mental Health Chairs Call
- NHS Confederation Event
- System Chair & CEO Meetings
- System Chair Meetings
- LNAHP Board Meeting
- Joint Strategic Freedom to Speak Meeting
- Joint NED Catch Up meetings, joined by NHSE Regional Chair
- Midlands Health & Wellbeing Guardian network meeting
- East Midlands Alliance Quality & Safety Committee Chairs network

Public, Patient and Staff Engagement

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

- Joint PRIDE Event
- DAISY Award Celebration
- Long Service Awards
- South Asian Hertitage Month event
- Judging Celebrating Excellence awards
- Big Pitch Event
- Service Visit: The Beacon
- Service Visit: Crisis Service
- Service Visit: Homeless Team

All relevant meetings, events and visits for the period are detailed in Appendix 1.

Proposal

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

Decision Required

Briefing – no decision required

Governance Table

For Board and Board Committees:	Trust Board July 2026
Paper sponsored by:	Faisal Hussain, Interim Group Chair
Paper authored by:	Sinead Ellis-Austin, Head of Chair/CEO Office
Date submitted:	15th July 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:	September 2026
THRIVE strategic alignment:	☒ **T**echnology ☒ **H**ealthy communities ☒ **R**esponsive ☒ **I**ncluding everyone ☒ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	N/A
Is the decision required consistent with LPT's risk appetite:	N/A
False or Misleading Information (FOMI) considerations:	None
Positive confirmation that the content does not risk the safety of patients or the public:	Yes
Equality considerations:	Incorporated in approach to recruitment and other activities.

Appendix 1

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Hetal Parmar	06/05/2026	SEND Alliance	I
Liz Anderson	14/05/2026	Clinical Academic Team and Fellows	I
Hetal Parmar	15/05/2026	GGI: NED's role in scrutiny	E
Hetal Parmar	20/05/2026	GGI: Changing financial governance	E
Hetal Parmar	21/05/2026	Audit & Risk Committee agenda review	I
Hetal Parmar	28/05/2026	360 Internal Audit catch-up	E
Hetal Parmar	28/05/2026	Well Led' governance conversation	I
Melanie Hall	01/06/2026	Finance & Performance Committee agenda planning meeting	I
Faisal Hussain	04/06/2026	LNAHP Board Meeting	E
Faisal Hussain	04/06/2026	Group Board Development Agenda Sign Off meeting	I
Faisal Hussain	04/06/2026	Group Chief Executive Officer	I
Hetal Parmar	05/06/2026	Service Visit: Homeless team	I
Faisal Hussain	08/06/2026	Joint Corporate Governance Catch Up	I

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Faisal Hussain	08/06/2026	DNDN Steering Group	E
Melanie Hall	09/06/2026	Freedom To Speak Up guardians	I
Faisal Hussain	09/06/2026	LNR System Chair meeting	E
Chris Skelton	10/06/2026	Service Visit to The Beacon	I
Melanie Hall	10/06/2026	Chairs Appraisal SID pre-meeting	I
Faisal Hussain	10/06/2026	NHS Confed	E
Faisal Hussain	10/06/2026	Mental Health Network Member Meeting	E
Faisal Hussain	10/06/2026	Group CEO/ICB Chair & CEO	E
Faisal Hussain	12/06/2026	NHSE Regional Chair	E
Melanie Hall/Chair	15/06/2026	Chairs Appraisal Panel	I
NEDs/Chair	15/06/2026	Joint NED Catch Up	
Tim Harrison	16/06/2026	Governor/NED constituency	I
Melanie Hall	17/06/2026	Pre-FPC meeting with CFO	I
Melanie Hall	17/06/2026	Midlands Health & Wellbeing Guardian network meeting	E

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Josie Spencer	17/06/2026	Meeting with NHFT QSC Chair	E
Faisal Hussain	17/06/2026	Chair/Deputy Chair Meeting	I
Faisal Hussain	17/06/2026	NHSE Regional COO	E
Melanie Hall	18/06/2026	Post Chair's Appraisal SID meeting	I
Tim Harrison	22/06/2026	Health inequalities workshop	I
Faisal Hussain	22/06/2026	Group CEO	I
Faisal Hussain	23/06/2026	LPT Managing Director	I
Faisal Hussain	23/06/2026	Armed Forces Community Webinar	E
Josie Spencer	24/06/2026	Mental Health Chairs Network Conference Call	E
Josie Spencer	24/06/2026	Daisy Award April Honouree	I
Faisal Hussain	24/06/2026	Joint Corporate Governance Catch Up	I
Tim Harrison	25/06/2026	Committee Chair & Vice Chairs mtg	I
Josie Spencer	26/06/2026	Daisy Award May Honouree	I
Liz Anderson	26/06/2026	Medical Directors Conference	I

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Tim Harrison	29/06/2026	10 point plan for resident doctors	I
Tim Harrison	29/06/2026	Joint People & Culture Committee agenda setting	I
Melanie Hall	29/06/2026	Pride event	I
Faisal Hussain	29/06/2026	NHSE Discussion	E
Melanie Hall/Chair	06/07/2026	Appraisal	I
Tim Harrison/Chair	07/07/2026	Appraisal	I
Faisal Hussain	07/07/2026	REACH Network South Asian Heritage Month Event	I
Josie Spencer	08/07/2026	East Midlands Alliance Quality & Safety Committee Chairs network	E
Faisal Hussain	08/07/2026	Mental Health Network Chairs Meeting	E
Faisal Hussain	08/07/2026	Freedom To Speak Up Guardians	I
Faisal Hussain	08/07/2026	LPT Board Agenda Setting Meeting	I
Faisal Hussain	09/07/2026	Long Service Awards	I
Hetal Parmar/Chair*	10/07/2026	Appraisal	I
Faisal Hussain*	10/07/2026	System Chairs & CEO's Meeting	E

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Faisal Hussain*	13/07/2026	Celebrating Excellence Awards Judging	I
Faisal Hussain/Melanie Hall*	13/07/2026	Joint Quarterly F2SU Meeting	I
Faisal Hussain*	14/07/2026	Group CEO	I
Faisal Hussain*	14/07/2026	LNR System Chair meeting	E
Faisal Hussain*	14/07/2026	Group CEO	I
Faisal Hussain*	14/07/2026	LNR System Chair meeting	E
Chris Skelton*	15/07/2026	NHS Efficiency Day	E
Josie Spencer *	15/07/2026	NED Best Practice Sessions	E
Josie Spencer/Chair*	15/07/2026	Appraisal	I
Chris Skelton/Chair*	16/07/2026	Appraisal	I
Liz Anderson/Chair*	16/07/2026	Appraisal	I
Faisal Hussain*	17/07/2026	MH Chairs Network Pre-Meet	E
Faisal Hussain*	29/07/2026	Meeting with SIDs	I
Faisal Hussain*	29/07/2026	NHSE Regional Chair Meeting	E

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Faisal Hussain*	29/07/2026	NHSE Regional Chair Meeting	E
Josie Spencer *	31/07/2026	Big Pitch Event	I

*Planned at time of writing

Abbreviations:

AGM = Annual General Meeting

ANED = Associate Non-Executive Director

AHPs = Allied Health Professionals

ARC = Audit and Risk Committee

CEO = Chief Executive Officer

CFC = Charitable Funds Committee

FTSU = Freedom To Speak Up

FPC = Finance & Performance Committee

FYPCLDA = Families, young people and children's, learning disabilities and autism services

GGI = Good Governance Institute

ICB = Integrated Care Board

ICS = Integrated Care System

LLR = Leicester, Leicestershire & Rutland

LPT = Leicestershire Partnership NHS Trust
LNAHP = Leicestershire & Northamptonshire Academic Health Partners
MECC= Making Every Contact Count
NED = Non-Executive Director
NRC = Nomination and Remuneration Committee
PCC = People and Culture Committee
NHFT = Northamptonshire Healthcare NHS Foundation Trust
NHSE = NHS England
NHS CFA = NHS Counter Fraud Authority
QI = Quality Improvement
QSC = Quality and Safety Committee
REACH = Race, Ethnicity and Cultural Heritage
SALT = Speech & Language Therapies
SIDs = Senior Independent Directors
UEC = Urgent & Emergency Care
UHL = University Hospitals of Leicester
UHN = University Hospitals of Northamptonshire
UoL = University of Leicester

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Leicestershire Partnership NHS Trust

Public Trust Board 28th July 2026

Chief Executive Officer Report

Purpose of the Report This paper provides an update on current national issues and policy developments that affect the Trust. 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 the Trusts consideration.

Analysis of the Issue

Extreme Heat Response

During recent periods of extreme heat, the Trust maintained service continuity across all operational areas, ensuring patients continued to receive safe and effective care. A range of proactive measures were implemented to support staff, patients and services, including regular weather updates, health and safety guidance, and operational advice to mitigate risks associated with high temperatures.

I would like to take this opportunity to thank our staff and volunteers for their commitment to ensure the population of Leicestershire are well looked after during these periods.

Advanced Foundation Trust and Integrated Healthcare Organisation status

Our Group Trust Northamptonshire Healthcare NHS Foundation Trust (NHFT) has successfully received Advanced Foundation Trust (AFT) and in addition, it has been agreed by NHSE that NHFT has been designated as eligible to take forward an Integrated Health Organisation (IHO) contract for Northamptonshire. NHSE has declared wave 2 sites for AFT, which is focused upon NHS oversight framework segment 1 organisations.

We continue to use their experience to build our own understanding ahead of any future application we may undertake.

East Midlands Mental Health and Learning Disability Alliance

The East Midlands Alliance has agreed its plan for 2026/27, setting out a shared programme of work across patient safety, quality improvement and productivity, workforce development, population health and reducing inequalities. Please see attached a copy of the Alliance plan for 2026/2027 in Appendix 1.

Deprivation of Liberty

The Department of Health and Social Care (DoHSC) has issued guidance following a significant Supreme Court judgment which revises the legal definition of deprivation of liberty. The judgment replaces the previous “acid test” approach with a broader, multi-factor assessment that considers an individual’s specific circumstances, wishes and the nature of any restrictions in place. The change has immediate effects nationally and is expected to influence future practice relating to the Mental Capacity Act, deprivation of liberty safeguards and care planning arrangements. We await revised guidance from NHSE and Local Authorities whilst work is taking place in the organisation to update our policies and practices in light of this ruling. We will continue to regularly review arrangements.

Further information can be found here: UK Supreme Court 2026 judgment on what constitutes a deprivation of liberty - GOV.UK

Independent Investigation into Maternity and Neonatal Services

Baroness Amos has published the findings of her independent investigation into maternity and neonatal services in England. The report identifies recurring concerns relating to patient safety, inequalities, culture, accountability and women not feeling listened to within maternity services. In response, the Government has accepted a number of recommendations, announced the creation of the UK’s first Maternity and Neonatal Commissioner and committed additional investment to improve safety and quality within maternity and neonatal services. NHSE has also launched a national improvement programme and 10-point action plan to support implementation of the recommendations.

We will continue to review and work with partners to understand these recommendations from both our own organisations point of view and how we work with partners across the wider health care system for all our population.

Further information can be found here: NHS England » Publication of Baroness Amos’ independent investigation into maternity and neonatal services in England

UK’s first maternity and neonatal commissioner to be appointed - GOV.UK

Access to Crisis Care via NHS 111

NHSE has published the latest data relating to access to crisis care through the NHS 111 mental health option. The publication provides new insight into demand, responsiveness and access to urgent mental health support following the national rollout of the service in April 2024. The data is intended to support service improvement, capacity planning and benchmarking across providers, while reinforcing the importance of ensuring timely access to mental health crisis support through a single, nationally recognised point of entry. We will use this data internally to understand our relative position and work with partners to ensure we best support our patients needs.

Further information can be found here: Access to crisis care via NHS 111 - Mental Health, April 2026 - NHS England Digital

Lord Mann Review on Antisemitism and Other Forms of Racism in the NHS

Lord Mann has published an independent review examining how the NHS and healthcare regulators identify, report and respond to antisemitism and other forms of racism. The review highlights the need for stronger accountability, improved reporting mechanisms, enhanced staff support and a renewed focus on embedding an anti-racist culture across healthcare organisations.

The Government and NHSE have accepted the recommendations relevant to them and have committed to actions including strengthened leadership accountability, mandatory training and improved workplace standards aimed at tackling discrimination and supporting inclusion.

Further information can be found here: Lord Mann review on antisemitism and other forms of racism in the NHS - GOV.UK

LPT has accepted all recommendations relevant to NHS trusts and are implementing them through our established Together Against Racism programme, including strengthening leadership accountability, anti-racism training, staff support, reporting arrangements and data collection, whilst continuing to work with staff networks to foster an inclusive culture for patients, service users and colleagues.

NHS Staff Standards

The Department of Health and Social Care and NHS England have published the first national NHS Staff Standards. The standards establish minimum expectations for NHS employers across six priority areas: line management, health and wellbeing, flexible working, violence prevention, sexual safety and tackling racism.

The standards are intended to improve staff experience, strengthen organisational accountability and support retention, with implementation monitored through existing oversight and assurance arrangements.

Further information can be found here: NHS England » NHS staff standards & NHS sets first-ever staff standards to tackle racism and violence - GOV.UK

Our Chief People Officer will lead a piece of work to embed these standards for our staff.

Online NHS Trust

NHSE has formally established the Online NHS Trust, the first national digital-first NHS trust. The organisation will support delivery of NHS Online from 2027, providing patients with access to specialist advice and planned care through the NHS App and virtual consultations. The new Trust aims to improve access to specialist services, reduce waiting times and provide greater flexibility for patients while maintaining the option of face-to-face care where clinically appropriate or preferred. John Browett has been appointed as Chair of the organisation

Further information can be found here: Online NHS Trust

Secretary of State for Health and Social Care

Following changes within Government, a new Secretary of State for Health and Social Care, James Murray, was appointed in May 2026. We continue to monitor details of policy priorities and implications for the NHS as they emerge.

Vaccinations

NHSE has launched a national vaccination campaign encouraging families to ensure children are protected against measles and other serious childhood illnesses. The campaign introduces a catch-up programme for eligible children aged between 12 months and 11 years who have missed routine vaccinations, including a new four-in-one vaccine providing protection against measles, mumps, rubella and chickenpox. The campaign follows an increase in measles cases nationally and aims to improve vaccination uptake and reduce health inequalities

Further information can be found here: NHS England » Around a million parents urged to book new 'four-in-one' NHS jab to protect young children against measles

NHSE has also published further guidance for the 2026/27 flu vaccination programme, setting out ambitions to improve uptake across all eligible cohorts and reduce winter pressures on health services. Particular emphasis has been placed on increasing vaccination rates amongst frontline healthcare workers, children and older adults, while reducing variation between organisations and regions. The programme forms part of broader efforts to reduce respiratory illness, prevent avoidable admissions and protect vulnerable communities during winter. The flu programme group is actively progressing work locally to support the nationally set programme.

Further information can be found here: NHS England » Flu Vaccination Programme 2026/27

CQC

The CQC has announced the appointment of Emily Miles as its new Chief Executive, with effect from Autumn 2026. Emily joins from the Department for Environment, Food and Rural Affairs, where she is Director General for Food, Farming and Biosecurity, and previously served as Chief Executive of the Food Standards Agency. CQC has highlighted her extensive regulatory leadership experience and her track record in organisational improvement and stakeholder engagement.

The CQC continues its programme of improvement following reviews of its assessment approach and operating model. Current work includes piloting and testing updated assessment methods designed to improve consistency, transparency and reliability while ensuring that regulation remains focused on the quality and safety of care. Learning from these pilots will inform the future development of the CQC's regulatory framework and inspection methodology. As an organisation we are actively engaged with this programme and have shared our feedback.

Further information can be found here: Piloting, testing and evaluation of new assessment method - Care Quality Commission

The Secretary of State for Health and Social Care has announced Rabbi Baroness Julia Neuberger DBE as the preferred candidate to become the next Chair of the CQC, subject to parliamentary approval. Baroness Neuberger brings extensive experience in healthcare leadership, policy and regulation, and her appointment comes at an important stage of the CQC's ongoing programme of organisational improvement and reform

Further information can be found here: Secretary of State announces preferred candidate for Chair of CQC - Care Quality Commission

Independent review into mental health conditions, ADHD and autism: interim report

The Department of Health and Social Care has published its interim findings of the independent review into mental health conditions, ADHD and autism, highlighting a sustained increase in demand for support and assessment services, exceeding capacity. The review is examining trends in the prevalence of mental health conditions, ADHD and autism, and the factors contributing to increasing demand for assessment, diagnosis and support services. The interim report highlights growth in service demand, variations in access to support, and the need for a better understanding of population needs, service pressures and wider social factors. The report does not make recommendations at this stage but outlines the areas that will be considered in the next phase of the review. A final report is expected later in 2026 and will provide recommendations to inform future policy and service development.

Further information can be found here: [Independent review into mental health conditions, ADHD and autism: interim report - GOV.UK]

Cross-governmental Mental Health Strategy

The Department of Health and Social Care has launched a national call for evidence to inform the development of a new cross-government Mental Health Strategy for England. The strategy will support delivery of the ambitions set out in the 10 Year Health Plan and will consider how services can improve prevention, early intervention, access to support and recovery outcomes. The call for evidence seeks examples of effective practice from health services, local government, education, workplaces and community organisations, with a particular focus on supporting a shift from hospital-based care to community-based support, improving access to timely care, reducing inequalities and strengthening partnership working across sectors. The findings will inform a new national strategy expected later in 2026. LPT has responded as a Trust.

Health Bill 2026

The Government has introduced the Health Bill, which sets out a range of reforms intended to support delivery of the 10 Year Health Plan for England. Key proposals include the creation of a single patient record to improve information sharing across services, the transfer of NHS England's functions into the Department of Health and Social Care, and changes to the roles and responsibilities of Integrated Care Boards and foundation trusts. The Bill aims to reduce bureaucracy, strengthen local decision-making and support more integrated, data-enabled models of care. It is currently progressing through Parliament, with further scrutiny and debate expected before implementation

Health Bill - GOV.UK

Relevant External Meetings attended since last Trust Board meeting

June 2026	July 2026
Deputy Director of System Co-ordination & Oversight NHSE	Deputy Director of System Co-ordination & Oversight NHSE
Secretary of State for Health and Social Care & CEO forum /NHSE	Midlands & East CEO Forum
LLR MH Collaborative	National NHSE Neighbourhood Mental Health Centres CEO Round Table
LNR CEOs	National NHSE Mental Health CEOs forum
East Midlands Alliance CEO Meeting	LNR System Chairs and CEOs
CEO Lincolnshire Partnership NHS Foundation Trust	NHSE Midlands Regional Director
CEO Nottinghamshire Healthcare NHS Foundation Trust	National NHSE Mental Health CEOs forum
National NHSE with CEO's meeting	LNR System Chairs and CEOs
CEO Pennine Care NHS Foundation Trust	NHSE Midlands Regional Director
CEO Coventry and Warwickshire Partnership Trust	NHFT/LPT Provider Review Meeting
East Midlands Alliance Lead	* LNR Health Executive Partners Meeting
CQC & LPT Quarterly Engagement	* East Midlands Alliance CEO Meeting
LLR ICB and NICB Private Board	*LNR ICB CEO
LNR Health Partners' Executive Meeting	*Regional Performance and Delivery Group
East Midlands Alliance Board	*LNR CEOs
	* NHSE Chief Executive working group (MH)
	*Midlands monthly update with Midlands NHSE Regional Director
	*Midlands CEOs monthly update with Midlands NHSE Regional Director

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

Governance Table

For Board and Board Committees:	Trust Board of Directors
Paper sponsored by:	Angela Hillery, Chief Executive Officer
Paper authored by:	Sinead Ellis-Austin, Head of CEO & Chair Office
Date submitted:	
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:	☒ **T**echnology ☒ **H**ealthy communities ☒ **R**esponsive ☒ **I**ncluding everyone ☒ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	
Is the decision required consistent with LPT's risk appetite:	Yes
False or Misleading Information (FOMI) considerations:	None
Positive confirmation that the content does not risk the safety of patients or the public:	Confirmed
Equality considerations:	None

East Midlands Alliance

for Mental Health, Learning Disabilities and Autism

Alliance Plan for 2026/27

Version 5

Enabling safe care

We will work together through our Medical and Nurse Director forum and with Health Improvement East Midlands to deliver our regional Patient Safety programme.

Priorities for 2026/27	**Lead**	**Delivery date**
We will develop a common Patient Safety framework	Patient Safety programme with HIEM reporting to the Medical and Nurse Directors	September 2026
We will develop tools to support the reduction of the risk of physical health deterioration in severe mental illness	Patient Safety programme with HIEM reporting to the Medical and Nurse Directors	September 2026
We will continue to run a sexual safety Community of practice across inpatient wards in the East Midlands.	Patient Safety programme with HIEM reporting to the Medical and Nurse Directors	March 2027
We will continue to run a suicide and self-harm reduction community of practice in the East Midlands	Patient Safety programme with HIEM reporting to the Medical and Nurse Directors	March 2027
We will continue to run a restrictive practice reduction community of practice in the East Midlands	Patient Safety programme with HIEM reporting to the Medical and Nurse Directors	March 2027
We will share learning from the pilot sites for Martha's Rule in mental health	Pilots and HIEM	March 2027
We will establish a group to share learning from work with the CQC and other regulatory bodies.	Medical and Nurse Director forum	July 2026

Quality improvement and productivity

We will take a joint approach to common and shared quality improvement and productivity challenges working with regional and national programmes.

Priorities for 2026/27	**Lead**	**Delivery date**
We will share our detailed cost improvement plans and update on delivery.	Chief Finance Officer forum	April 2026
We will progress joint work to digitise the Mental Health Act processes.	Derbyshire Healthcare	March 2027
We will work with the regional lead for the national Inpatient Quality Improvement programme.	Medical and Nurse Directors	March 2027
We will hold an Alliance learning event for Board members in October.	Communications team	October 2026
We will hold a workshop to share learning from the local funding from the Alliance to improve therapy supervision.	Therapy leads	July 2026
We will establish a collective programme of work on medical job planning in mental health, fund local activity and share learning.	Leicestershire Partnership and Lincolnshire Partnership with the Medical Directors.	March 2027
We will bring Procurement leads together to share their procurement work programmes and develop a proposal for an Alliance wide approach to aspects of procurement.	Procurement leads	September 2026
We will establish a Heads of Legal Services forum, share benchmark spend and activity data and work with the national NHS England lead to share learning from other collaborative approaches to accessing legal advice and support.	Heads of Legal Services	September 2026

Developing our workforce

We will work together to address our shared workforce challenges and learning through our HR Director network.

Priorities for 2026/27	Lead	Delivery date
We will scope the opportunity to undertake work together on the job evaluation of Nursing and Midwifery roles.	HR Director network	July 2026
We will develop a collective approach to health and wellbeing, sharing good practice, and aligning with the Medium-Term Plan goal of achieving a 4% sickness rate.	HR Director network	October 2026
We will benchmark bank rates and work towards rate alignment.	HR Director network	October 2026
We will run two further cohorts of the core Clinical Support Worker development programme (cohorts 21 and 22).	HR Director network	September 2026
We will run three further cohorts of the Clinical Support Worker line manager development programme (cohorts 15, 16 and 17).	HR Director network	September 2026
We will run a further set of local Clinical Support Worker recruitment and retention activities and share learning in March 2027.	HR Director network	June 2026
We will produce a bi-monthly workforce benchmarking report.	Nottinghamshire leading on behalf of the HR Director network	March 2027
We will re-run the RRP and Golden Hello audit in autumn 2026	HR Director network	October 2026
We will produce a review with recommendations on the effective use of Physician Associates in Mental Health providers	Patient Safety programme with HIEM reporting to the Medical and Nurse Directors	July 2026

Improving population health

We will work together to improve population health through our regional specialised service collaboratives.

Priorities for 2026/27	Lead	Delivery date
A Gambling Harm service funding bid has been submitted to NHS England to support data-led service improvements and reduce inequalities within the East Midlands. The proposal focuses on strengthening equitable access in line with deprivation-related need, improving outcomes for people experiencing complex co-morbidities, and addressing the current under-representation of women in treatment.	Derbyshire Healthcare	March 2027
We will understand our baseline position and then design and deliver a plan to improve population health and reduce inequalities in Mother and Baby Units through tracking clinical recovery, maternal-infant bonding, and access equity across demographics.	Perinatal Collaborative	March 2027
We will continue to develop working relationships between inpatient Mother and Baby Units and community Teams via Case Management and learning events.	Perinatal Collaborative	March 2027
The Strategy Directors will hold two sessions in the year to share progress and learning on neighbourhood health, 24/7 neighbourhood mental health centres and Place based working.	Strategy Directors	March 2027
We will establish a new East Midlands Collaborative Hub to lead on all of the East Midlands Collaborative work.	Strategy Directors and lead Collaborative directors	July 2026
We will TUPE Hub staff from Nottinghamshire Healthcare to Northamptonshire Healthcare to create a single East Midlands Hub.	Northamptonshire Healthcare and Nottinghamshire Healthcare	June 2026
We will appoint to a new Director to lead the single hub.	Strategy Directors and lead Collaborative directors	September 2026

We will revise the governance of the regional Collaboratives to align it to the Alliance Board.	Strategy Directors and lead Collaborative directors	September 2026
Workshop session to share learning on the Advanced Foundation Trust and IHO process.	Northamptonshire Healthcare	September 2026
We will begin to gather learning from the CAMHS Day services pilots in Leicestershire and Lincolnshire to inform the next stage of the roll out in Derbyshire.	CAMHS Collaborative, Leicestershire Partnership and Lincolnshire Partnership	March 2027
Adult Eating Disorders – We will review the potential expansion of the Enhanced Care Referral Team approach to cover Adult Eating Disorders.	Adult Eating Disorder Collaborative	March 2027
Adult Eating Disorders – We will work with stakeholders to develop a provider collaborative wide approach to MEED (Managing Emergencies in Eating Disorders) in acute hospitals.	Adult Eating Disorder Collaborative	March 2027
Adult Eating Disorders – We will explore the development of all-age eating disorder service including the potential for expansion of the Waterlily project for those young people aged 16-17 yrs old.	Adult Eating Disorder Collaborative	March 2027
Op Courage - We will establish and develop assessment clinics across the region to support reduce waiting times and improve assessment experience	Op Courage programme	March 2027
Op Courage - We will use veteran population data to examine inequalities in access and conduct targeted work to improve access for underrepresented groups.	Op Courage programme	March 2027
Adult Secure – We will ensure all patients at St Andrew's are safe and have suitable progressive placements following transfer of care	Impact Collaborative	March 2027
Adult Secure – We will work with partners to address the underlying deficits, identifying and implementing transformation initiatives to reduce the cost of care	Impact Collaborative	March 2027

whilst working with strategic commissioners to ensure equity in meeting East Midlands population health needs.		

Reducing inequalities

We will work together to reduce inequalities with a specific focus on race equality.

Priorities for 2026/27	**Lead**	**Delivery date**
We will re-establish the Alliance PCREF forum if the Midlands regional forum is stood down.	PCREF leads	July 2026
A Gambling Harm service funding bid has been submitted to NHS England to support data-led service improvements and reduce inequalities within the East Midlands. The proposal focuses on strengthening equitable access in line with deprivation-related need, improving outcomes for people experiencing complex co-morbidities, and addressing the current under-representation of women in treatment.	Derbyshire Healthcare	March 2027
We will develop lived experience engagement and co-production in the Perinatal Provider Collaborative through recruitment to a Co-production Lead role.	Perinatal Collaborative	March 2027
The Strategy Director forum will hold a workshop to share learning and agree future priorities to address health inequalities.	Strategy Directors	October 2026
The Strategy Director forum will receive the feedback on good practice in the provision physical healthcare for people with SMI and agree how it could be applied at an East Midlands level.	Strategy Directors	October 2026

Alliance Board meetings

Face to face in Leicester

26 June

25 September

4 December

Chair and CEO meeting

Ahead of the Alliance Board on 26 June

Alliance learning event

13 November

Strategy Directors

22 May

31 July

11 Sept

27 Nov

22 Jan 27

12 March 27

HR Directors

4 June

10 Sept

10 Dec

4 March 27

Medical and Nurse Directors

9 June

22 Sept

8 December

16 March 27

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Leicestershire Partnership NHS Trust

Public Trust Board 28 July 2026

Managing Director's Report – Public

Purpose of the Report

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

Local developments and innovation

National Oversight Framework

Our latest NHS National Oversight Framework ranking retains our position within Segment 2, which moves us from 27th to 23rd out of the 61 community and mental health trusts in the country.

Capability ratings

These ratings measure how well the local leadership teams manage their Trust finances and care quality. NHS England gives Trusts a colour score based on the traffic light system. LPT is proud to have been awarded a GREEN rating; indicating our Trust is being 'run well' and there is 'high confidence' in our leadership.

Long service awards

More than 170 staff members and volunteers from Leicestershire Partnership NHS Trust (LPT) came together for this year's Long Service Awards, which was held at a fully-sponsored event on Friday 9 July at The Kube, Leicester Racecourse. Everyone who attended enjoyed an afternoon tea followed by a presentation ceremony, where each person received a certificate, and commemorative pin badge. Between them they have served 3,395 years. The total number of years worked in the NHS by the 728 eligible staff during 2025/26 is 13,105 years between them. The Trust is also marking staff who have achieved 10 years of service in the NHS by sending them a special certificate and pin badge.

Co production charter

For the first time, LPT and Northamptonshire Healthcare Foundation Trust have come together to co-create shared foundations for lived experience co-production across Leicester, Leicestershire and Rutland, and Northamptonshire.

By bringing people with lived experience, carers, and staff together as equal partners, we're strengthening how services are designed, delivered, and improved, ensuring real voices shape real decisions.

This isn't just ideas on paper. It's about creating meaningful, consistent co-production that makes a difference for our communities.

T H R I V E

Helping mentally ill patients live longer lives
An LPT-led team has helped LLR become the second highest ranking area of the country in terms of carrying out physical health checks for people with serious mental illnesses. These checks, covering things such as blood pressure and cholesterol, can be used to signpost patients to healthier lifestyles. The LLR team did checks on 76 per cent of the target group, well ahead of the 60 per cent target.

Temporary ward closure
North Ward at Hinckley and Bosworth Community Hospital has closed temporarily to allow essential estate improvement works that will directly enhance patient safety, comfort, and overall experience.

The decision follows ongoing drainage issues that led to blocked patient and staff toilets, on a number of occasions, over the past four years. Addressing this problem permanently is critical to ensuring a reliable, hygienic, and dignified environment for everyone using the ward.

Cleanliness
Our Trust has again been recognised among the best-performing providers in England, achieving a 100% cleanliness score for the third consecutive year in the 2025 Patient-Led Assessments of the Care Environment (PLACE). LPT is one of only five out of 54 community and mental health trusts to secure full marks, reinforcing its position as a leading provider of safe, high-quality environments for patients.

The Trust also delivered consistently high scores across all key domains, including 99.97% for condition, appearance and maintenance and 98.7% for privacy, dignity and wellbeing, ranking second nationally in both categories within its peer group.

Celebrating South Asian Heritage Month
July is South Asian Heritage month, with this year's theme being 'Unity in Diversity'. There will be an in-person event for LPT colleagues on Wednesday 22 July to celebrate, connect and learn from each other.

HSJ award shortlisting
Paediatric teams at our Trust and the University Hospitals of Leicester NHS Trust (UHL) have been shortlisted for a national HSJ Award for their work to improve care for children and young people with Functional Neurological Disorder (FND).

Functional Neurological Disorder (FND) is a condition that affects how the brain sends and receives messages, causing symptoms such as weakness, seizures, or speech difficulties, even though scans and tests usually appear normal.

Parking sign-ups
More than 3,000 members of staff have applied to have permits for LPT's new parking system.

From later this summer we are introducing a fines-based system for vehicles who have no right to park in LPT car parks at Loughborough Hospital, the Glenfield Hospital site, and the Leicester General site. Parking will remain free for registered staff, patients and visitors.

Top post for LPT consultant
Professor Nandini Chakraborty, a consultant psychiatrist at our Trust, has been elected as Dean of the Royal College of Psychiatrists (RCPsych).

The position of Dean of RCPsych is one of the most senior roles in the College and plays a significant part in their efforts to ensure their workforce meets the needs of communities across the UK. The Dean also provides strategic leadership on psychiatric training and supports the development of a valued and sustainable workforce.

Pride month event
Staff from LPT and NHFT held a joint online event to mark Pride Month (June). The session explored some of the key challenges faced by the LGBTQ+ community and how these intersect with the experiences of many other communities. The conversation highlighted the importance of allyship, understanding, and creating inclusive environments where everyone feels valued and supported.

Volunteering Week
Volunteering week 2026 was marked by a series of videos featuring four of LPT's volunteers and ex-volunteers, which were shared on our social media channels, to celebrate and recognise their invaluable contribution to LPT. A separate video with interviews of staff who work with volunteers was shared internally, with the aim of encouraging other LPT teams to host volunteers.

Learning Disability Week
Learning Disability Awareness Week (15-21 June) highlighted the importance of inclusion, understanding, and making reasonable adjustments so people can access the care and support they deserve. We shared powerful examples from our teams of how personalised, compassionate care can make a real difference. From building trust and reducing anxiety to creating access and improving health outcomes, each story reflected what it means to truly see the person.

Team Time to Thrive
Team Time Out was introduced two years ago across out Trust to help embed healthy team behaviours. We have rebadged this as Team Time to Thrive across our Group. All teams are being asked to spend two to three hours by next April to pause, reflect, and focus on what matters most to make their working life as a team as healthy and as manageable as possible, to better support them to deliver the best services and care.

Standards and leadership
The new NHS standards and leadership framework has been published. We welcome these standards, as they reflect the focus of our current organisational priorities. We will be mapping these out against our current activity and leadership offer to implement them in due course.

Celebrating our sustainability journey
Our latest Group Sustainability Annual Report for 2025/26-2026/27 showcased how LPT and NHFT (Northamptonshire Healthcare NHS Foundation Trust) are working together to deliver to our green ambitions while also providing safe, high-quality care. It highlighted key headline initiatives, as well as placing a spotlight on the power of partnership working across our Group.

School Aged Immunisation Service
The SAIS service were invited by Leicester City Council to take part in a House of Lords inquiry into childhood vaccinations. The committee selected Leicester to share valuable insights, including what is working well and areas requiring improvement. The session was positive and well received.

House of Lords tabletop discussion
Gail Evans-Hughes, Senior Immunisation Nurse, was proud to have been invited to a meeting consisting of 8 representatives from the House of Lords, who formed a Cross-Party Committee, to write a report that will contribute to the new health bill.

The meeting took the format of attendees being questions about the barriers faced regarding vaccination uptake across maternity, pre-school and school aged immunisations. Gail talked about the lack of awareness/education about the vaccines/diseases they prevent, cultural barriers, digital poverty etc. Gail showcased the efforts that her team go to e.g. contacting parents individually whilst she also contributed to a discussion about Community engagement and collaborative working. Manage Vaccinations in Schools (MAVIS) was discussed, as well as national resources and the prevention agenda.

New video project launched to raise awareness of knife crime across LLR
A new interactive video project has been launched across LLR to help raise awareness of the dangers of knife crime, particularly among young people. Developed in partnership between LPT, the Violence Reduction Network, Leicestershire Police and Leicester City Council Youth Service, the resource features over 40 real-life videos from young people, families and professionals, showing the impact knife crime has on individuals and communities.

The project supports the 'We Don't Carry' #LivesNotKnives campaign and aims to help young people make safer choices, while reinforcing that it's never too late to change.

Find out more about the project and view the videos on our website.

Our Future Our Way (OFOW) showcased at national conference
We proudly shared LPTs culture improvement journey at the national HFMA workforce conference where we showcased our improvement story, empowering over 90 change leaders across our Trust to co-design sustainable improvements around culture, wellbeing, leadership and inclusion through Our Future Our Way change programme. This six-year journey has played a significant part in helping our organisation to become one of the best performing Trusts for staff survey results in the NHS. Our change leaders have not only improved staff experience, but their work has had a direct impact on patient outcomes and feedback.

Our continuously improving culture, with a focus on staff wellbeing, has been directly cited in our recent trio of 'Good' CQC results. Valuing our people is at the heart of our Together We Thrive strategy. Our Future Our Way has helped our people to thrive so that they can help our patients and service users to thrive.

Blood taking pathway for people with a learning disability
As part of ongoing work to improve access to blood testing, a clear pathway has been set out to support people with a learning disability across Leicester, Leicestershire and Rutland.

Clear guidance has been developed to help clinicians choose the most appropriate approach based on individual needs, ensuring care is safe, supportive and equitable.

Health and Wellbeing Boards
Rutland County Council Health and Wellbeing Board -**19 May** - LPT presented "Neighbourhoods: Lessons Learnt" from the West Leicestershire Neighbourhoods programme and the implications for Rutland. Papers available via Leicester City Council website link.

Leicester County Health and Communities Overview Scrutiny Committee - **3 June** - LPT attended to present "Learning Disability Annual Health Check – Progress Update" around increasing the number of people with a learning disability (aged 14+) receiving an annual health check from their primary care provider. Papers available via Leicester County Council website link.

Leicester City Council Health and Wellbeing Board – **4 June** – at which LPT recognised for their contribution as a lead in the Hypertension Prevention and Case-Finding discussion and Leading Better Lives programme. LPT recognised as a key partner in driving forward the Mental Health Friendly Places initiative. Papers available via Leicester City Council website link.

Leicester County Council Health & Wellbeing Board – **15 June** — agenda included an update on Staying Healthy Safe and Well, Better Care Fund 2025-26 year end and 2026-27 plan. Healthwatch reported in Improving Hospital Discharge. Papers available via Leicester County Councils website here.

Leicester County Council Health & Wellbeing Board Development/workshop session - **23 June** – held to review the purpose and structure of the Board to ensure fit for purpose.

Leicester City Public Health and Health Integration (PHHI) – **30 June** - LPT presented an introduction around LPT service provision. Papers available via Leicester City Council link.

Staff Voice

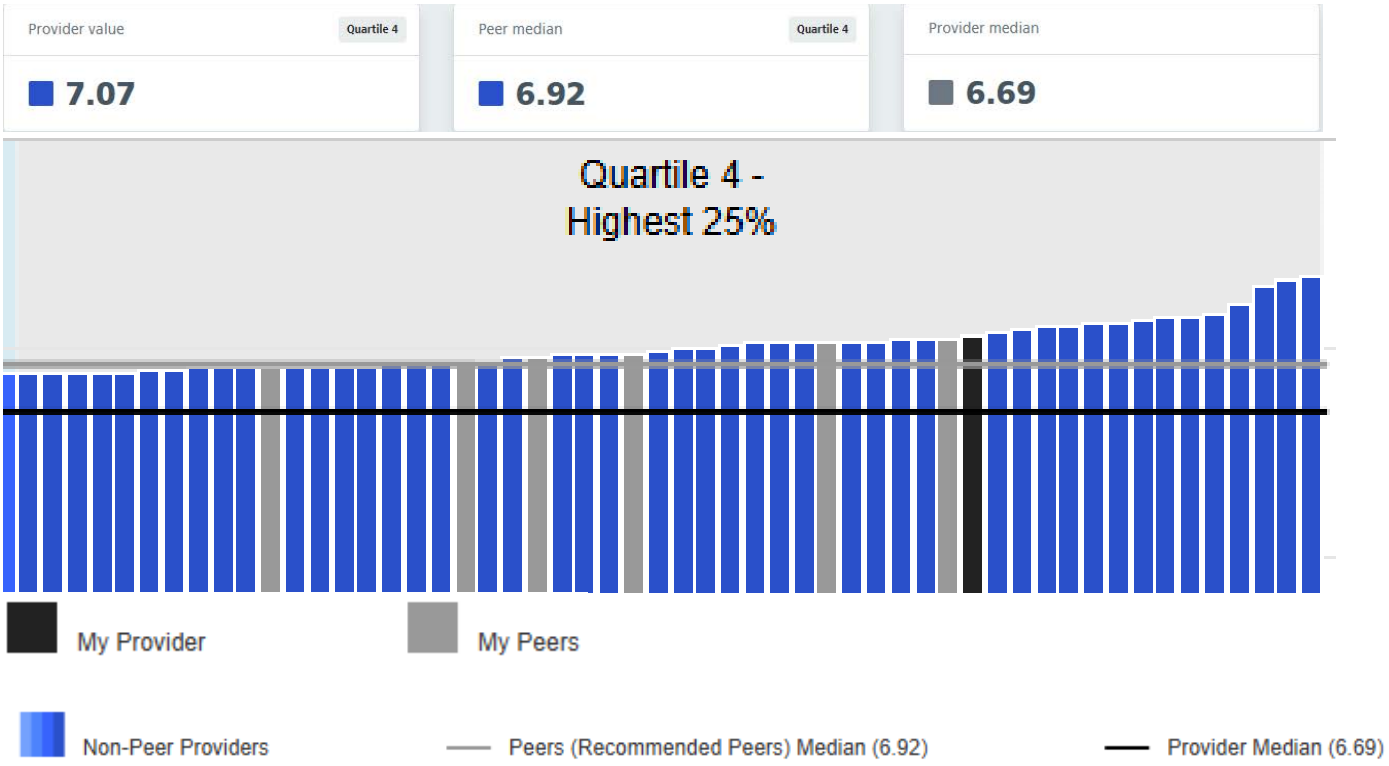
Service visits
The Board undertook 30 service visits in May and June across a wide-ranging range of operational and enabling services and sites, including several community-based mental health services for adults of working age locations, mental health long say/rehabilitation wards, wards for people with learning disabilities or autism, community inpatients, forensic inpatients and the Homeless Team. Visits continue to be undertaken both within and outside of 'normal working hours'. A repeating theme from staff continues to be feeling part of a team, strong support of colleagues and witnessing patient's recovery being the most rewarding aspects of their role.

Heatwave
Thanks to our incredible staff and volunteers' commitment and dedication, all our services remained open and running smoothly, with patients remaining safe, despite the recent spells of extreme heat.

Staff were issued regular forecast updates and reminded of suitable precautions to keep themselves and their patients safe. LPT listened to feedback from staff and made adjustments to their working lives to ease the discomfort of working under the additional pressure that comes with hot weather; medication and condition sensitivities recognised and safe transportation of medication reminders issued, considered options to hold patient appointments virtually when appropriate if patient didn't want to travel; heat exhaustion guidance; relaxed uniform codes which we are grateful to patients for allowing, battery and charging safety guidance, emergency care for school closures procedure reminders, contacts for support issued.

Throughout the spells of extreme heat staff were listened to and the feedback received by the Facebook page led to changes based on the staff voice.

We each have a voice that counts People Promise element score
The chart shows results from the NHS Staff Survey (2025-26 Qtr4), which has been updated to reflect the NHS People Promise.



Patient Voice

People's Council
The Trust continues to strengthen how patient and carer voice informs service delivery, with a comprehensive approach to gathering and acting on feedback through complaints, PALS, FFT, surveys and co production. There is strong evidence of meaningful co production and lived experience influence, including service design (e.g. CAMHS toolkit and youth led improvements), patient information development via the Reader Panel, and carer involvement embedded through the Triangle of Care programme, now integrated into governance and workforce development.

Lived Experience Partners are playing an increasingly influential role in shaping education, recruitment processes and quality improvement initiatives, while forums such as the Youth Advisory Board and People's Council help ensure a wide range of perspectives are represented. Overall, the Trust is continuing to develop a culture where patient and carer voices are routinely captured and embedded within decision making, although further work is needed to increase feedback participation, reduce variation across services and maintain improvements in the timeliness of complaint resolution.

Service visits
An important aspect of the Board service visits is to listen to what our patients and their families think of our services and learn from staff about the initiatives they have implemented to ensure

everyone feels engaged with our services and able to feedback. During recent service visits it was shared that on Gwendolen Ward (Evington Centre), regularly community meetings are held to which families are invited onto the wards for a feedback session.

On the Aston and Bosworth Wards (Bradgate Mental Health Unit), the patients felt looked after and the food was good. On the Charnwood Ward (Loughborough Hospital, Community Inpatients), two patients shared they felt well cared for on the ward and appreciated the support staff gave them in their rehabilitation journey.

International DAISY Awards
Patients, families, carers and members of the public can nominate nurses for a DAISY Award and can either nominate using our online nomination form or can ask for a paper copy at any reception area across our sites. Three nurses from our Trust have been recognised recently for their outstanding compassion and care:

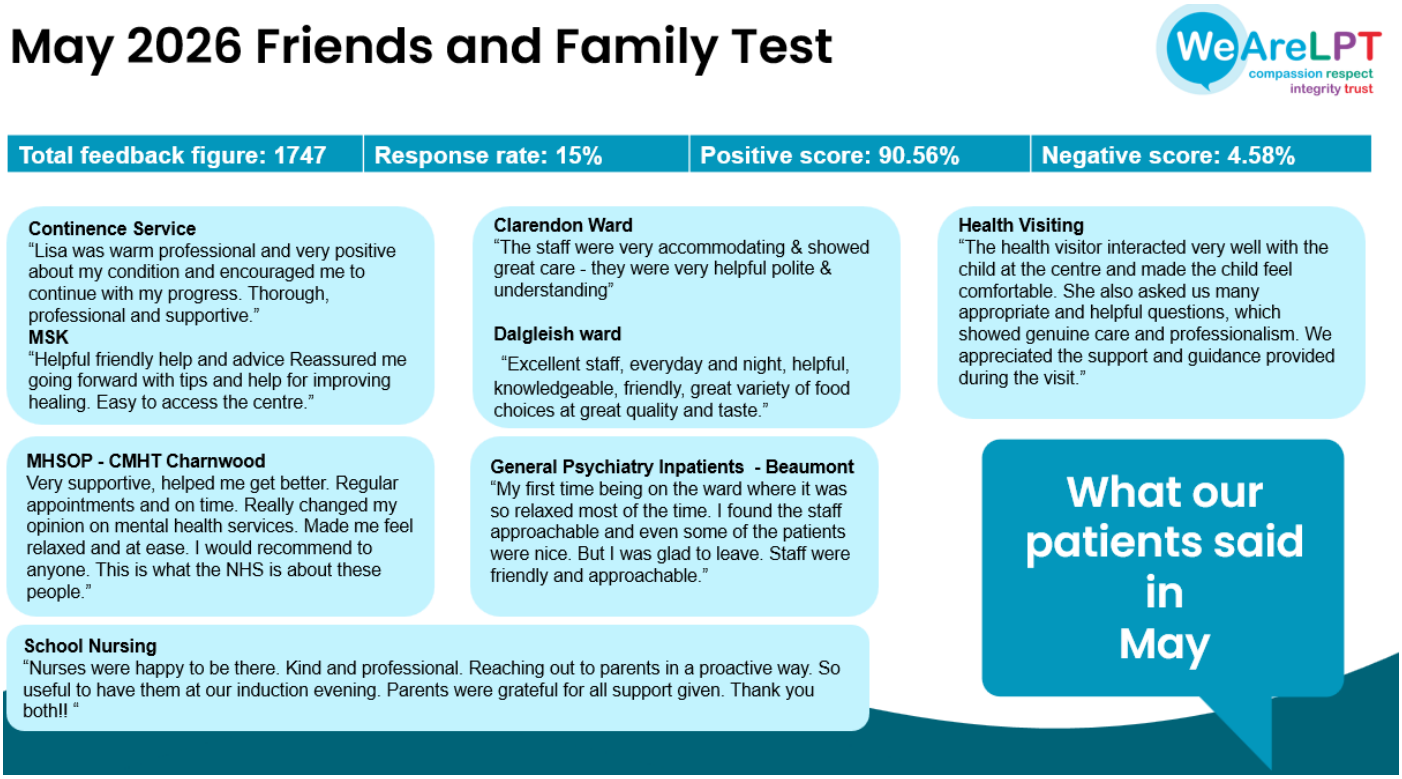
- Beth Kitchin, a mental health practitioner with the Mental Health Response Vehicle and Urgent Care Hub, was nominated by a patient for delivering calm, person-centred support during a crisis, including adapting communication to meet individual needs.
- Michelle Morris, a community staff nurse with the Rutland District Nursing team, was honoured for providing exceptional, compassionate end-of-life care and ensuring continuity and dignity for a patient and their family.
- Giane Bishop, a Healthy Child Programme Nurse, has been recognised for the “extraordinary compassion, genuine kindness and unwavering support” she provided to a family during a challenging time.

Mental Health Awareness Week activity in Hinckley & Bosworth
This activity reached a wide cross-section of the community through a series of events, including a veterans’ coffee morning, rural outreach in Markfield, and a wellbeing presence at the Hinckley BID Garden Show. Engagement levels were strong, with positive feedback highlighting the value of visible, community-based support and the importance of extending reach into rural areas. Over 100 residents were engaged at the garden show alone.

Charnwood Roadshow delivered a series of outreach events across the borough, engaging a wide range of local residents. Activities included sessions in Syston, Anstey, Birstall, Shepshed and Loughborough, as well as wider community events such as Fearon Hall Sports Day and a Health & Wellbeing event at Loughborough Wellbeing Centre. Engagement was particularly strong at Loughborough Market, where a lived experience–led stall supported over 120 conversations, and in Syston, where follow-up visits to the local café have already been seen. The roadshow highlighted emerging needs, including demand for additional support in Anstey, and was positively received in new locations such as Shepshed.

Friends and Family Test (FFT) – May and June

FFT posters continue to be displayed in all LPT service areas as LPT encourages patients, friends and families to all have their say in the service they receive. Through this all voices can be heard, improvements made and positives celebrated. In May and June 2026, our Trust received a total of 3,619 Friends and Family Test (FFT) feedback responses from our patients; overall 15% response rate, with an overall positive score of 91.2%.



June 2026 Friends and Family Test

WeAreLPT
compassion respect
integrity trust

Total feedback figure: 1872	Response rate: 15%	Positive score: 91.83%	Negative score: 3.31%

Tissue Liability

"The people involved are absolutely brilliant. Everything was done in a most professional manner and with the upmost care I cannot praise them enough | Everything was explained clearly and with sympathy nothing was ever to much trouble | Nothing you can't improve on perfection."

Mental Health Practitioners

"Always listened to. Advice and support given to me was as an individual always. Support worked and progress was achievable with useable strategies. Always happy to go over old ground. Really really really helped my mental well-being from the first visit."

Neurodevelopment nursing team

"I have been listened by the person who called me. He not just been kind and patient to listen but gave further advice regarding to my child's issues. I am really grateful for the service this person provided and felt relieved after listening and understanding what my child might be experiencing."

Respiratory

"Because they was very patient and listen to everything you have to say a lovely team | The one-to-one service and the location was very close to where I live hoping to learn more with the exercise."

All aged CAP

"She was really nice and helpful. She spoke to my other mental health teams to help me sort out the issues I was facing, which was really kind and thank you so much!."

Community LD teams

"The OT was very responsive she gets to the see the patient in the timely manner. Everything that was suppose to do, she did and was able to provide us support on how to move forward. "

What our patients said in June

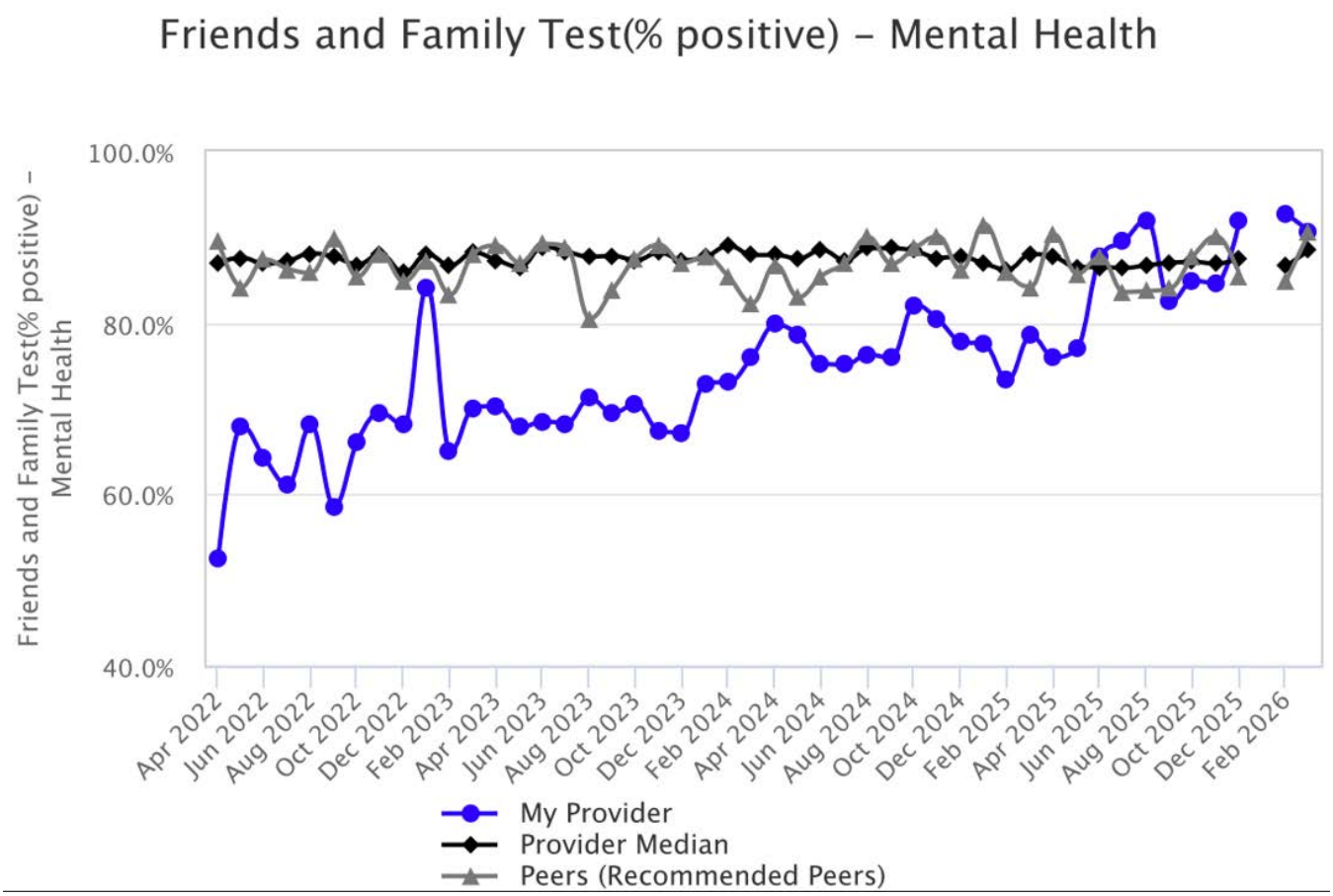
FFT Benchmarking

Benchmarking against peer organisations using Model Hospital data indicates that, based on available information to February 2026, there has been strong patient satisfaction, with a likelihood to recommend, for three consecutive quarters giving our patients consistency in their experience. In comparison to our peers, LPT sits close to, or slightly above, the median and peer lines at many points.

% of people who would recommend LPT for Mental Health Services

Provider value	Quartile 3	Peer median	Quartile 3	Provider median
90.7%		90.6%		88.5%

T H R I V E



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

Relevant external meetings attended since last Trust Board meeting

June 2026	July 2026
Leicestershire Health and Wellbeing Board	Midlands and East CEO Forum
ND Local Intelligence Network	*LPT/NHFT Performance Review Meeting (NHSE)
CQC / LPT Quarterly Engagement Meeting	*LNR Health Partners' Executive
LLR Sync	
LNR Health Partners' Executive	
Reservist Day Event	
Assurance Webinar (NHSE)	

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

Proposal

It is proposed that the Board considers this report and seeks any clarification or further information pertaining to it as required.
Decision Required

Briefing – no decision required
The Board is asked to consider this report and to decide whether it requires any clarification or further information on the content.

Governance Table

For Board and Board Committees:	Trust Board of Directors
Paper sponsored by:	Jean Knight, Managing Director
Paper authored by:	Sam Beaty, Business Manager
Date submitted:	20.07.26
Name and date of other committee / forum at which this report / issue was considered:	N/A
Level of assurance gained if considered elsewhere	☐Assured ☐ Partially assured ☐ Not assured
Date of next report:	September 2026
THRIVE strategic alignment:	☒ **T**echnology ☒ **H**ealthy communities ☒ **R**esponsive ☒ **I**ncluding everyone ☒ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	
Is the decision required consistent with LPT's risk appetite:	Yes
False or Misleading Information (FOMI) considerations:	None
Positive confirmation that the content does not risk the safety of patients or the public:	Confirmed
Equality considerations:	None

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Leicestershire Partnership and Northamptonshire Healthcare Associate University Group

NHS

Board Assurance Framework

July 2026

Quick Guide

Leicestershire Partnership and Northamptonshire Healthcare Associate University Group

NHS

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 Associate University Group

NHS

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 17 July 2026
Strategic Link	**T**HRIVE: 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 • AVT roll out – acute trust prioritisation, impact on MH services roll out	**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 - complete** • Implement InTune – **CIO June 26 - complete** • Work ongoing with NHSE to identify opportunities to remove/update EOL software – **CIO June 26 - complete** • 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 – meetings to outline digital priorities taken place with leads from LPT & NHFT - BAU – **July 26 - complete**	• Pillar under the new Digital Transformation Group in place to review Cyber opportunities • Mobile phone replacement programme being started along with rollout of InTune • HEIDI roll out prioritisation to TQI June 26 for approval – run rate being confirmed currently
Effect: Insufficient resilience to provide access to digital systems					
• Group Digital transformation programme. • Group Digital Transformation Group • Digital Prioritisation Process – LPT & NHFT		**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			

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.	
Date	1 April 2026 - initial score (I4/L2)	Last updated 18 June 2026
Strategic Link	T**H**RIVE: 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	
Context	Healthy Communities are essential to the delivery of our system strategy, preventing ill-health and reducing demand on NHS services	

Current Risk Position: Impact 4 (major) / Likelihood 2 (unlikely)
Heatmap position: **Green** (Low)
Rationale: Good system approach, further maturity anticipated

Target Risk Position: Impact 3 (moderate) / likelihood 2 (unlikely)
Target zone: Green (Low)
Rationale: Increasing positive impact on population health

Control Summary: **High** strong control framework

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 –** draft approved at June GSEB, comms to follow	
		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.	
Date	1 April 2026 - initial score (I4/L2)	Last updated 17 July 2026
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	
Context	Innovation, research for new treatments, redesign of care delivery models with a focus on patient outcomes and experience	

Current Risk Position: Impact 4 (major) / Likelihood 2 (unlikely)
Heatmap position: **Green** (Low)
Rationale: Progressing maturity

Target Risk Position: Impact 3 (moderate) / likelihood 2 (unlikely)
Target zone: Amber
Rationale: Strategic commitment with progressing maturity

Control Summary: **Medium** some gaps remain

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	Assurance over uptake and PRES survey outcomes	• 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 Sept 26** • Principal investigators review across the group **– Sept 26** • Group Joint Roles with medical nursing & AHP research element – **Aug 26** • to develop models for interprofessional learning across the Directorates – **Medical Directors** – **Sept 2026** • Outline digital & clinical priorities to improve quality & safety across the board – **July 26** • LPT & NHFT build links with universities for both training & research –**Medical Directors - Sept 26**	Oversight of research participant recruitment numbers to form part of reporting to QSCs Monthly group Research & Innovation Oversight Group – started May 26
		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	Assurance over success rate for attracting high quality commercial trials		
		3rd Line: University Led Non-Executive Director - LPT			
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		• 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 - complete**	Ongoing discussions with Health Innovation East Midlands re translating national projects to local needs.
		2nd Line QI and Transformation Committee AAA report to Finance and Performance Committees and Group Strategic Executive Board.	Impact of learning from research into service redesign		
		3rd Line - CQC inspection feedback and ratings			

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 17 July 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	Progress
Cause: **timeliness of access to services**					
• Access Policy • Performance Management Framework • Urgent and Emergency Care Framework • Medical Workforce Plan • LLR ICB 5-year strategy and 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 for group – **Group Chief Nurse - September 26** • ND pathway work across the system – chaired by Andy Ahow & Sam Hamer – to identify clinical pathways based on thresholds for prioritisation – **October 26**	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	• LPT Waiting Well Harm Whilst Waiting T&F Group developing priorities & workplan for 26 -27 – update to Safety Forum – **Group Chief Nurse - July 26** • LPT Accountability and Empowerment Framework 2026-27 – including draft quality framework - for approval at EMB – **Group Chief Nurse - Aug 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.	
Date	1 April 2026 - initial score (I5/L3)	Last updated 15 July 2026
Strategic Link	THRIVE: 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	
Context	PSIRF, PCREF, Just Culture, Prevention of harm, learning	

Current Position: Impact 5 (catastrophic) / Likelihood 3 (possible)
Heatmap position: **Red** (high)
Rationale: Criticality and responsiveness

Target Position: Impact 5 (catastrophic) / likelihood 2 (unlikely)
Target zone: Red (high)
Rationale: Criticality remains, ongoing need for maturity

Control Summary: **Medium** some gaps remain

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					
• Clinical Governance Processes • Patient Safety Improvement Groups for monitoring of clinical patient safety risks • System and process learning shared through governance meetings • Incident reporting & management - PSIRF processes through to Quality Improvement • CQC mock inspections & quality visits • Complex Case Huddles • Safer Staffing Reporting • FTSU & Listening & responding Culture • Medicines Management Processes • Safeguarding Processes	Fragmented system clinical pathways	**1st Line:** Service level oversight; Executive Service Visits & feedback; NED Board Walks; Compliance Team visits; PSIRF, IRLM (LPT) & ROSE (NHFT), Directorate Clinical Governance processes & quality & safety meetings, Quality Summits.	Access and waiting times for access & treatment Patients leaving the justice system (NHFT) Transition from children to adult's services	• Completion of the agreed LPT PSIRF thematic reviews- 1 complete, 2 further dues for completion – going to July Safety Forum - **Chief Nurse update Aug 26** • Waiting Well initiatives – ongoing – **Chief Nurse April 27** • Clinical harm reviews – Chief Nurse – **Oct 2026**	Staff undertaking STORM training
		2nd Line: EMB, Group SEB, Q&S Committee, Safety Forum. PSIG, Safeguarding, Sexual Safety, Suicide & Self Harm, Least Restrictive Practice Groups, Policy compliance oversight			
		3rd Line: External reporting (ICB); HOSCs; CQC Visits & outcomes; MHA Visits & reports, learning shared from national reports, LLR System Quality meetings, External Accreditation (SIRAN)			
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 17 July 2026
Strategic Link	THRIVE: 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 **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		• Continued testing of BCPs; NHFT conducted organisational wide test week of 29 June 2026 (seasonal impacts) - complete	Joint EPRR lead in place and in process of reviewing all related policies Submitted & received full assurance received on the core standards assessment to NHSE
Effect: **Continuity of Services**					
• Business continuity plans • Disaster recovery exercises • Industrial Action plans • Director on Call arrangements • Training of strategic, tactical and operational responders • ICC assurance flow via 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 **2nd Line:** Training oversight and management Submitted EPRR core standards assessment for 2025/26 **3rd Line** • Internal Audit – Business Continuity August 2022 Significant Assurance • EPRR core standards assessment 2025/26 – full assurance received.	Completeness and robustness of trust wide continuity plans	• BCP reviews underway reporting into EPPR Group – **Dec 2026** • EPPR Core Standards submission **(Aug 26) – Nov 2026**	Taken part in industrial action audit for national review.

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.	
Date	1 April 2026 - initial score (I4/L3)	Last updated 15 July 2026
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	
Context	Innovation, research for new treatments and redesign of care delivery models with a focus on patient outcomes and experience	

Current Risk Position: Impact 4 (major) / Likelihood 3 (possible)
Heatmap position: **Amber** (Medium)
Rationale: Good staff survey, strong controls, some gaps remain

Target Risk Position: Impact 3 / likelihood 2 (unlikely)
Target zone: Amber
Rationale: retaining strong staff feedback and filling gaps

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: **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 across the group **Ongoing Group Chief People Officer 31.3.27** • NHFT & LPT Staff Survey 25-26 – actions & implementation of priority areas **Group Chief People Officer 31.3.27 –** 4 group actions plus 2 NHFT & 1 LPT – approved by JPCC • Developing reasonable adjustment clinics in NHFT – **Sept 26** • Developing joint EDI plan – **Sept 26**	Team Time Out 26-27 plans underway Delivery of TAR actions ongoing across group
		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	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 18 June 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)	Control Summary: **Medium** some gaps remain
Governance	LPT and NHFT workforce development groups Joint People and Culture Committee, Group Strategic Executive Board, Group Trust Board		Assurance Summary: **Medium** some gaps remain
Context	Talent management, OD, growth and retention		

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 • People plans NHFT and LPT • Joint People Dashboard	• 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 **2nd Line:** • Group People and Culture Committee • System People and Culture Board • Workforce deep dives. • Jobtrain effectiveness Review (LPT) **3rd Line:** • Benchmarking against workforce metrics • Internal Audit	• Actions resulting from recent staff survey findings when available • Delivery of the workforce and agency reduction plan • Delivery of the Workforce efficiency value programme	• Delivery of the workforce and agency reduction plan and value programme 2026/27 **Group Chief People Officer March 27** • Delivery of staff survey actions identified - **Group Chief People Officer March 27** • Improving working lives of Drs 10 Point Plan	Engagement with the NHSE price cap work for medical agency costs commenced Feb 2025 - ongoing People plans developed
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. **2nd Line** Agency and bank reduction to Group People & Culture Committee through people dashboards **3rd Line** • LLR People Programme Delivery Group • Internal Audit	Delivery of the workforce and agency reduction plan / value programme	Delivery of the workforce and agency reduction plan **Group Chief People Officer March 27** 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

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 15 July 2026	Target Risk Position: Impact 4 / likelihood 2 (unlikely) Target zone: Amber (Medium) Rationale: Standards are met and need maintaining
Strategic Link	THRIV**E**: EFFICIENT AND EFFECTIVE	Exec lead(s) Group Chief Commissioning Officer (PS)	Control Summary: **Medium** some gaps remain
Governance	LPT and NFHT estates groups LPT and NHFT Finance and Performance Committees, Group Strategic Executive Board, Group Trust Board		Assurance Summary: **Medium** some gaps remain
Context	Therapeutic, patient experience, fit for purpose, meet standards, agile working, sustainable		

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 • Health and Safety Committee	• 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** • Review building compliance standards with DoN – **Chief Finance Officer May 26 - complete**	
		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 • Health and Safety Committee • 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 – **Sept 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		Current Risk Position: Impact 5 (major) / Likelihood 4 (likely) Heatmap position: **Red** (High) Rationale: **Crucial to retain fit for purpose estate**
Date	1 April 2026 - initial score (I5/L4)	Last updated 15 July 2026	Target Risk Position: Impact 3 / likelihood 3 (possible) Target zone: Amber Rationale: Requires sufficient & sustained capital allocations
Strategic Link	THRIV**E**: EFFICIENT AND EFFECTIVE	Exec lead(s) LPT Chief Finance Officer (SM) NHFT Chief Finance Officer (PS)	Control Summary: **High**
Governance	LPT and NHFT capital committees LPT Finance and Performance Committee, Group Strategic Executive Board, Trust Boards		Assurance Summary: **Medium** some gaps remain
Context	Delivery within available capital resources. Estates, digital regulatory, constitutional and legal requirements.		

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 • 2025/26 accounts – CRL delivered		• External audit of 25/26 accounts **CFOs** –June 2026 - **complete** • Manage Trust's capital plans, **CFOs March 27**	Audits concluded & accounts submitted
		2nd Line: Accounting policies / SFIs and SORD [Audit and Risk Committee]	Policy compliance		
		3rd Line: External Audit 2025/26 annual accounts unqualified opinion	26/27 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 – NHSE advised there is a pause on MOU approvals	Escalation as required to NHSE until approval received. CFOs July 2026	NHSE pause on approvals – following up with leads.
		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 - complete**	Audits concluded & accounts submitted
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.	
Date	1 April 2026 - initial score (I5/L4)	Last updated 15 July 2026
Strategic Link	THRIV**E**: 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	
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.	

Current Risk Position: Impact 4 (major) / Likelihood 4 (likely)
Heatmap position: Amber (Medium)
Rationale:

Target Risk Position: Impact 3 / likelihood 4 (likely)
Target zone: Amber
Rationale:

Control Summary: Medium

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 2025/26 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 – NHFT complete**	
		2nd Line: Accounting policies / SFIs and SORDs	Policy compliance		
		3rd Line: External Audit 25/26 annual accounts unqualified opinions	26/27 annual accounts audit	• External audit of 25/26 accounts - **CFOs June 2026 - complete**	Audits concluded & accounts submitted
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 – NHFT complete** • Submit NHSE weekly tracker weekly - **CFOs August 2026**	Not fully identified by deadline, revised internal target of 30 June.
		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 2025/26 annual accounts and VFM conclusion	26/27 annual accounts audit	• External audit of 26/27 accounts - **CFOs June 2027**	
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.	
Date	1 April 2026 - initial score (I4/L4)	Last updated 17 July 2026
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	
Context	Population health, transformation, NHS environment	

Current Risk Position: Impact 4 (major) / Likelihood 4 (likely)
Heatmap position: **Amber** (Medium)
Rationale: Significant reform creating uncertainty

Target Risk Position: Impact 3 (moderate) / likelihood 2 (unlikely)
Target zone: Amber
Rationale: Decreasing uncertainty

Control Summary: **Medium** some gaps remain

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 Group NOF dashboard design underway
		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 –**Group Chief Integration and Delivery Officer - March 27** • Ongoing development of data dashboards in LPT for supporting the Accountability Framework governance -**Group Chief Integration and Delivery Officer** March 27 • Use of Organisational Structure to allow 'single language' across PAS's **Group Chief Integration and Delivery Officer** - March 27 • 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). **Group Chief Integration and Delivery Officer –** Dec 26 • 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:			

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Leicestershire Partnership NHS Trust

Level 1, 2 and 3 Alert, Advise and Assure (AAA) Highlight Report
LPT Committee / Group : Audit and Risk Committee
Date of Meeting: 12 June 2026
Meeting chair and Report Author: Hetal Parmar / Val Glenton

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

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
			No issues to highlight.			

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

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
			No issues to highlight.			

ASSURE: Inform the Board where positive assurance has been received

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Risk Management Framework	ARC/26/037	Director of Governance and Risk	ARC approved the updated framework following its review as part of the integration in governance structures between LPT and NHFT. It had been revised to take account of the integrated way that risk was managed across the Group and to reflect all the Group arrangements. The new framework also took account of new roles and responsibilities and a new risk scoring methodology from non-multiplicative scoring to applying a zoning based on the strength of controls and assurances as well as a score.	All		

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Governance and Risk Report	ARC/26/038	Director of Governance and Risk	ARC received assurance that robust systems and processes were in place to secure an effective governance and risk framework. Key areas of work included; • A revised outline governance structure for the level two and three delivery groups had been supported at the Accountability Framework Meeting in May as part of an ongoing review and update of the governance structure. • All policies were currently in date and not due for a scheduled review. The policy management process had been aligned to NHFT's and the Group SEB had recently supported having policies in common across the Group.	All		
Annual Update of SFIs and SORD	ARC/26/043	Chief Finance Officer	ARC reviewed and approved the proposed changes to the Standing Financial Instructions (SFIs) and Scheme of Delegation (SORD).	BAF10 BAF11		
Trust Going Concern Assessment 2025/26 Annual Accounts	ARC/26/044	Chief Finance Officer	ARC agreed the Going Concern Assessment be submitted to Trust Board to request support of the assertion that the Trust was formally recognised as a Going Concern.	BAF10 BAF11		
Losses and Special Payments 2025/26 Annual Report	ARC/26/046	Chief Finance Officer	ARC received assurance on the annual summary of losses and special payments. A total of £300k was reported as at 31st March 2026 (58 cases) compared to the previous year's payments of £122k (103 cases). This was an increase of £178k but a reduction of 45 cases.	BAF11		

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

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Head of Internal Audit Opinion 2025/26	ARC/26/034	Director of 360 Assurance	A significant assurance opinion was given on the basis that LPT had a generally sound framework of governance, risk management and control designed to meet the organisation's objectives. The Trust also had a robust process and proactive culture on the completion of internal audit actions with an implementation rate of 100%.	All		
External Audit Annual Report 2025/26	ARC/26/036	Director of KPMG	The audit of 2025/26 annual accounts was being finalised but was in a good position and KPMG expected to issue a clean Auditor's Report.	N/A		

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the group/committee considers to be outstanding						
Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
			Thanks were extended to KPMG for the very smooth process this year and for the positive way queries had been handled over the course of the audit. No recommendations had been made in the ISA 260 which was an excellent outcome. KPMG had responded to say the process would not have gone as smoothly without the support and understanding of LPT's Finance Team.			

Decision Escalations: Level 2 Group decisions to escalate to EMB [decisions L2 were unable to make]						
Agenda Item:	Reference:	Lead:	Decision Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
			N/A			

ALERT Tracker: Progress against previously alerted items [until closure]							
Date of Alert:	Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
				N/A			

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Leicestershire Partnership NHS Trust

Trust Board 28 July 2026

Adoption of the Lord Mann Report Recommendations Report – Public

Purpose of the Report

To seek formal adoption of the Lord Mann review recommendations

Analysis of the Issue

The Lord Mann Review to address antisemitism and racism within the NHS was published at the beginning of June. There are a number of specific immediate actions NHS England have asked trusts to implement:

- Signing up to the NHS Race and Health Observatory Seven Anti-Racism Principles - outlined in this paper for formal adoption by Trust Board.
- Ensure implementation of the Violence Prevention and Reduction Standard, including data capture and use to target improvement with affected groups, this will be monitored via the NHS Oversight Framework – being implemented by the Trust.
- Add Sikh and Jews to our protected characteristics – in place at the trust.
- Prepare to implement the forthcoming NHS Staff Standards – currently being reviewed.
- Ensure all staff have completed the NHS Core Skills Framework module on Equality, Diversity and Human Rights (EDHR), which includes content on antisemitism and Islamophobia – in place and being monitored through training compliance.
- Ensure all staff complete the new bitesize module co-created with faith leaders in the NHS when it becomes available (with the exception of those who have completed EDHR mandatory training in the last 6 months) – awaiting release of the module by NHS England.
- Ensure Board agreement to undertake new anti-racism training when it becomes available – awaiting release of module. Previous sessions undertaken around Together Against Racism and Active Bystander training.
- Ensure colleagues, staff representatives, patients and communities are aware of your actions through your internal and external communications channels and are appropriately engaged in further developments to address antisemitism and all forms of racism locally – robust communication plans in place that already disseminates Together Against Racism (anti-racism) messages that will be strengthened as a result of adoption of the Lord Mann recommendations.
- Ensure your Board and its relevant committees fully understand your staff survey data on the experience of racism in your organisation and are taking appropriate action on key problem areas related to this issue and monitoring progress – staff survey results are regularly communicated to Trust board and a targeted workstream on addressing experiences of racism has been established to take specific action on key priority areas under the Trust's culture change programme Our Future Our Way.

- Confirm whether your organization has adopted the IHRA definition of antisemitism and the Government definition of anti-Muslim hostility by Friday 31 July 2026 – outlined in this paper for formal adoption by Trust board.

The 7 principles of anti-racism, definitions of antisemitism and anti-Muslim hostility have been attached as appendix 1, 2 and 3 in order that Trust board are aware of the content of the documents and to adopt these formally across the Group and at Trust Board. A mapping exercise was carried out and the trust response to the specific recommendations mapped and is attached as appendix 4.

A letter from the Chief Executive has been sent to staff outlining where we have been progressing our anti-racism agenda through Together against Racism and the Group will ensure that we will build on and strengthen our approach in line with the recommendations and monitor these through our WRES Anti-Racism action plans.

Proposal

To formally adopt the Lord Mann recommendations outlined in this paper including the

- 7 principles of anti-racism
- definition of antisemitism
- definition of Anti-Muslim Hostility.

Accept the progress on each one outlined in this paper and to delegate responsibility for the delivery of the recommendations arising from the Lord Mann review to the Group Chief People Officer to be monitored via the Trust's EDI governance structures.

A robust communications and engagement plan will link the actions to existing activity around Together Against Racism and Our Future Our Way, aligned to our Group EDI plan.

Decision Required

Decision required – detail below

To adopt the Lord Mann recommendations in full and delegate responsibility to the Chief People Officer for the implementation plan to be monitored via the EDI governance frameworks.

Governance Table

For Board and Board Committees:	
Paper sponsored by:	Sarah Willis, Group Chief People Officer
Paper authored by:	Haseeb Ahmad, Joint Head of EDI
Date submitted:	20 July 2026
Name and date of other committee / forum at which this report / issue was considered:	Executive Management Board, 7 July 2026
Level of assurance gained if considered elsewhere	☒Assured ☐ Partially assured ☐ Not assured
Date of next report:	N/A
THRIVE strategic alignment:	☐ **T**echnology ☐ **H**ealthy communities ☐ **R**esponsive ☒ **I**ncluding everyone ☒ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	07 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.
Is the decision required consistent with LPT's risk appetite:	Yes
False or Misleading Information (FOMI) considerations:	N/A
Positive confirmation that the content does not risk the safety of patients or the public:	Yes
Equality considerations:	The report focuses solely on the Lord Mann recommendations to improve the experiences of racism for staff working within the NHS. EDI implications are relevant throughout the report.

Appendix 1: NHS Race and Health Observatory – Seven Principles of Anti Racism

The NHS Race and Health Observatory has developed a set of seven evidence-based principles to support organisations in addressing racial inequities and embedding anti racist practice across healthcare systems. These principles emphasise practical, sustained action to improve outcomes, experience, and equity.

1. **Name Racism** - Organisations must explicitly recognise and name racism. Open acknowledgement enables transparency, creates psychological safety for staff and patients, and lays the foundation for meaningful change.
2. **Understand and Acknowledge** - Develop a shared understanding of how racism operates across structures, institutions, and individual interactions. Recognising its impact is essential to addressing inequalities in access, experience, and outcomes.
3. **Meaningfully Involve Communities** - Place lived experience at the centre of decision making. Engage and co produce solutions with racially minoritised communities, patients, and staff to ensure interventions are relevant and effective.
4. **Collect and Publish Data** - Use robust ethnicity and equality data to identify disparities, monitor progress, and inform targeted action. Transparency is critical for accountability and improvement.
5. **Identify Racial Bias** - Systematically identify and address bias in clinical care, policies, and organisational processes. This includes challenging assumptions that may influence decision making and outcomes.
6. **Apply a Race Critical Lens** - Assess services, policies, and practices through a race equity perspective. Evaluate who benefits, who is disadvantaged, and where structural barriers persist.
7. **Evaluate and Reflect-** Continuously evaluate the impact of interventions, reflect on learning, and adapt approaches to sustain long term, measurable change.

These principles support NHS organisations to move beyond intent towards measurable, evidence-based action in tackling racial inequalities and improving health outcomes for all communities. [nhsrho.org]

Appendix 2: IHRA non-legally binding working definition of Antisemitism

International Holocaust Remembrance Alliance - 26 May 2016

IHRA non-legally binding working definition of antisemitism Adopted by the IHRA Plenary in Bucharest In the spirit of the Stockholm Declaration that states: “With humanity still scarred by …antisemitism and xenophobia the international community shares a solemn responsibility to fight those evils” the committee on Antisemitism and Holocaust Denial called the IHRA Plenary in Budapest 2015 to adopt the following working definition of antisemitism.

On 26 May 2016, the Plenary in Bucharest decided to:

Adopt the following non-legally binding working definition of antisemitism: “Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities.”

Adopt the following non-legally binding working definition of antisemitism: “Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities.”

To guide IHRA in its work, the following examples may serve as illustrations: Manifestations might include the targeting of the state of Israel, conceived as a Jewish collectivity. However, criticism of Israel similar to that leveled against any other country cannot be regarded as antisemitic. Antisemitism frequently charges Jews with conspiring to harm humanity, and it is often used to blame Jews for “why things go wrong.” It is expressed in speech, writing, visual forms and action, and employs sinister stereotypes and negative character traits.

Contemporary examples of antisemitism in public life, the media, schools, the workplace, and in the religious sphere could, taking into account the overall context, include, but are not limited to:

• Calling for, aiding, or justifying the killing or harming of Jews in the name of a radical ideology or an extremist view of religion.

• Making mendacious, dehumanizing, demonizing, or stereotypical allegations about Jews as such or the power of Jews as collective — such as, especially but not exclusively, the myth about a world Jewish conspiracy or of Jews controlling the media, economy, government or other societal institutions.

• Accusing Jews as a people of being responsible for real or imagined wrongdoing committed by a single Jewish person or group, or even for acts committed by non-Jews.

• Denying the fact, scope, mechanisms (e.g. gas chambers) or intentionality of the genocide of the Jewish people at the hands of National Socialist Germany and its supporters and accomplices during World War II (the Holocaust).

• Accusing the Jews as a people, or Israel as a state, of inventing or exaggerating the Holocaust.

• Accusing Jewish citizens of being more loyal to Israel, or to the alleged priorities of Jews worldwide, than to the interests of their own nations.

• Denying the Jewish people their right to self-determination, e.g., by claiming that the existence of a State of Israel is a racist endeavor.

• Applying double standards by requiring of it a behavior not expected or demanded of any other democratic nation.

• Using the symbols and images associated with classic antisemitism (e.g., claims of Jews killing Jesus or blood libel) to characterize Israel or Israelis.

• Drawing comparisons of contemporary Israeli policy to that of the Nazis.

• Holding Jews collectively responsible for actions of the state of Israel.

Antisemitic acts are criminal when they are so defined by law (for example, denial of the Holocaust or distribution of antisemitic materials in some countries).

Criminal acts are antisemitic when the targets of attacks, whether they are people or property – such as buildings, schools, places of worship and cemeteries – are selected because they are, or are perceived to be, Jewish or linked to Jews.

Antisemitic discrimination is the denial to Jews of opportunities or services available to others and is illegal in many countries.

In November 2025, in the Group CEO newsletter we shared the following with all staff from our chief executive and chair:

As part of our work through the Together Against Racism programme, we reject all forms of hatred, antisemitism, Islamophobia, racism and any form of discriminatory behaviour.

In line with NHS England and other providers across the country, we are formally and actively adopting the IHRA working definition of antisemitism:

"Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and their property, toward Jewish community institutions and religious facilities."

Appendix 3: Definition of anti-Muslim hostility

The UK government's non-statutory definition of anti-Muslim hostility is the following:

Anti-Muslim hostility is intentionally engaging in, assisting or encouraging criminal acts – including acts of violence, vandalism, harassment, or intimidation, whether physical, verbal, written or electronically communicated – that are directed at Muslims because of their religion or at those who are perceived to be Muslim, including where that perception is based on assumptions about ethnicity, race or appearance.

It is also the prejudicial stereotyping of Muslims, or people perceived to be Muslim including because of their ethnic or racial backgrounds or their appearance, and treating them as a collective group defined by fixed and negative characteristics, with the intention of encouraging hatred against them, irrespective of their actual opinions, beliefs or actions as individuals.

It is engaging in unlawful discrimination where the relevant conduct – including the creation or use of practices and biases within institutions – is intended to disadvantage Muslims in public and economic life.

The purpose of the definition is to protect Muslims from hostility. It must be read alongside the accompanying text set out below, which makes clear that open debate in the public interest is important and must be fully safeguarded. Context must also always be taken into account when interpreting and applying the definition.

Everyone should feel able to contribute to the exchange of ideas that supports a free and thriving society, participate in academic and political discussion and feel able to raise concerns. This accompanying text is intended to make clear that these principles are essential and must be upheld.

It is important to bear in mind the fundamental right of every person in the United Kingdom to exercise freedom of speech and expression within the law. Examples of expression that are protected include:

- criticisms of a religion or belief, including Islam, or of its practices, or critical analyses of its historical development
- ridiculing or insulting a religion or belief, including Islam, or portraying it in a manner that some of its adherents might find disrespectful or scandalous
- criticism of the belief systems or practices of individual adherents of a religion or belief, including Islam
- raising concerns in the public interest
- contributing to debates in the public interest, including academic and political debate

Published 9 March 2026

Appendix 4: Action Plan - Implementation of the Lord Mann review recommendations

Action	Category	Current Position	Response	Completion date
Sign up to NHS Race and Health Observatory Seven Anti-Racism Principles	Immediate	Requires formal adoption	Pledge to adopt as a Board	31-Jul-26
Implement Violence Prevention and Reduction Standard (incl. data capture/use)	Immediate	Adopted. Ian Cromarty to pick up across the Group	Adopted - to be strengthened. Ensure Jewish and Sikh in protected characteristics datasets.	31-Jul-26
Adopt IHRA definition of antisemitism and govt definition of anti-Muslim hostility	Immediate	Requires formal adoption	Pledge to adopt as a Board - was in a board report re antisemitism. Link to TAR commitment	31-Jul-26
Ensure staff complete EDHR Core Skills training	Immediate	Already mandatory and is monitored through frequent training reports. May need to give additional push in areas where completion rates are falling below acceptable thresholds.	This is already mandatory and compliance levels tracked	Complete
Engage stakeholders and communicate actions on racism	Immediate	We already communicate regularly about our anti-racism work; however, we will need to more clearly articulate the Lord Mann recommendations, including the additional definitions and practices we are required to adopt, and set out how these will be embedded into our day-to-day operations.	Message from Angela sent on 11.6.26 to all staff. Regular comms moving forward and include on website. Integrate into our toolkits	30-Jun-26
Board review of staff survey data on racism and act on findings	Immediate	2025/26 staff survey results were shared with Joint PPC in April and Trustwide and directorate action plans shared at June PPC – including link to OFOW work signed off by EMB around racism and discrimination and equitable career progression. Lord Mann's and NHS England's recommendations and priorities will be incorporated into the action plan and shared at next PPC. Lord Mann's recommendations will be integrated into the final products being worked on by the change leader group.	We do this already on a regular basis at WDG, PPC and Board – tracking staff survey actions.	Complete
Prepare to implement NHS Staff Standards	Preparation	These will be flagged to Trust Board and Execs.	We'll review and adopt as they are launched	TBC
Ensure staff complete new bitesize module when available	Preparation	This needs to be flagged to L&D and SHRMT so it gets included on training dashboard.	We will share with staff	TBC
Board to undertake anti-racism training when available	Preparation	Add to Board Development Day. Opportunity for Execs to review their anti-racism pledges.	Flag at next board session. Doing session on active bystanders. All members have a TAR pledge	30-Jun-26
Confirm adoption of definitions via national return (by 31 July 2026)	Immediate	Report needed for Joint SEB with the definitions included for official adoption. May also need to take to Trust Boards for completion.	Will have adopted by then	31-Jul-26

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Leicestershire Partnership NHS Trust

Level 1, 2 and 3 Alert, Advise and Assure (AAA) Highlight Report
LPT Committee/Group: Quality and Safety Committee
Date of Meeting: 19th May 2026
Meeting Chair and Report Author: Josie Spencer Non-Executive Director & Interim Deputy Chair
Quorate Y – Meeting had to be stood down part way through as the Chair had to leave therefore it was no longer quorate. The report reflects the discussion whilst the meeting was quorate The remainder of the agenda items were presented to Confidential Trust Board on Tuesday 26th May.

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

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)

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

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Clinical Plan 2025-30	QSC/26/033	Dr Bhanu Chadalavada	The committee received LPT Clinical Plan 2025-30, the paper remained in draft form and has not yet been presented to the Executive Management Board, and therefore represented an interim position rather than a fully validated plan. There had been significant engagement across directorates in the development process, with clinical and operational leaders identifying priority areas aligned to the Trust's strategic direction and the THRIVE strategy. The Committee noted that the plan is	05		

T H R I V E

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
			structured around several core priority domains, within which specific improvement initiatives and workstreams have been identified for delivery during the current year. The scale and ambition of the programme was noting, in particular the breadth of activity and the number of significant transformation initiatives underway. The Committee recorded moderate assurance for the Clinical Plan 2025-30 and requested that this is presented to EMB for consideration and for a further update to come to the Quality and Safety Committee in August 2026.			
Mental Health Act Annual Report 2025-26	QSC/26/034	Dr Bhanu Chadalavada	The committee received the Mental Health Act (MHA) Annual Report and accompanying dashboard outlining activity data relating to use of the Act for April 2025 – March 2026. Members raised concerns regarding the clarity of the report, particularly in distinguishing statutory compliance from good practice standards. It was highlighted that this lack of clarity could lead to misinterpretation, especially where compliance rates appeared below 100% for measures that may be assumed to be statutory. In response, it was agreed that the report should more explicitly differentiate statutory requirements from good practice metrics and provide a clear summary statement of compliance. Members also requested additional context for the data presented, including benchmarking against other organisations and greater longitudinal analysis rather than reliance on point-in-time (census) data, highlighting the need for clearer interpretation of statistical tables and appendices, including drawing out key learning, risks, and implications for clinical practice and service planning. It was suggested that graphical information should also be improved for readability.	05		

The AAA Highlight Report should include a maximum of 3 items per category. If the group is unable to make a decision as they need a wider audience, this should be listed above to be escalated to EMB. Please include all unresolved previous alerts with details of progress.

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
			The Committee concluded that while there were no substantive concerns regarding compliance or performance, the current presentation of the report limited the level of assurance that could be achieved. It was therefore agreed that the report would be revised to incorporate the requested clarifications, improved narrative, clearer distinction between statutory and good practice measures, and enhanced data interpretation. The revised report will be brought back to the June 2026 Quality and Safety Committee.			

ASSURE: Inform the Board where positive assurance has been received

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Same Sex Accommodation Annual report 2025-26 and Declaration of compliance	QSC/26/035	Linda Chibuzor	The Committee was assured that appropriate systems are in place to monitor and report breaches in relation to mixed sex accommodation, and that the organisation is meeting national compliance requirements. In addition it was agreed that the report could be strengthened in future, by making explicit reference to all breaches being reported and by including comparative data.	05		
Research and Development Annual Plan and Annual Report 2025-26	QSC/26/036	Dr Bhanu Chadalavada	The committee received the Research and Development (R&D) Annual Plan taking assurance from the report. The report highlighted that LPT remains compliant with established governance processes, including the Organisation Research Capacity Assessment (ORCA), and	03		

T H R I V E

The AAA Highlight Report should include a maximum of 3 items per category. If the group is unable to make a decision as they need a wider audience, this should be listed above to be escalated to EMB. Please include all unresolved previous alerts with details of progress.

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
			continues to operate within National Institute for Health and Care Research (NIHR) systems. LPT is within the top 92% for confirming local research capacity within 60 days. Additionally, the Trust is meeting targets for "first patient, first visit" within 30 days of capacity confirmation and is achieving activity within 90 days of Health Research Authority (HRA) approval. These indicators evidence effective delivery against national expectations. The committee noted the very comprehensive report and commented positively on the breadth and depth of research activity within LPT.			

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

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)

Decision Escalations: Level 2 Group decisions to escalate to EMB [decisions L2 were unable to make] – None

ALERT Tracker: Progress against previously alerted items [until closure] – Not applicable

T H R I V E

The AAA Highlight Report should include a maximum of 3 items per category. If the group is unable to make a decision as they need a wider audience, this should be listed above to be escalated to EMB. Please include all unresolved previous alerts with details of progress.

NHS
Leicestershire Partnership
NHS Trust

Level 1, 2 and 3 Alert, Advise and Assure (AAA) Highlight Report
LPT Committee/Group: Quality and Safety Committee
Date of Meeting: 16th June 2026
Meeting Chair and Report Author: Josie Spencer Non-Executive Director & Interim Deputy Chair
Quorate Y

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

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
			Nil			

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

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Accountability Framework Meeting Triple A report	QSC/26/050	Jean Knight	The committee was advised of a notable increase in referrals to community mental health services, particularly within City West, where referrals are significantly higher than in other areas. A key contributing factor is the absence of mental health workers within the relevant Primary Care Network funded through the Additional Roles Reimbursement Scheme. Further exploration is needed to understand why some networks are not fully utilising this opportunity. unlike other areas where these roles are established. This issue will be escalated with Integrated Care Board (ICB) colleagues to better understand and address the disparity.	04 05		

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Quality and Safety Dashboard	QSC/26/052	Linda Chibuzor	The committee revisited performance on complaint response times, specifically the target of closing 90% of complaints within 40 working days. Whilst the target has not yet been achieved, progress is being made, with a revised timeline and further detail being brought back to the committee in August 2026, The committee also noted that reporting currently reflects old data (i.e. February 2026) and would benefit from seeing more current performance information to give further assurance on progress.	05		
Learning from Deaths	QSC/26/063	Dr Bhanu Chadalavada	The committee received Learning from Deaths report for the period January to March 2026. The report has been revised to provide additional clarity around in-scope criteria across directorates, the screening processes in place, and the resulting data, themes, and actions. The introduction of automated screening has significantly increased the number of cases identified for review, rising from approximately 5–8 per month to 25–30 or more in DMH. This reflects broader criteria capture within the system (e.g. related conditions such as bipolar disorder being flagged alongside psychosis and schizophrenia). As a result, additional clinical screening is now required to confirm whether a full review is necessary. A clinical lead has been appointed to support this work, including strengthening thematic analysis and a focus on health inequalities. It was noted that there remains a notable number of cases awaiting full review following screening, reflecting the increased throughput. Directorates continue to identify themes, learning, and actions, and to share these both internally and, where appropriate, with wider system partners. The Committee also noted the separate LEDeR (Learning Disabilities Mortality Review) process, which provides more detailed national-level analysis alongside local reviews.	05		

The AAA Highlight Report should include a maximum of 3 items per category. If the group is unable to make a decision as they need a wider audience, this should be listed above to be escalated to EMB. Please include all unresolved previous alerts with details of progress.

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
			The Committee concluded that improvements are underway but not yet complete. The revised reporting format and action tracker were endorsed as meeting the Committee's requirements.			

ASSURE: Inform the Board where positive assurance has been received

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
LPT Medical Director update	QSC/26/048	Dr Bhanu Chadalavada	Mental Health Act Annual report 2025-26 The Committee noted the additional information provided in response to previous request for clarity around statutory requests and approved sign off of the updated version.			
Quality Assurance Report	QSC/26/054	Linda Chibuzor	The Committee noted several positive developments and areas for celebration. In particular, the recent CQC inspection feedback for Specialist Community Mental Health Services for Children and Young People was highly positive, contributing to an improved overall rating of "good." Similarly, inspection activity within Mental Health Services also resulted in positive feedback and an improved overall position. The significant efforts of teams involved were acknowledged. It was further reported that a warning notice previously issued to Community Mental Health Teams (CMHTs) had been removed, with continued progress being made against improvement trajectories, including reductions in waiting times. The Committee was informed of resumed Mental Health Act (MHA) review visits following a period of inactivity, likely reflecting the regulator returning to routine activity after staffing changes and re-organisation.	05		

T H R I V E

The AAA Highlight Report should include a maximum of 3 items per category. If the group is unable to make a decision as they need a wider audience, this should be listed above to be escalated to EMB. Please include all unresolved previous alerts with details of progress.

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Quality Summit Overview	QSC/26/057	Linda Chibuzor	The committee received a summary report on Quality Summits held over the past year. The summits are treated as a joint venture with directorates and are maintained until there is sufficient assurance that the identified issues have been addressed. This assurance is achieved when improvements are embedded into business-as-usual processes, governance frameworks, or when the issue is fully resolved. Assurance was provided that all Quality Summits held during the year have now been closed.	05		
Level 2 Health and Safety Committee AAA Report	QSC/26/060	Jean Knight	An alert relating to the Trust's fire alarm systems was raised. Discussion was held at the June 2026 Executive Management Board (EMB) an independent review has since been commissioned to provide additional assurance and a corresponding risk added to the Corporate Affairs risk register. Since the writing of the report it had been confirmed that appropriate mitigating actions are in place.	05		
Safeguarding Annual Declaration	QSC/26/062	Linda Chibuzor	The Committee formally approved the Annual Safeguarding declaration, which is now published on the Trust's Public website			
Sexual Safety Annual report 2025-26	QSC/26/065	Linda Chibuzor	The committee noted the significant progress made over the past year in terms of raising awareness and increasing staff training. The report reflected the Trust's commitment since signing up to the Sexual Safety Charter and progressing associated actions. There is an established working group supporting this work, there is improved reporting of incidents, which demonstrates increased staff confidence in recognising and reporting concerns. The report was commended as a comprehensive reflection of the work undertaken.	05		

The AAA Highlight Report should include a maximum of 3 items per category. If the group is unable to make a decision as they need a wider audience, this should be listed above to be escalated to EMB. Please include all unresolved previous alerts with details of progress.

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

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Accountability Framework Meeting Triple A report	QSC/26/050	Jean Knight	The committee were made aware of the significant achievement in exceeding targets for physical health checks for patients on the Severe Mental Illness (SMI) register, demonstrating strong commitment to improving physical health outcomes for this cohort. Additionally, progress in co-production within Community Health Services was commended, recognising the efforts made to engage patients who are often harder to reach, including those who are housebound.			

Decision Escalations: Level 2 Group decisions to escalate to EMB [decisions L2 were unable to make]

Agenda Item:	Reference:	Lead:	Decision Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
			Nil			

T H R I V E

The AAA Highlight Report should include a maximum of 3 items per category. If the group is unable to make a decision as they need a wider audience, this should be listed above to be escalated to EMB. Please include all unresolved previous alerts with details of progress.

ALERT Tracker: Progress against previously alerted items [until closure]

Date of Alert:	Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
16th June 2026	Accountability Framework Meeting Triple A report	QSC/26/050	Jean Knight	The committee noted the ongoing alert relating to the number of patients waiting over 52 weeks which had been raised in the committees AAA for many months. It was noted that significant work has been undertaken to improve support for these patients. This includes enhancements to the Waiting Well website to provide better information and support for those experiencing extended waits. In addition, operational teams have continued to work extensively to reduce waiting lists within the constraints of commissioned capacity. It was agreed that this area will remain under ongoing review and monitoring.	04		

T H R I V E

The AAA Highlight Report should include a maximum of 3 items per category. If the group is unable to make a decision as they need a wider audience, this should be listed above to be escalated to EMB. Please include all unresolved previous alerts with details of progress.

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Leicestershire Partnership NHS Trust

Trust Board 28 July 2026

Safe Staffing May 2026

Purpose of the Report

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

Key staffing areas to note, potential risks, and actions to mitigate to ensure that safety and care quality are maintained as presented on page 4.

This report triangulates in-patient nursing workforce metrics; fill rates, Care Hours Per Patient Day (CHPPD), Nurse Sensitive Indicators (NSI's), and patient experience feedback. (Scorecard, Appendix 1).

Background

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

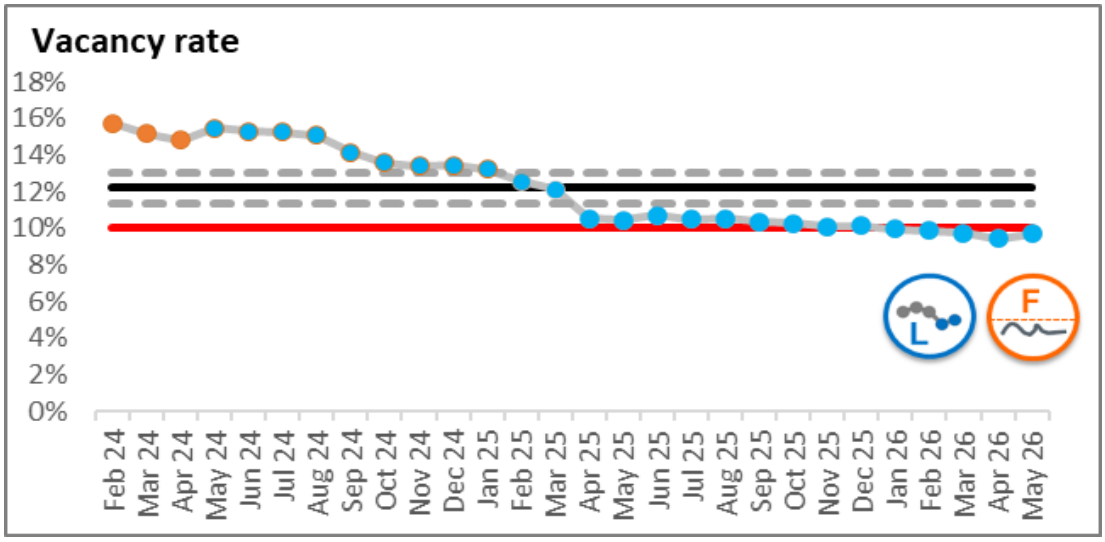
The Trust demonstrates its position regarding mandatory submission of fill rates required by the Department of Health via UNIFY and paying attention to any variance below 80% and above 110%. The upload of these figures to UNIFY occurs on the 15th of each month following review and sign off by the Group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

Analysis of the issue

Right Staff

Trust overall vacancy rate

In May 2026, the overall Trust vacancy rate was 9.7% which is slightly below the Trust target of 10%.



Registered Nurses

- Vacancy position is at 237 Whole Time Equivalent (WTE) with a 11.7% vacancy rate, an increase of 0.7% since April 2026.
- Turnover for nurses is at 5.7% which is below the Trust target of 10%.
- Sickness reported at 6.8% an increase of 0.2% since April 2026.
- 1.0 WTE nursing staff (bands 5 to 8a) were appointed in May 2026.

Health Care Support Worker (HCSW)

- Vacancy position is at 170.2 WTE with a 15.7% vacancy rate, an increase of 0.1% since April 2026.
- Turnover rate is at 8.0%. which is below our internal target of no more than 10%.
- Sickness reported at 7.3% which is a decrease of 0.1% since April 2026.
- A total of 8.6 WTE HCSW were appointed in May 2026.

Allied Health Professionals (AHPs)

- Vacancy position is at 59.5 WTE with a 6.5% vacancy rate, a decrease of 0.9% since April 2026.
- Turnover rate remains at 8.8%, which is below our internal target of no more that 10 % turnover.
- Sickness reported at 4.5%, which is a slight increase of 0.1% since April 2026.
- 1.2 WTE AHP was appointed in May 2026.

Medical

- Vacancy position is at 10.8 WTE with a 6.8% vacancy rate with a decrease of 1.2% since April 2026.
- Turnover rate is at 6.8%, a decrease of 0.7% since April 2026.
- Sickness reported at 2.2 % which is an increase of 0.7% since April 2026.
- 2.0 WTE were appointed in May 2026.

Temporary workforce

- Temporary worker utilisation rate reduced this month by 0.28% % reported at 22.38% overall, of this, Trust wide agency usage decreased this month by 0.34% to 1.10% overall.

Right Skills

- Across the Trust on average core and Clinical mandatory training compliance is currently compliant (green). Paediatric Resuscitation level 3 is amber at 80%.
- Across the Trust, on average appraisal rates and clinical supervision remain consistently compliant (green).

Right Place

- In May 2026, the total Trust Care Hours Per Patient Per Day (CHPPD average), including ward based AHPs, is calculated at 11.0 CHPPD (national average 10.8) consistent with April 2026.

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

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

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

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

Table 1 – Key Areas to Note

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
CHS In-patients	Temporary workforce utilisation higher for: Rutland ward at 30.3% and Snibston at 26.3% temporary workforce due to vacancies and sickness. Daily staffing reviews, and staff movement to ensure substantive Registered Nurse (RN) cover in each area, or regular bank and agency staff for continuity to mitigate the risks.	**Green**
CHS In-patients	**Fill rate** Fill rate above 110% of HCSW day shifts on Dalgleish, ward 3 St Lukes, Snibston and Swithland Fill rate above 110% of HCSW night shifts on Rutland, North ward, Snibston and Swithland HCSW fill rate above 110% is due to increased patient acuity and dependency, increased Enhanced Therapeutic Observations of Care (ETOC) following transfer from acute providers requiring additional staff to meet the patient care needs. Improvement work with an ETOC task and finish group has commenced linked to the trust wide NHS England ETOC programme.	**Green**
CHS In-patients	**Nurse Sensitive Indicators (NSIs)** **Falls** Falls reduced from 39 to 33. 1 moderate harm fall and 1 severe harm fall reported, both patients transferred to acute services and ISMR's requested. All other falls were reported as low, or no harm and staffing was not identified in initial review as a contributory factor. It is noted 8 falls on Charnwood due to high patient acuity, support, oversite, and monitoring provided by the matron no further action needed.	**Green**

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
	Medication incidents No significant change in medication incidents since last month. **Pressure Ulcers** The number of category 2 pressure ulcers developed or deteriorated in our care has increased from 8 in April to 10 in May 2026. Pressure ulcer improvement work continues with weekly and additional monthly meetings to monitor the refined validation process for all pressure ulcers in care. Ward mattress usage is also monitored on a weekly basis by CHS Matron team. **Staffing Related Incidents** The number of safe staffing related incidents increased from 12 in April to 13 in May 2026 across five wards. Incidents reported were relating to staffing shortages due to sickness, high acuity and patients requiring ETOC. All staffing related incidents reported as low/no harm.	
DMH In-patients	**Staffing:** High percentage of temporary workforce to meet planned staffing on Watermead at 51.9% and Heather at 42.8%. Ashby, Beaumont, Belvoir, and Bosworth over 30% temporary workforce. High utilisation of temporary workforce was due to a number of factors including increased acuity for patients with high-risk behaviours, increased therapeutic observations, backfilling with additional HCSW's so staff can be moved to support Thornton ward which is planned to close early June 2026, staff sickness and maternity leave. Staffing is risk assessed daily through a staffing huddle across all DMH wards and staff moved to support safe staffing levels and skill mix, patient needs, acuity and dependency and we use regular temporary staff who know the ward areas well and support continuity of patient care. **Allied Health Professional (AHP) Staffing:** Current reduction in Technical Instructor (TI) post in Mental Health Services for Older People due to a vacancy, recruitment in progress and band 6 Physiotherapist due to sickness. Huntington's disease team providing cross cover. Band 7 Occupational Therapist (OT) returning to work in Rehabilitation and a short-term OT staffing challenge in PICU due to sickness, mitigation includes a temporary reduced offer.	**Green**

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
DMH In-patients	**Fill rate:** Fill rate RN on day shifts above 110% on Aston due to rostering of additional staff hours, honouring existing shift pattern of a band 6 and staff being re-deployed to other areas to support staffing pressures. Fill rate HCSW on day shifts above 110% on Ashby, Aston, Beaumont, Heather, Watermead, Gwendolen, Kirby and Langley. Fill rate HCSW night shifts above 110% on all wards apart from Belvoir, Phoenix, Stewart House and Willows. HCSW fill rate above 110% was due to increased patient acuity and dependency requiring increased therapeutic observations to manage increased incidences of physical aggression and behavioural distress, patients requiring additional staff for personal care, management of falls and deterioration in mental and physical health needs.	**Green**
DMH In-patients	**Nurse Sensitive Indicators:** **Falls** An increase in the number of falls incidents from 50 in April to 61 in May 2026. 1 moderate harm fall and 1 severe harm fall reported, both patients transferred to acute services and Incident Service Management Reviews (ISMRs) requested. All other falls were reported as low, or no harm and staffing was not identified in initial review as a contributory factor. Falls huddles are in place and physiotherapy reviews for patients with sustained falls and increased risk of falling, where themes and trends in falls are being discussed to share, learn and support safe care. **Medication Incidents** The number of medication incidents increased from 20 in April to 25 in May 2026. All incidents were reported as no, or low harm and staffing was not a contributory factor. **Pressure Ulcers** One category 2 pressure ulcer confirmed as present on admission in May 2026, an increase from April 2026.	**Green**

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
FYPC.LDA in- patient	**Staffing:** 36.1 % temporary workforce at Beacon to ensure continuity of care to meet safe planned staffing due to high levels of acuity/complex needs and increased therapeutic observations to maintain patient safety. Agnes Unit at 26.6% % of which 9.4% was agency. One patient requires up to six staff to deliver safe and effective care during May 2026. Safe staffing is reviewed daily due to increased patient acuity and complexity with staffing levels adjusted accordingly. Beacon and Agnes Unit continue with reliance on high temporary workforce (reducing slightly) with advance booking of staff. Mitigation remains in place; potential risks being closely monitored.	**Green**
FYPC.LDA in- patient	**Fill Rate:** Below 80% for RNs on day shifts and night shifts at the Grange and below 80% for HCSWs on day shifts at the Grange and Gillivers. Above 110% for RN on days at the Agnes unit and above 110% for RN on nights at the Gillivers. Above 110% for HCSWs on day shifts at the Beacon, day and night shifts on Welford ED and on night shifts only at the Gillivers. The Grange & Gillivers offer planned respite care, the staffing model is dependent on individual patient need, presentation, and associated risks. As a result, this fluctuates the fill rate for RNs and HCSWs on days and nights for the month in both services. Mitigation was provided with cross cover for significant reduced RN fill rate on the day and nights shifts at the Grange during May 2026. Work is in progress to align the Gillivers and the Grange fill rate analysis, to potentially enable joint reporting as short breaks going forward recommendation being considered by Directorate Management Team in June 2026. Staffing levels reviewed and adjusted accordingly at the Agnes unit. Increased RN fill rate continues due to high patient acuity and support required on Pod 1. Beacon unit continue with high levels of acuity and patient complexity.	**Green**

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
	Welford ED continues with high patient acuity, a number of patients requiring additional staff to provide increased therapeutic observations, supervision at mealtimes and Naso-Gastric feeding.	
FYPC.LDA in- patient	**Nurse Sensitive Indicators:** **<u>Falls</u>** The number of falls incidents increased from 3 in April to 5 in May 2026. All reported as low/no harm and staffing was not a contributory factor. No significant changes in falls since last month. **<u>Medication Incidents</u>** The number of medication related incidents decreased from 5 in April to 2 in May 2026 and staffing was not a contributory factor.	**Green**
CHS Community	Overall community nursing Service OPEL has been level 2, working to level 2/3 actions. Daily review of caseloads, review of non-essential activities and ongoing reprioritisation of visits conducted to enable the service to meet essential patient visits. Ongoing review of bank and agency usage and reduction and continuing quality improvement work focusing on pressure ulcer and insulin continues. The community nursing transformation programme has concluded, however ongoing actions from the transformation programme relating to service specification, care planning/ documentation, training/ competency continue and are monitored through the service Operational Development Group. Community Nursing Safer Staffing Tool II (CNSST II) implementation continues across the service.	**Green**
DMH Community	Key areas to note - Mental Health Urgent Care Hub (MHUCH) for registered clinicians, nurses and HCSW's. Sickness impacting the Crisis team. Working to OPEL level 3. City West has significant pressure due to high referral rates requiring longer management time in daily huddles and high sickness in MHSOP community teams. South Leicestershire now separating into 2 teams and City East continue to review patient tracker list, case management and waiting times for Community Psychiatric Nurse (CPN) input. Psychosis Intervention Early	**Green**

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
	Recovery (PIER) caseloads remain high, overall reducing and some delays in transferring patients to Neighbourhood Mental Health Teams (NMHT). The CMHT leadership team review staffing weekly and request additional staff via bank and agency, mitigation includes staff movement across the service, potential risks are closely monitored within the Directorate Quality and Safety meetings or escalated via the daily community assurance huddle. Quality Improvement plan continues via the transformation programme. Crisis Resolution Home team (CRHT) staffing model fluctuates in response to case load and clinical risk. OPEL level 3 enacted team leads continue stepping into planned staffing to support safe staffing. Challenges continue in MHUCH, Place of Safety Assessment Unit (PSAU) and Mental Health Response Vehicle service with Mental Health Practitioner (MHP) vacancies being backfilled with additional temporary workforce and overtime. Active targeted on-going recruitment. Challenges in Criminal Justice Liaison and Diversion (CJLD) due to sickness mitigated by leadership team stepping into planned staffing. **AHP Community** Occupational therapy (OT) posts in Adult Mental services in City West, City East, Charnwood, East Leicestershire, Forensics and Mental Health Services for Older People in South Leicestershire, Melton, Rutland and Harborough and Charnwood affected by vacancies, sickness, and maternity leave. Recruitment is progressing and staff returning from maternity leave and long-term sickness in July 2026. New ways of working to support workflow and reduction in waiting times continue. Registered staff currently being aligned to new neighbourhoods. Attendance at referral huddles by OTs continues to identify an increase in referral rates. MHSOP community OT team cross covering across LLR to support waiting list management. Patient Tracker list meetings commenced in both AMH and MSOP.	
FYPC.LDA Community	Learning Disability (LD) city and county nursing, LD access and LD Crisis Response Intensive Support Team (CRIST) continue as areas to note due to maternity leave and sickness. Mental Health Support Teams (MHST) in schools, County Healthy Together teams in Hinckley and Bosworth and a number of city teams remain grouped together to mitigate and maintain service stability. LD physiotherapy	**Green**

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
	experiencing significant increase in referrals and Diana Respiratory Physiotherapy reached maximum caseload capacity; mitigation includes prioritising end of life patients. Mental Health school team (MHST) challenge continues due to recruitment to Children's Wellbeing Practitioner roles (nationally driven), however the British Association for Behavioural and Cognitive Psychotherapies (BABCP) advised they cannot support with the Whole School and College Approach impacting on capacity of the wider team. Working with leads and system partners. Audiology and Dynamic Support team also listed as fragile service. Child Adolescent Mental Health Service Eating Disorder Team (CAMHS EDT) staffing significantly reduced due to sickness/maternity leave now listed as a fragile service and Child Adolescent Mental Health Service Young Persons team (CAMHS YPT) also due to maternity and sickness, alongside significant increase in complex referral and attendance of Looked After Children (LAC) in the emergency department. Mitigation continues in place with potential risks being closely monitored within Directorate. Safer staffing plans/models reviewed including teams operating in a service prioritisation basis.	

Summary

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

Appendix 1 – May 2026 scorecard

Proposal

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

Decision required.

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

Governance table

For Board and Board Committees:	Trust Board
Paper sponsored by:	Linda Chibuzor Group Chief Nurse/Executive Director of Nursing, AHPs and Quality
Paper authored by:	Elaine Curtin Workforce and Safe Staffing Matron, Jane Martin Assistant Director of Nursing and Quality, Emma Wallis Deputy Director of Nursing and Quality
Date submitted:	28 July 2026
Name and date of other committee / forum at which this report / issue was considered:	Executive Management Board 7.7.2026
Level of assurance gained if considered elsewhere	☒Assured ☐ Partially assured. ☐ Not assured
Date of next report:	Bi-Monthly
THRIVE strategic alignment:	☐ **T**echnology ☐ **H**ealthy communities ☐ **R**esponsive ☐ **I**ncluding everyone ☐ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	BAF 04 Timely Access BAF 05 Patient Safety BAF 07 Culture BAF 08 Workforce resourcing strategies
Is the decision required consistent with LPT's risk appetite:	Yes
False or Misleading Information (FOMI) considerations:	None
Positive confirmation that the content does not risk the safety of patients or the public:	Yes
Equality considerations:	None

Appendix 1: Safe Staffing May 2026 Scorecard

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

Ward Name	Average Beds	Average Occupied Beds	% Fill Rate Registered Nursing Day	% Fill Rate Unqualified Nursing Day	% Fill Rate Registered Nursing Night	% Fill Rate Unqualified Nursing Night	% Fill Rate Allied Healthcare Professional Registered Day	% Fill Rate Allied Healthcare Professional Unregistered Day	Temporary Workers % (Nursing)	Bank % (Nursing)	Agency % (Nursing)	Overall Care Hours Per Patient Day	Medication Errors (and monthly movement)	Falls (and monthly movement)	Complaints (and monthly movement)	Pressure Ulcers Category 2 (and monthly movement)	Pressure Ulcers Category 4 (and monthly movement)	End Of Data Report
Beechwood Ward - BC03	24	24	90.4% Green	103.1% Green	96.8% Green	106.0% Green	100.0%	100.0%	10.2% Green	9.7% Green	0.5% Green	8	0 No Change	5 Up	0 No Change	0 Down	0 No Change	
Clarendon Ward - CW01	21	20	91.4% Green	108.7% Green	100.0% Green	109.7% Green	100.0%	100.0%	10.3% Green	10.1% Green	0.2% Green	10	2 No Change	5 Up	0 No Change	0 No Change	0 No Change	
Dalgleish Ward - MMDW	17	16	100.3% Green	110.4% Blue	98.4% Green	106.1% Green	100.0%	100.0%	17.3% Green	15.2% Green	2.1% Green	9	1 No Change	3 No Change	0 No Change	1 No Change	0 No Change	
Rutland Ward - RURW	18	17	100.3% Green	104.3% Green	99.8% Green	152.4% Blue	100.0%	100.0%	30.3% Amber	24.7% Amber	5.6% Green	8	2 Up	2 No Change	0 No Change	0 Down	0 No Change	
Ward 1 - SL1	21	18	95.7% Green	100.9% Green	100.0% Green	99.9% Green	100.0%	100.0%	20.3% Amber	19.4% Green	1.0% Green	10	0 Down	2 Down	0 No Change	0 No Change	0 No Change	
Ward 3 - SL3	14	13	102.9% Green	112.9% Blue	100.0% Green	102.9% Green	100.0%	100.0%	23.3% Amber	23.0% Amber	0.2% Green	9	1 No Change	1 Down	0 Down	1 Up	0 No Change	
Charnwood Ward - LBCW	18	17	94.6% Green	98.1% Green	100.0% Green	102.2% Green	100.0%	100.0%	16.6% Green	16.4% Green	0.2% Green	10	1 Down	8 Up	0 No Change	0 Down	0 No Change	
East Ward - HSEW	28	27	82.1% Green	98.7% Green	95.9% Green	99.7% Green	100.0%	100.0%	19.4% Green	18.9% Green	0.5% Green	9	2 Down	1 Down	0 No Change	4 Up	0 No Change	
Ellistown Ward - CVEL	19	18	95.8% Green	105.5% Green	98.4% Green	104.3% Green	100.0%	100.0%	15.2% Green	13.3% Green	1.9% Green	11	3 Up	1 Down	0 No Change	2 Up	0 No Change	
North Ward - HSNW	19	19	99.1% Green	101.7% Green	100.0% Green	115.0% Blue	100.0%	100.0%	16.7% Green	16.5% Green	0.2% Green	9	3 Up	0 Down	0 No Change	1 Up	0 No Change	
Snibston Ward - CVSN	21	18	101.3% Green	110.3% Blue	100.3% Green	123.7% Blue	100.0%	100.0%	26.3% Amber	25.5% Amber	0.8% Green	10	2 Up	2 Down	0 No Change	0 No Change	0 No Change	
Swithland Ward - LBSW	21	20	85.8% Green	115.5% Blue	100.0% Green	116.1% Blue	100.0%	100.0%	18.0% Green	17.6% Green	0.4% Green	9	4 Up	2 No Change	0 Down	0 Down	0 No Change	
Ward 4 - CVW4	15	14	100.4% Green	102.9% Green	100.1% Green	109.7% Green	100.0%	100.0%	8.9% Green	8.9% Green	0.0% Green	11	0 Down	1 Down	0 No Change	1 No Change	0 No Change	
Ashby	14	14	93.9% Green	154.6% Blue	102.1% Green	163.9% Blue		100.0%	32.0% Amber	31.7% Amber	0.2% Green	10	3 No Change	3 Up	0 No Change	0 No Change	0 No Change	
Aston	17	17	113.7% Blue	123.2% Blue	100.4% Green	130.6% Blue		100.0%	14.5% Green	14.5% Green	0.0% Green	8	0 No Change	1 No Change	0 Down	0 No Change	0 No Change	
Beaumont	21	20	82.3% Green	144.2% Blue	96.8% Green	161.1% Blue		100.0%	39.9% Amber	39.2% Amber	0.7% Green	9	1 Down	2 Up	0 No Change	0 No Change	0 No Change	
Belvoir Unit	11	10	102.6% Green	100.0% Green	98.7% Green	108.0% Green		100.0%	35.0% Amber	35.0% Amber	0.0% Green	16	0 No Change	1 No Change	0 Down	0 No Change	0 No Change	
Bosworth	14	14	88.1% Green	106.1% Green	99.7% Green	114.3% Blue		100.0%	32.6% Amber	32.3% Amber	0.3% Green	8	1 Down	1 No Change	0 No Change	0 No Change	0 No Change	
Griffin - Herschel Prins	6	6	102.6% Green	95.8% Green	99.0% Green	110.8% Blue		100.0%	19.9% Green	19.9% Green	0.0% Green	26	1 Up	0 Down	0 No Change	0 No Change	0 No Change	
Heather	18	18	89.2% Green	123.3% Blue	103.4% Green	127.5% Blue		100.0%	42.8% Amber	40.9% Amber	1.9% Green	8	3 Up	4 Up	0 No Change	0 No Change	0 No Change	
Watermead	19	18	94.9% Green	187.5% Blue	97.7% Green	191.0% Blue		100.0%	51.9% Red	51.2% Red	0.7% Green	10	4 No Change	1 No Change	0 No Change	0 No Change	0 No Change	
Coleman	19	16	103.2% Green	108.7% Green	100.0% Green	140.5% Blue	100.0%	100.0%	21.8% Amber	21.8% Amber	0.0% Green	17	0 Down	4 Down	0 No Change	0 No Change	0 No Change	
Gwendolen	19	16	84.9% Green	114.2% Blue	97.4% Green	136.4% Blue		100.0%	27.4% Amber	27.0% Amber	0.5% Green	15	1 Up	23 Up	0 No Change	0 Down	0 No Change	
Kirby	23	21	99.3% Green	113.6% Blue	91.0% Green	117.7% Blue	100.0%	100.0%	16.1% Green	16.1% Green	0.0% Green	9	1 No Change	6 Down	0 Down	0 No Change	0 No Change	
Langley (MHSOP)	20	15	95.7% Green	127.3% Blue	100.1% Green	123.3% Blue			18.4% Green	18.4% Green	0.0% Green	9	1 No Change	10 Up	0 No Change	0 Down	0 No Change	
Mill Lodge	14	7	95.0% Green	92.4% Green	96.8% Green	133.3% Blue		100.0%	15.1% Green	14.9% Green	0.2% Green	23	1 No Change	1 No Change	0 No Change	0 No Change	0 No Change	
Phoenix - Herschel Prins	12	12	87.9% Green	82.9% Green	100.0% Green	100.0% Green		100.0%	13.8% Green	13.5% Green	0.3% Green	11	1 Up	0 No Change	0 No Change	0 No Change	0 No Change	
Skye Wing - Stewart House	30	30	84.8% Green	109.8% Green	100.0% Green	103.5% Green		100.0%	15.6% Green	15.4% Green	0.2% Green	5	3 Up	4 Up	0 No Change	0 No Change	0 No Change	
Willows	9	9	93.5% Green	104.6% Green	100.1% Green	100.5% Green		100.0%	17.5% Green	17.3% Green	0.2% Green	11	3 No Change	0 Down	0 No Change	0 No Change	0 No Change	
CAMHS Beacon Ward - Inpatient Adolescent	17	5	108.7% Green	110.6% Blue	98.4% Green	73.6% Red			36.1% Amber	35.4% Amber	0.8% Green	33	0 Down	2 Down	0 No Change	0 No Change	0 No Change	
Welford (ED)	15	14	96.7% Green	149.4% Blue	101.5% Green	137.1% Blue	100.0%	100.0%	22.9% Amber	22.5% Amber	0.4% Green	13	2 Up	0 No Change	0 No Change	0 No Change	0 No Change	
1 The Grange	1	1	73.7% Red	61.8% Red	32.2% Red	80.8% Green			9.7% Green	9.7% Green	0.0% Green	39	0 No Change	1 Up	0 No Change	0 No Change	0 No Change	
Agnes Unit	1	1	118.5% Blue	84.0% Green	103.6% Green	81.1% Green			26.6% Amber	17.2% Green	9.4% Red	98	0 Down	2 Up	0 No Change	0 No Change	0 No Change	
Gillivers	2	2	108.9% Green	41.5% Red	111.9% Blue	111.8% Blue			2.2% Green	2.2% Green	0.0% Green	27	0 No Change	0 No Change	0 No Change	0 No Change	0 No Change	

Metric	Average Fill Rate Thresholds Registered Nursing,			Temporary Workers % Nursing (Total and Bank)			Agency	
Threshold	Below <=80%	Above >80%	Above >110%	Below < 20%	Between 20% - 50%	Above >50%	Below <=6%	Above > 6%
Rag Rating	Red	Green	Blue	Green	Amber	Red	Green	Red

Fill rate will show in excess of 110% where shifts have utilised more staff than planned or due to increased patient acuity requiring extra staff. Highlighted for trust wide monitoring purpose only.

Please see table (in main report) for high level exception reporting highlighting reduced fill rate below 80% threshold and key areas to note due to high bank and agency utilisation.

M

Leicestershire Partnership NHS Trust

Public Trust Board – 28th July 2026

Patient Safety & Learning Assurance Report for May/June 2026

Purpose of the Report

This document is presented to the Trust Board bi-monthly to provide assurance of the efficacy of the incident management and Duty of Candour compliance processes. Incident reporting supporting this paper has been reviewed and refreshed to assure that systems of control continue to be robust, effective, and reliable thus underlining our commitment to the continuous improvement of incident and harm minimisation.

The report will also provide assurance around 'Being Open' supporting compassionate and timely engagement with patients and families following a patient safety incident, numbers of investigations and the themes emerging from recently completed investigation action plans, a review of recent Ulysses patient safety incidents and associated lessons learned/opportunities for learning.
The patient safety team have explored the opportunity for bench marking our incident data against other similar organisations. The new National system Learning from Patient Safety Events (LFPSE) does provide some data on overall reporting numbers for different organisations. Due to the diversity and size of organisations this can only give an indication of each organisations reporting culture and National Health Service England (NHSE) do not recommend its use for bench marking.

Analysis of the Issue

The 'top 5' reported patient safety incidents are considered and reported on in this paper, however, it should be noted that in addition, all incident types for the reporting period are reviewed to establish changes within all categories that may present emerging themes for wider consideration.

Review of Top 5 reported patient safety incidents

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

Top 5 reported patient safety incidents May and June 2026

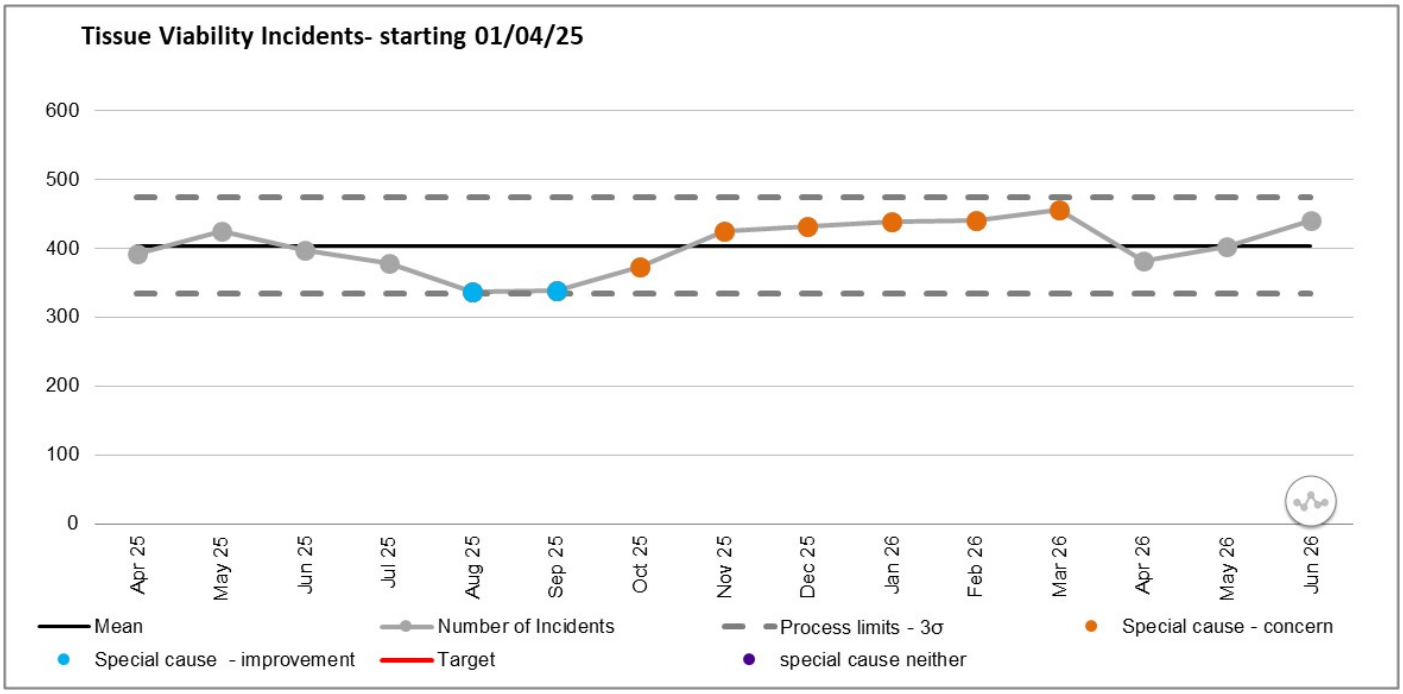
Category	Number of incidents	Directorate with highest % of the total reported
1. Tissue Viability	842	CHS (98.81%)
2. Self-Harm	677	DMH (85.82%)
3. Care/Treatment Under Restraint	355	DMH (63.94%)
4. Violence/Assault	348	DMH (87.35%)
5. Clinical Condition	264	CHS (51.52%)

Degree of harm recorded for all patient safety incidents for May and June 2026

Reported degree of harm	Number	% of total incidents reported
No Harm	2117	55.12%
Minor/Low Harm	1660	43.22%
Moderate Harm	33	0.86%
Severe Harm	6	0.16%
Death	25	0.65%

NB: these incidents were reported in May and June 2026 and will be being reviewed through local and corporate governance structures and the degree of harm may change. Since moving to the national NHSE Learning from Patient Safety Events (LFPSE), there is a requirement to report incidents by 'harm' to the patient even if it does not involve care delivered in your organisation's care as well as the harm as a result of an incident.

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



21.92% of all patient safety incidents reported relate to 'Tissue Viability' during May and June 2026; this equates to 842 incidents. This category includes pressure ulcers on admission, developed or deteriorated in our care, skin tears, scalds, wounds, and moisture associated skin damage. As Pressure ulcers (category 2,3,4 and unstageable) represent 64.01% of these, we will focus on this aspect of patient harm.

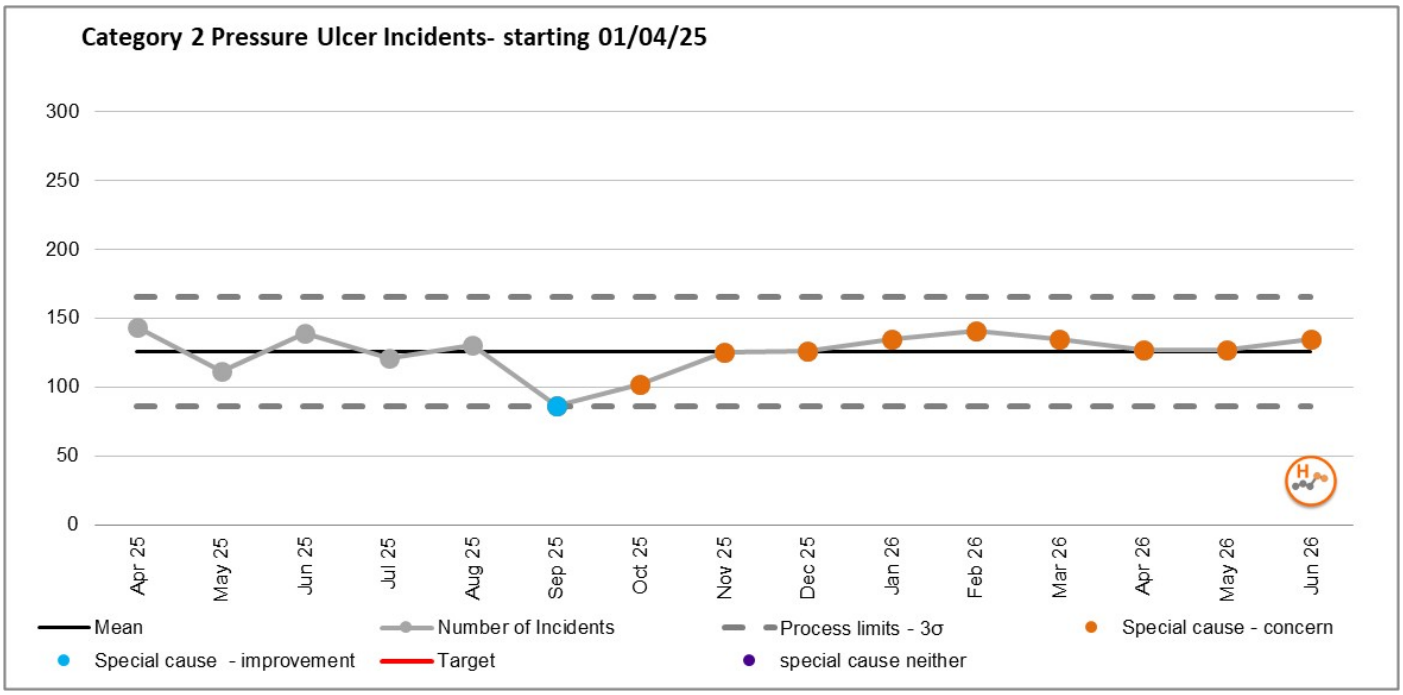
In May and June 2026, there were 539 reported incidents where patients had been affected by category 2,3,4 and unstageable pressure ulcers reported to have developed or deteriorated in LPT care. This is a 4.43% decrease in pressure ulcers reported in comparison to the previous 2 months reporting.

During this period, 502 (93.14%) were reported in Community Health Services (CHS) Community Nursing Services and 32 (5.94%) were reported in Community Hospitals (Inpatients).

Of the remaining 5 incidents (0.93%), 4 were reported in Directorate of Mental Health (DMH), all of which were Category 2 Pressure Ulcers – 3 reported by Gwendolen Ward and 1 reported by DMH Charnwood CMHT. 1 Pressure Ulcer was reported in Families, Young People, Children's, Learning Disability & Autism directorate (FYPCLD), an Unstageable Pressure Ulcer reported by the Diana Service.

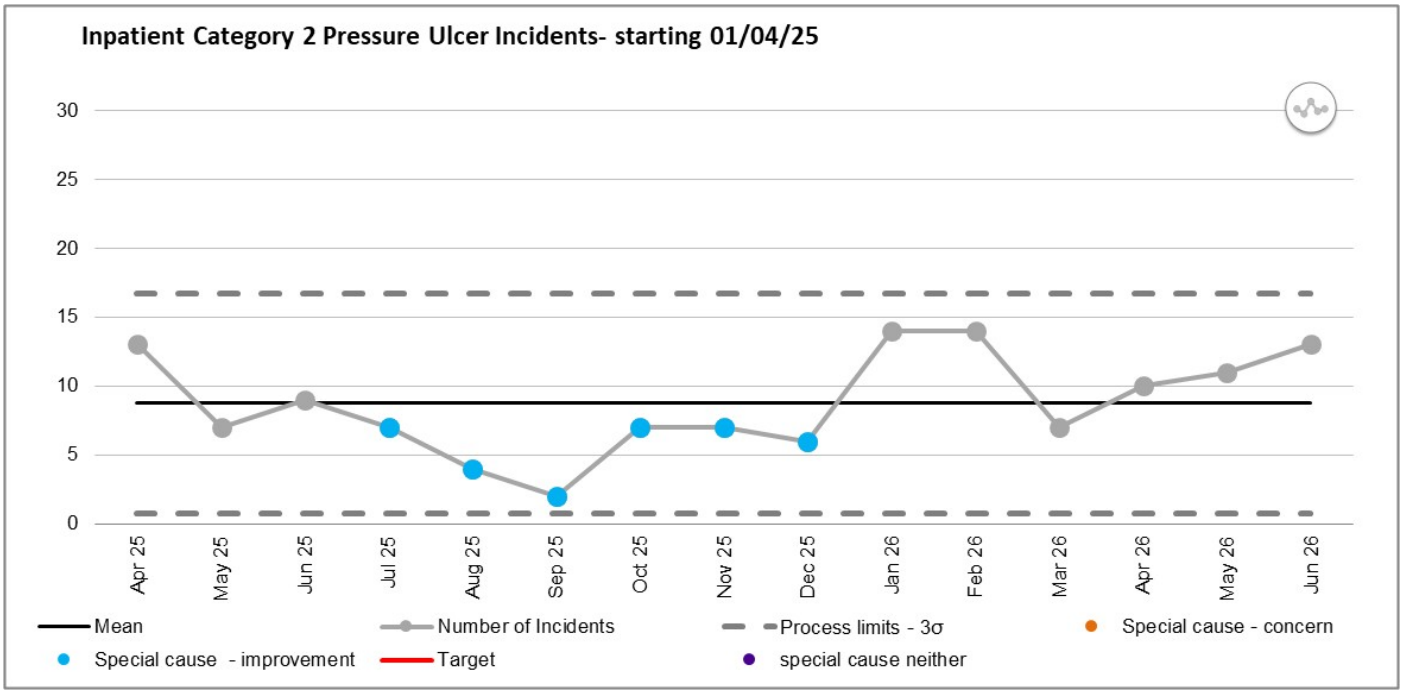
Category 2 pressure ulcers developed or deteriorated in LPT care – Trust wide.

A Category 2 Pressure Ulcer is defined as; partial thickness skin loss, the top layer of skin is damaged, appearing as a shallow open sore or a blister.



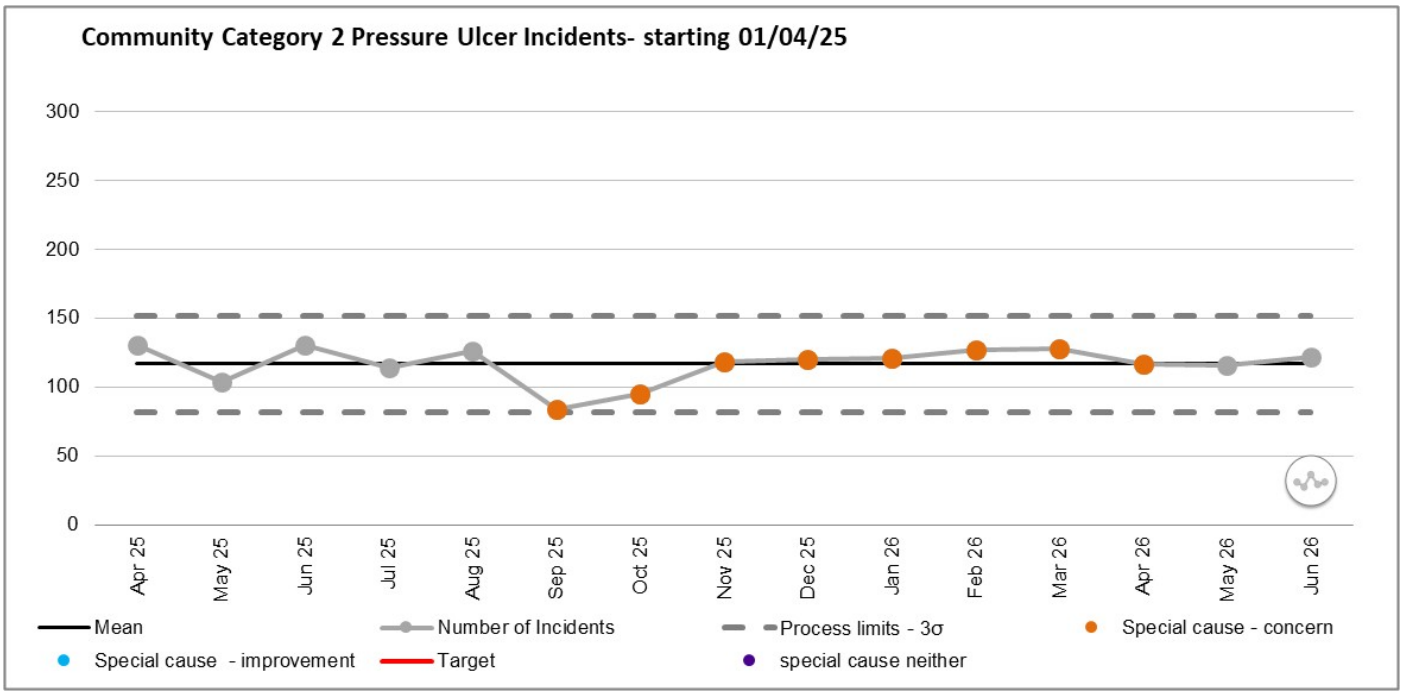
The statistical process control (SPC) chart shows special cause concern for Category 2 pressure ulcers developed or deteriorated in LPT care, it is noted there is nine consecutive points increasing (trend up), however close to the mean number of incidents, this will continue to be monitored by the pressure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

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



The chart above shows common cause variation, the last 3 months have been above the mean for this dataset and will continue to be monitored by the pressure ulcer steering group to understand if there are any themes. There is a community hospital pressure ulcer validation and learning meeting held monthly focussing on category 2 pressure ulcers developed in care led by a Matron, to learn and share from incidents and ensure an evidence-based review process for hospital acquired pressure ulcers.

Community Category 2 pressure ulcers developed in our care.



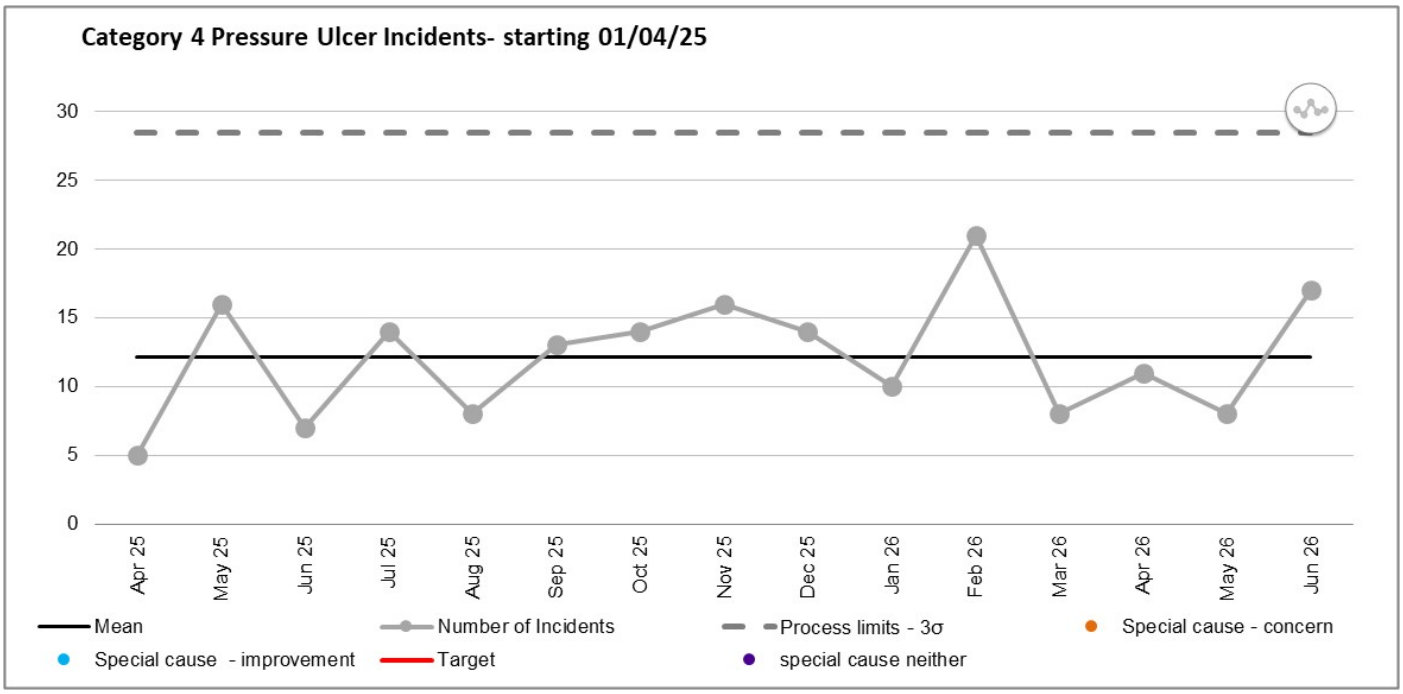
The chart above details the number of patients who have developed a Category 2 pressure ulcer in LPT community nursing services. It is noted that there is special cause concern for the numbers of pressure ulcers, however it is close to the mean number of incidents and within the process limits.

There are 6683 patients on the community nursing caseload, the percentage of patients with pressure ulcers developed or deteriorated in our care remains low at 2.29%. A Category 2 Pressure Ulcer is defined as; partial thickness skin loss, the top layer of skin is damaged, appearing as a shallow open sore or a blister. Treatment typically focuses on protecting the wound from further friction, relieving pressure on the affected area, and keeping the wound bed clean to promote healing.

Improvement work continues through the CHS pressure ulcer delivery group to support actions and themes from incident reviews.

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

A Category 4 Pressure Ulcer is defined as full thickness tissue loss.



The SPC chart shows common cause variation for category 4 pressure ulcers developed or deteriorated in our care. This is demonstrating a stable and predictable statistical position for the numbers of category 4 pressure ulcers developed or deteriorated in our care.

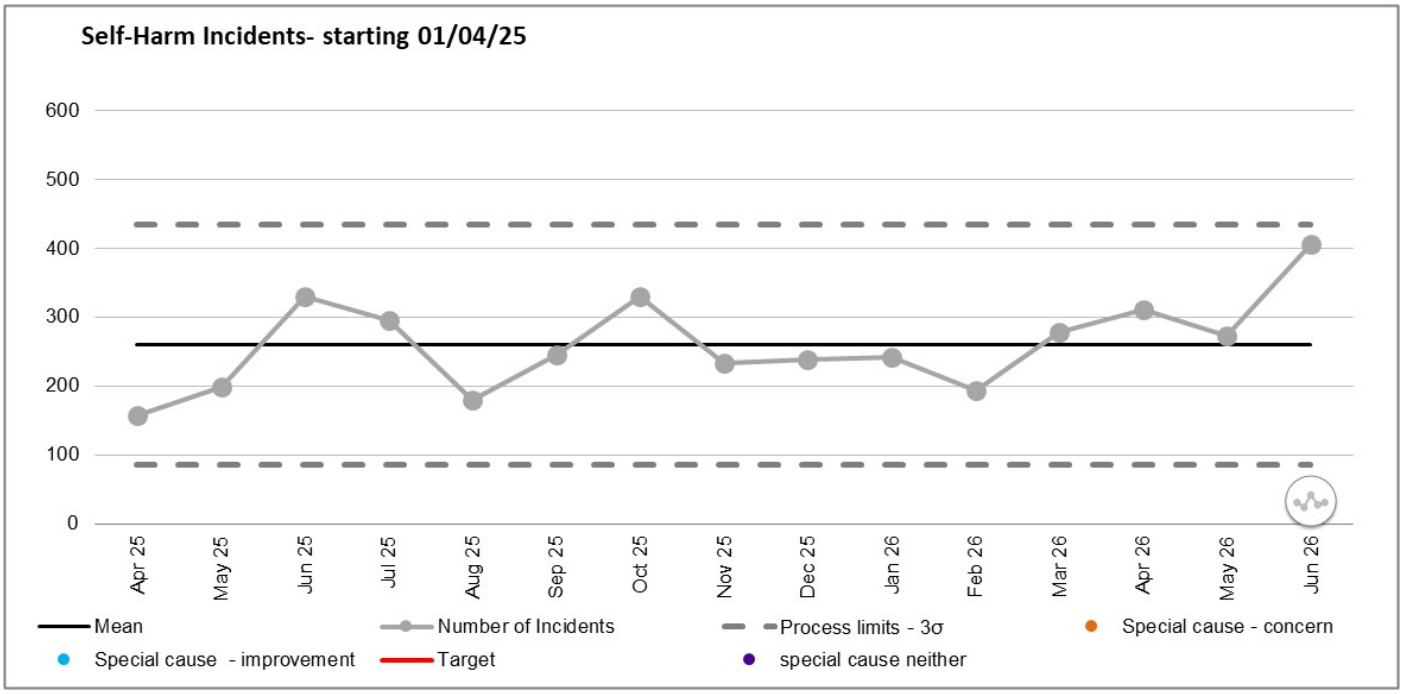
Unlike a controlled hospital environment, common cause variation in a community or district nursing setting reflects the multi-factored systems and processes when delivering care at home in the community such as repositioning/visiting schedules, equipment concordance, complex patient factors, environment, cross agency working.

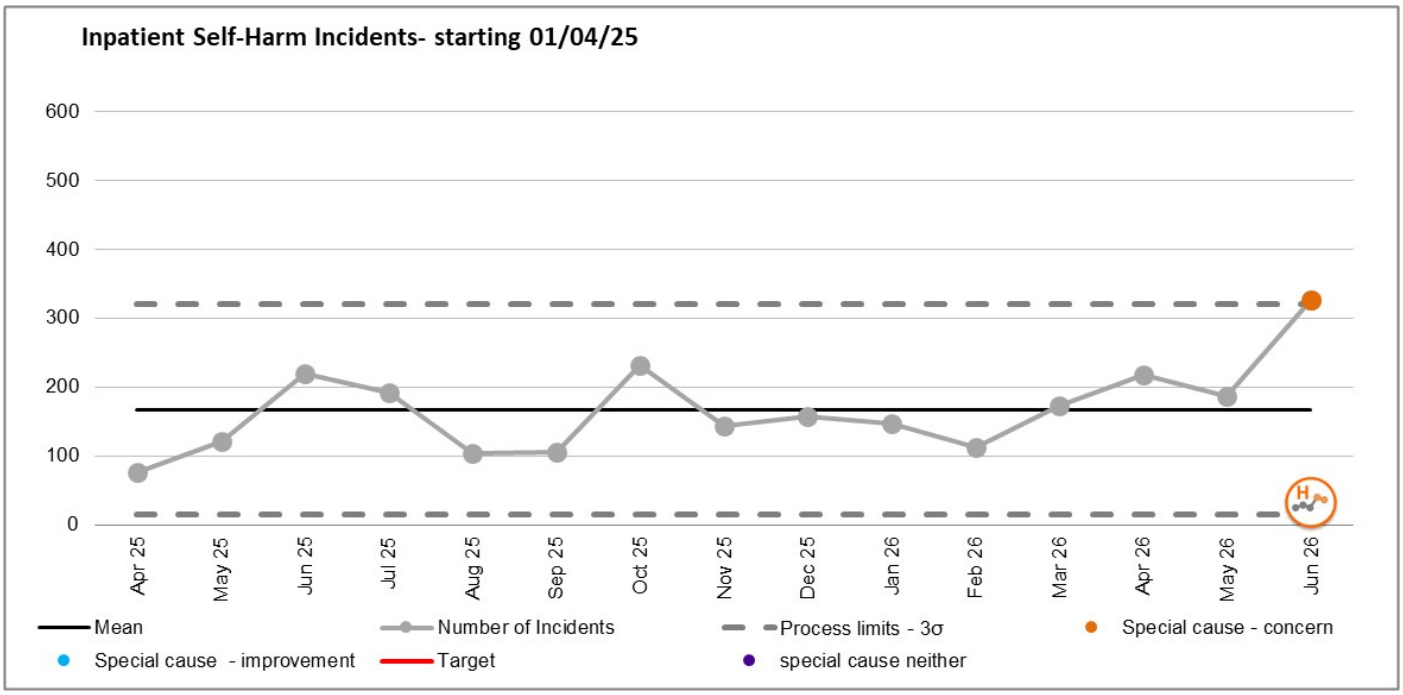
The CHS Pressure ulcer delivery group continues to learn from finding of reviews of category 4 pressure ulcers developed or deteriorated in our care, there is focused prevention work to improve repositioning in community and care home settings and work to strengthen the pressure ulcer audit process and equipment processes.

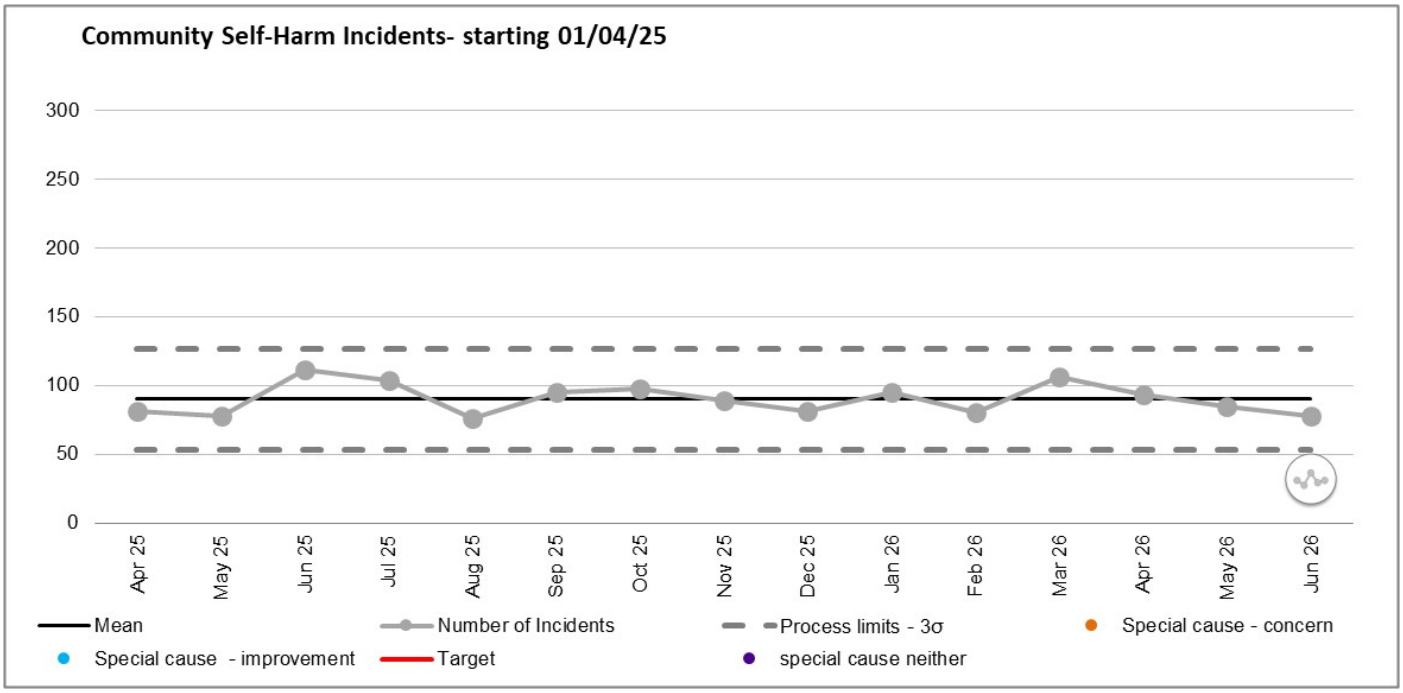
The Trust wide Pressure Ulcer Prevention group workplan focuses on the National Institute Clinical Excellence (NICE) quality standards for pressure ulcer prevention. Current priorities include implementing the change to using PURPOSE-T instead of Waterlow as the standardised risk assessment tool. PURPOSE-T is the pressure ulcer risk assessment tool advocated in the National Wound Care Strategy as a more reliable and valid tool, less subjective and improves outcomes for patients through accurate assessment of pressure ulcer risk. The plan is to implement by November 2026. Role specific pressure ulcer prevention, moisture associated skin damage and wound assessment training, and embedding of the care bundle; assessment Skin, Surface, keep moving, Nutrition, Incontinence assessment and giving information (aSSKINg) to all

fields of practice to guide and document pressure ulcer prevention and many associated interventions aimed at reducing the risk of this patient harm.

2. Self-Harm – inpatient and community







There were 677 patient self-harm incidents reported during May and June 2026, this equates to 17.63% of all reported patient safety incidents during this period. Of the 677 incidents reported as patient self-harm, 514 were inpatient incidents and 163 were community incidents.

During the previous reporting period, there were 585 self-harm incidents reported across both inpatient and community settings, this shows an increase of 15.73% during the current reporting period. This increase is entirely within inpatient incidents, which saw a 126 incident (32.47%) increase, while community incidents saw a 34 incident (17.26%) decrease, as measured against the previous reporting period.

The number of incidents has been analysed and over the reporting period there are 3 areas with the largest number of self-harm incidents reported relative to the total number (677) of such incidents reported:

- Watermead Ward – 134 incidents (19.79%) This figure involves 6 patients; this is an increase from 19 total incidents reported in the previous reporting period. The Suicide and self-harm prevention Lead has reviewed this data together with the ward team and identified that1 patient has had 30 incidents. Currently being supported closely by nursing staff and awaiting supported accommodation to facilitate safe discharge.
- Sycamore Ward - Acute – 130 incidents (19.20%) This figure involves 5 patients; this is an increase from 32 total incidents reported in the previous reporting period. This increase is largely attributable to 2 patients. The Multi-Disciplinary Team (MDT) are actively involved in working together with these patients to reduce the risk.
- Beaumont Ward – 82 incidents (12.11%) This figure involves 14 patients; this is an increase from 66 total incidents reported in the previous reporting period.

In Summary this increase is attributable to a small number of patients for whom self-harm is a feature of their coping mechanism. The Self- Harm and Suicide Prevention Lead who is now established in post is meeting with the ward leaders of the above three wards to offer support and review this data look at some of the drivers for the increase and to consider what actions can be implemented to reduce incidents. There is a proposal they have also developed being reviewed through the Directorate governance with some interventions to support patients to reduce their self-harming.

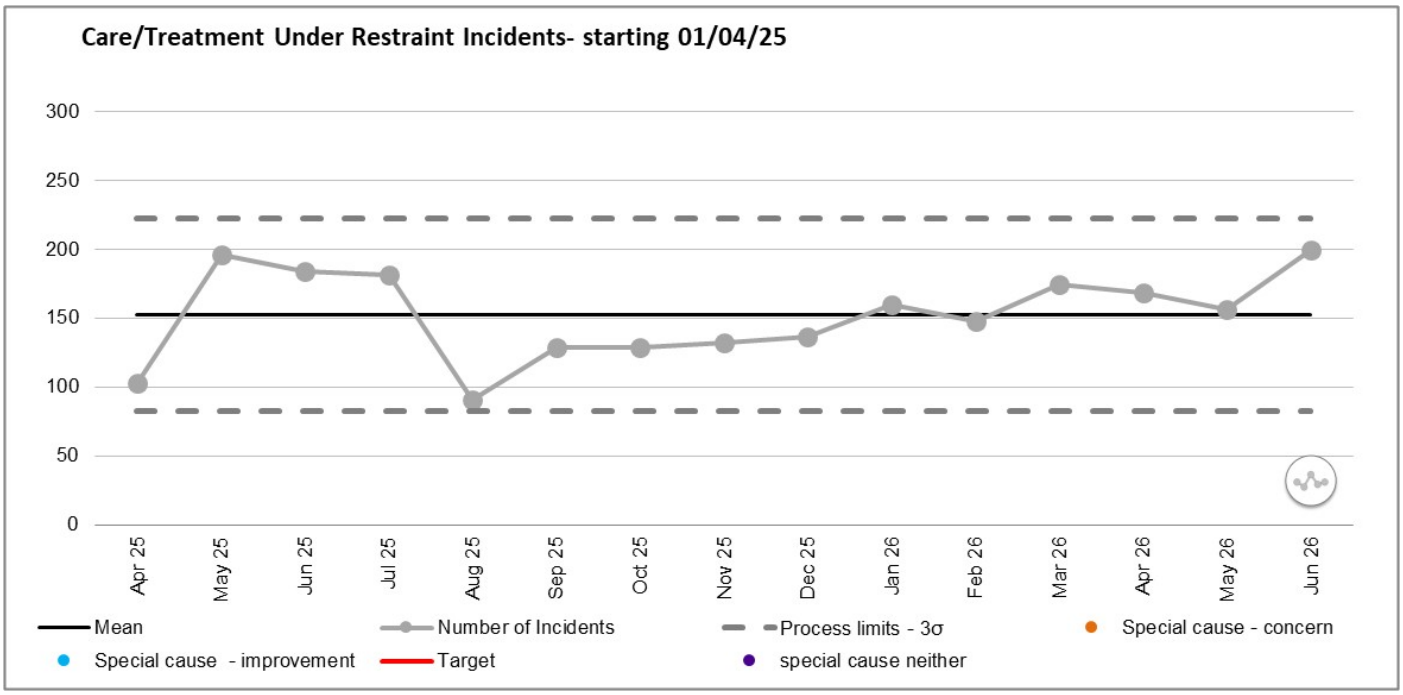
Harm Levels
Within the 3 areas of Watermead Ward, Sycamore Ward - Acute, and Beaumont Ward there was one incident reported as moderate harm or above. Of the 134 incidents reported by Watermead Ward, 58 (43.28%) were recorded as minor/low harm, with the remaining 76 (56.72%) being reported as no harm. Of the 130 incidents reported by Sycamore Ward - Acute, 97 (74.62%) were recorded as minor/low harm, with the remaining 33 (25.38%) being recorded as no harm. Of the 82 incidents reported by Beaumont Ward, 1 (1.22%) was recorded as major harm, with 42 (51.22%) being recorded as minor/low harm, and the remaining 39 (47.56%) being recorded as no harm.

Overall, of the 677 total reported self-harm incidents, 3 (0.44%) was recorded as major harm, 6 (0.89%) have been recorded as moderate harm, 363 (53.62%) have been recorded as minor/low harm, and 305 (45.05%) have been recorded as no harm.

Self-harm and management of self-harm is currently captured in the risk assessment and risk management training in LPT. However, the Self-Harm Reduction Training developed in Nottingham has been reviewed and identified as a valuable and supportive approach. The Self Harm and Suicide Prevention Group and have shared the training with the Learning and Development Team to support the development of staff training specifically focused on managing and reducing self-harm.

Of the 6 incidents reported as moderate harm 2 have been reviewed at the Incident Review and Learning Meeting and assessed as not requiring further escalation. 1 is due to be reviewed at Incidents Review and Learning Meeting (IRLM) and the other three are still under review in directorate.

3. Care & Treatment Under Restraint



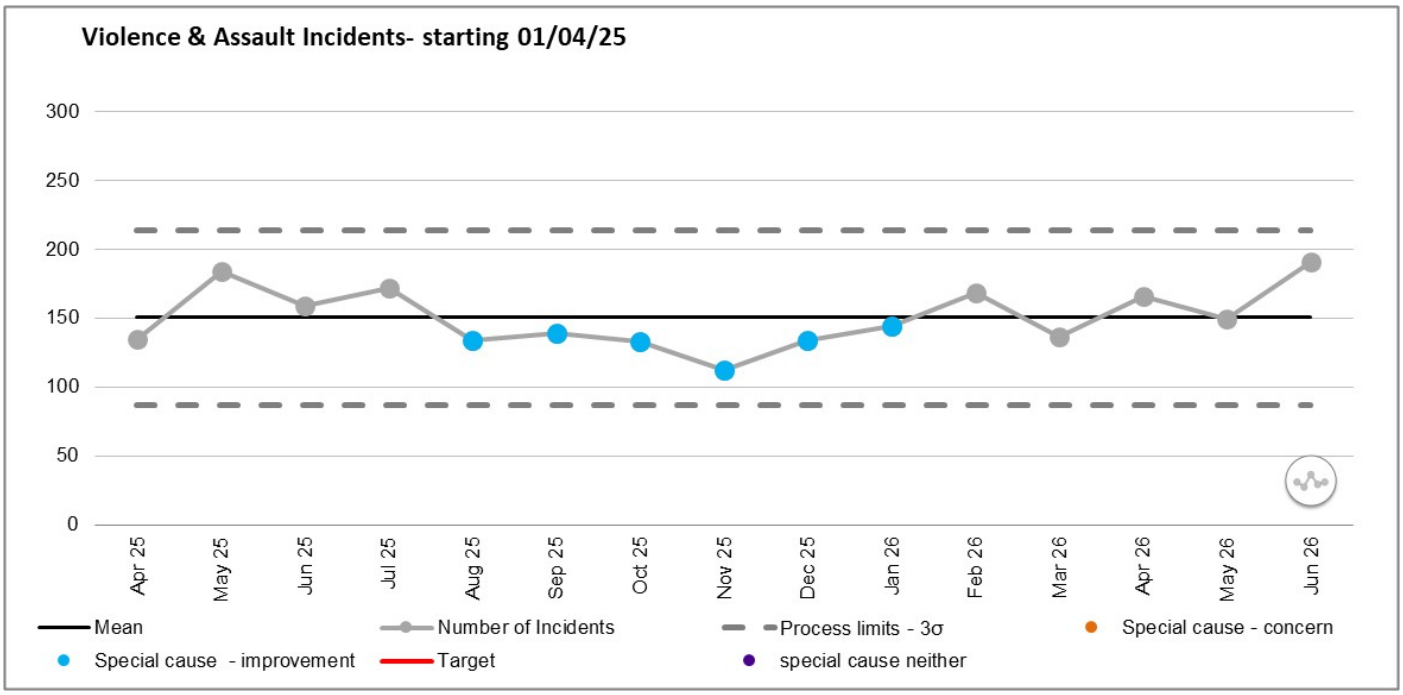
There were 355 incidents where restraint holds were used to support care delivery during May and June 2026, representing 9.24% of all reported patient safety incidents during this period. During the previous reporting period, there were 340 incidents reported where restraint was utilised, therefore this shows an increase of 4.41% during the current reporting period.

The reporting of incidents using restraint currently fall into 2 categories; those related to the management of violence, aggression, and acute self-harm and those where restraint holds have been utilised to support care activities such as carrying out feeding regimes or personal care – washing and changing incontinence wear. The Least Restrictive Practice Group has scoped additional training options for 'clinical holding' and have established additional holds and scenarios to include in Safety Intervention training; some staff will require an additional level of training, and this is being reviewed by the learning and development team.

The analysis of incidents where restraint has been used to deliver care shows that over the reporting period, there have been 3 areas with a significant number of incidents reported relative to the total number (355) incidents. The restraint in Mill lodge is relating to the safe care and management using safeholds during personal care interventions to maintain the safety of the patients and staff delivering care – this is care planned and reviewed regularly with senior staff and the wider multidisciplinary team. There were 136 (38.31%) incidents, compared to 161 during the last reporting period, due to another patient requiring holding during personal care. The restraint incidents at the Child and Adolescent Mental Health Services (CAMHS) Beacon Unit are part of the young people's care and treatment, balancing least restrictive practice with the need to keep them safe from self-harm and includes feeding regimes. There were 118 (33.24%) incidents, a decrease on the 125 reported during the last reporting period. Gwendolen Ward had 50 (14.08%) incidents involving care and treatment under restraint, which is an increase from 22 incidents in the previous reporting period.

Overall, of the 355 incidents reported where restraint was utilised, 85 (23.94%) were reported as minor/low harm, and 270 (76.06%) were reported as no harm.

4. Violence & Assault



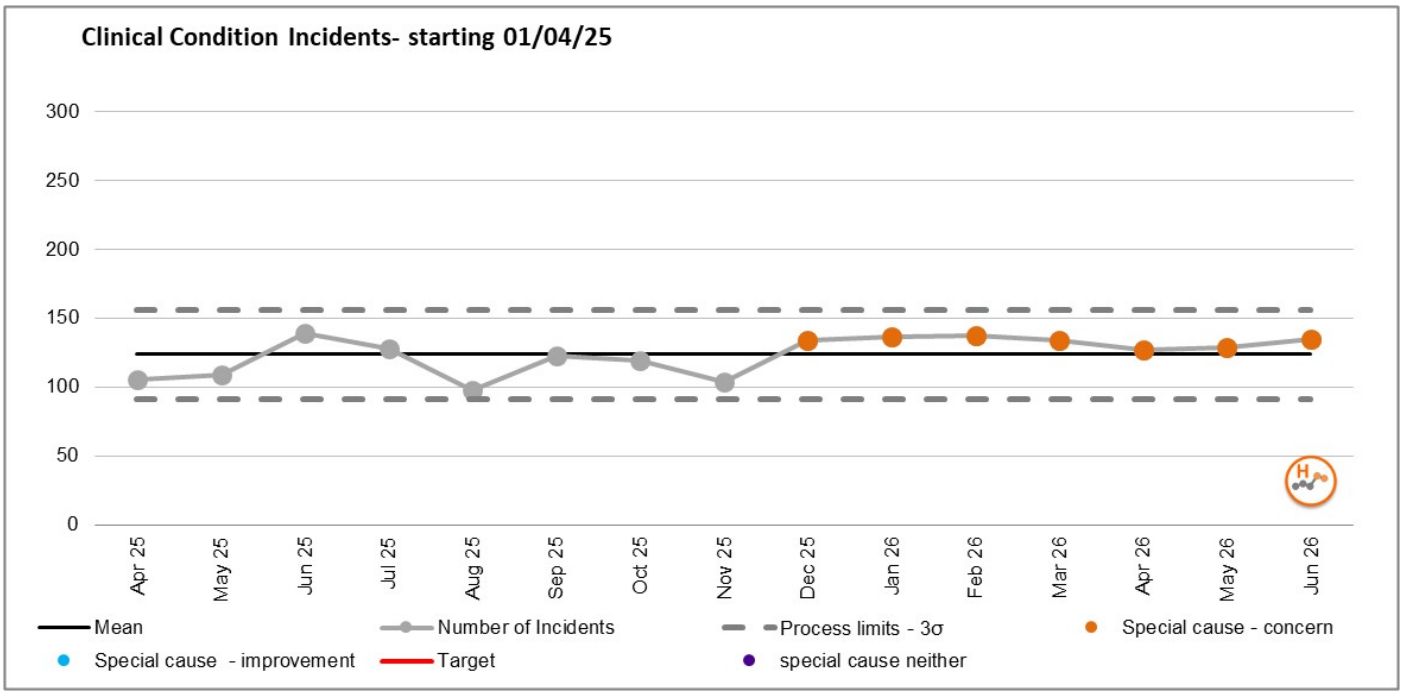
There were 340 incidents of violence and assault reported during May and June 2026. These incidents are reported under the category's patient violence towards other patients, people not employed by the trust and incidents of disruptive behaviour towards others. This represents 8.85% of all reported patient safety incidents. During the previous reporting period, there were 301 violence and assault incidents reported, this shows an increase of 12.96% during the current reporting period.

The number of violence and assault incidents has been analysed and over the reporting period, there are 3 areas with the highest number of incidents reported relative to the total number (340) of violence and assault incidents, Belvoir Ward with 61 (17.94%) incidents, Ashby Ward with 31 (9.12%) incidents, and Griffin Ward with 28 (8.24%) incidents. Of these 340 incidents, 178 (52.35%) were reported as physical disruptive behaviour. Belvoir Ward has a group of patients requiring more complex treatment approaches to support recovery and this has increased resulted in increased incidents of violence and aggression requiring the use of physical restraint and medication. Beaumont Ward also had a complex group of patients, some with autism spectrum disorder requiring community placements and exhibiting behaviour when anxious and frustrated and one requiring safe hold related to medication administration and self-harm prevention. In FYPC/LDA there has been an increase in use of safe holds related predominantly to safe holding for NG feeds, intervention to prevent self-harming, ligatures, headbanging and aggression towards staff.

Of the 340 incidents reported as Violence and Assault, 1 (0.29%) was recorded as major harm, 1 (0.29%) was recorded as moderate harm, 92 (27.06%) were recorded as minor/low harm, and 246 (72.35%) were recorded as no harm.

The 2 incidents resulting in Major or moderate harm will be reviewed at IRLM for opportunities for learning. Where appropriate Health and Safety have been involved.

5. Clinical Condition



There were 264 clinical condition incidents during May and June representing 6.87% of all reported patient safety incidents. During the previous reporting period there were 260 clinical condition incidents reported, this shows an increase of 1.54% during the current reporting period.

The number of clinical condition incidents have been analysed and over the reporting period, out of the 264 reported clinical condition incidents, the top 2 areas were East Ward at the Hinckley & Bosworth Community Hospital who reported 22 (8.33%) incidents, and Dalgleish Ward at Melton Mowbray Hospital who reported 17 (6.44%) incidents.

Of the 264 reported clinical condition incidents, 1 (0.38%) incident was recorded as catastrophic/death, 1 (0.38%) incident was recorded as major harm, 3 (1.14%) incidents were recorded as moderate harm, 79 (29.92%) incidents were recorded as minor/low harm, and 180 (68.18%) incidents were recorded as no harm.

Of the three moderate incidents one does not appear to have caused moderate harm and the directorate are reviewing, another is coming to IRLM and the third is still under review in directorate.
The incident reported as Major was a patient fall and this was reviewed at IRLM and no further review required. The incident reported as death is coming to IRLM in July.

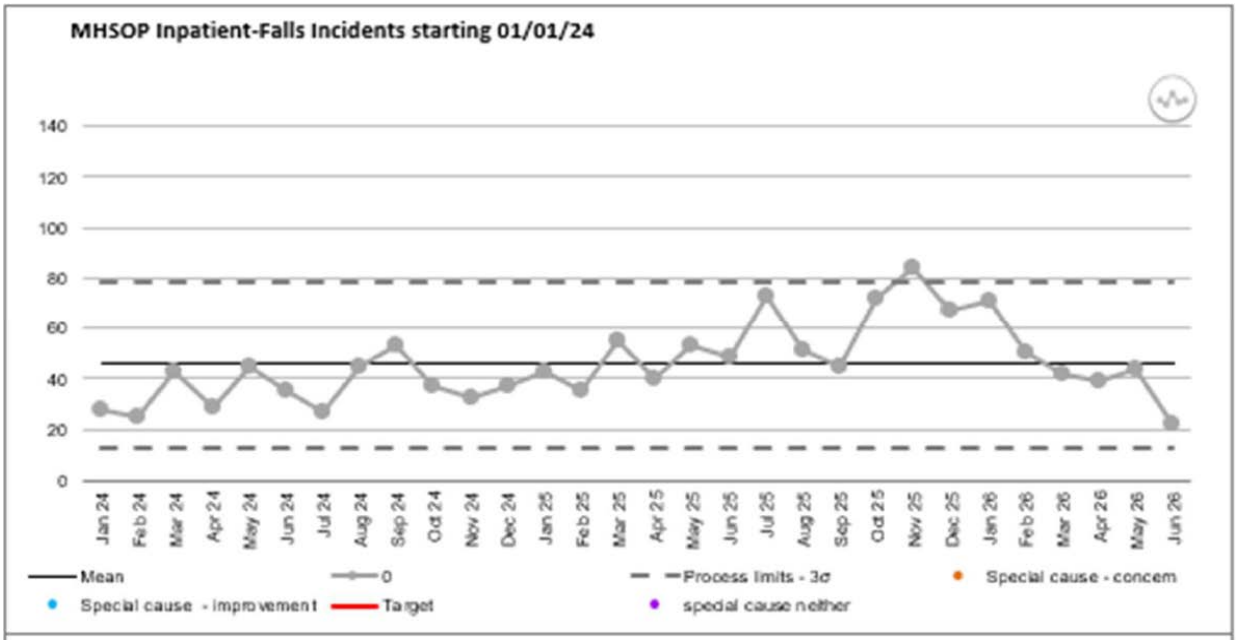
Falls

DMH

MHSOP (Mental Health Services for Oder People)

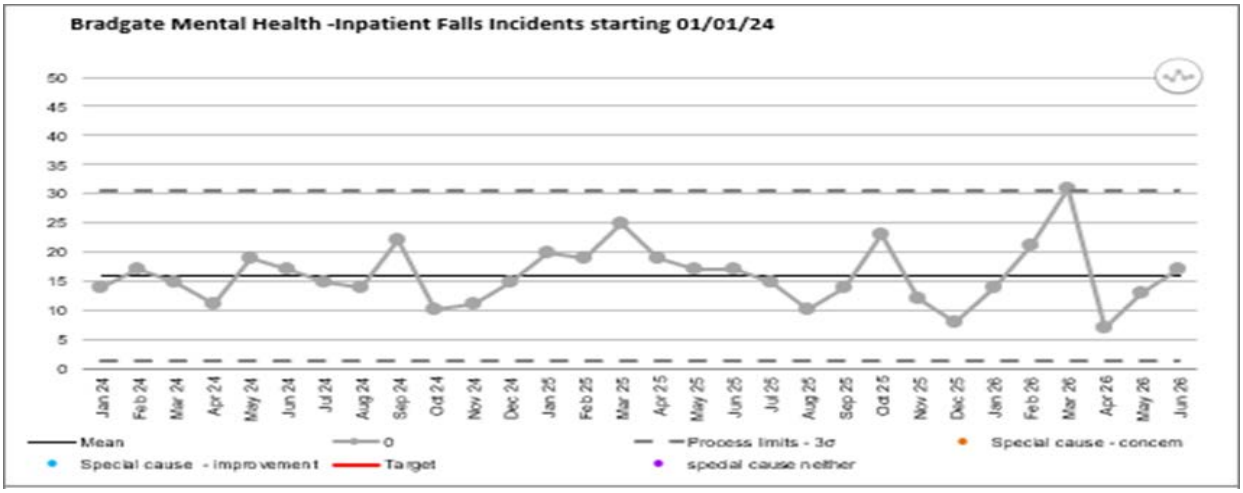
The number of falls on all MHSOP wards has continued to drop since January with a significant drop in numbers in June 2026. 22 Falls incidents reported in June 2026, a reduction from previous month (44).

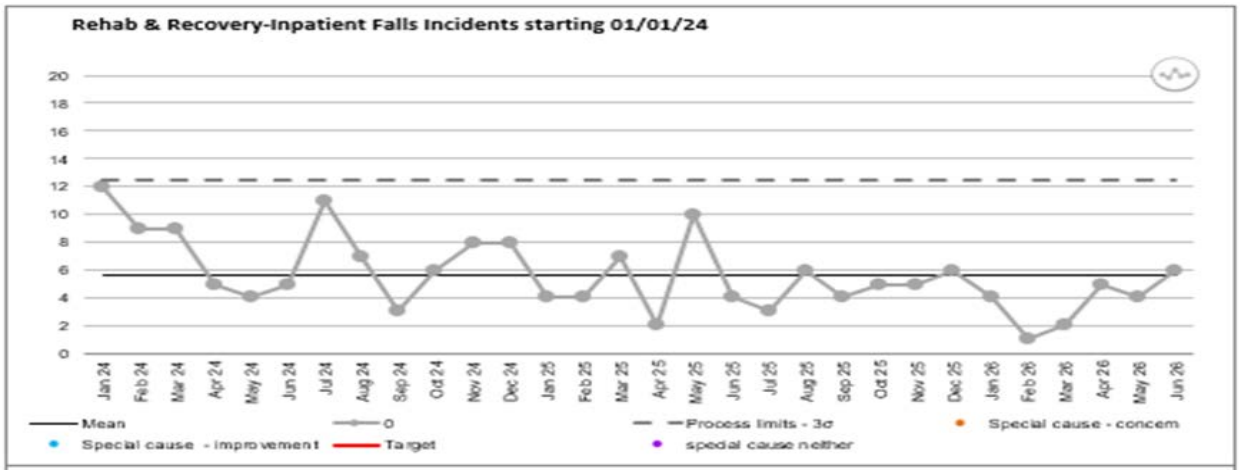
The number of falls on Kirby Ward has significantly dropped, 3 falls in June 2026 from 36 falls in January 2026, due in part to one patient who was regularly placing themselves on the floor being discharged from the ward.



Bradgate Unit and Rehabilitation Wards

Nothing to escalate – ongoing work to improve post falls processes particularly on Cedar Ward (Rehabilitation).

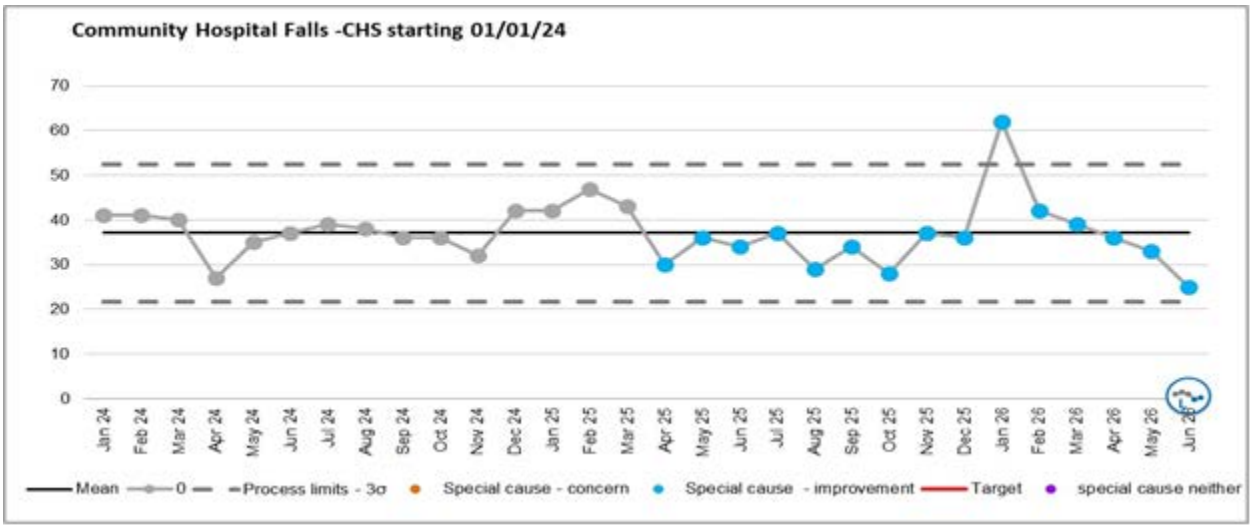




CHS

The number of falls continue to reduce on the CHS wards with 22 falls reported in June 2026. The falls were spread across a number of wards but no cause for concern on any ward. It is noted that North Ward closed mid-June and St Lukes Ward 1 and Ward 3 and Coalville Ward 4 reported no falls.

Feedback from St Lukes Ward 1 report that they feel they have been working differently in line with Enhanced Therapeutic Observations and Care (ETOC) practice and are better able to anticipate patients' needs and situations where they may be at risk of falls.



FYPC/LDA

Continue to report low numbers of falls across both inpatient and community areas. Falls mainly related to clinical presentations (e.g. epilepsy) and engagement in physical activity. They are working on improving falls risk assessment process to reduce risk as far as possible. Due to low numbers the directorate provide quarterly reviews into the Falls Steering group and are next due to report back in August 2026.

Review of Prevention of Falls Trips and Slips policy has started and will reflect national guidance, updates and learning from National Institute for Health and Excellence (NICE) and Royal College of Physicians National Audit for Inpatient Fractures (NAIF)

Participation in National Audit for Inpatient Fractures (NAIF)

For past couple of years, we have been working to align with NAIF recommendations on the inpatient wards, and we will be participating in the audit for the first time this year.

Review of Falls Documentation

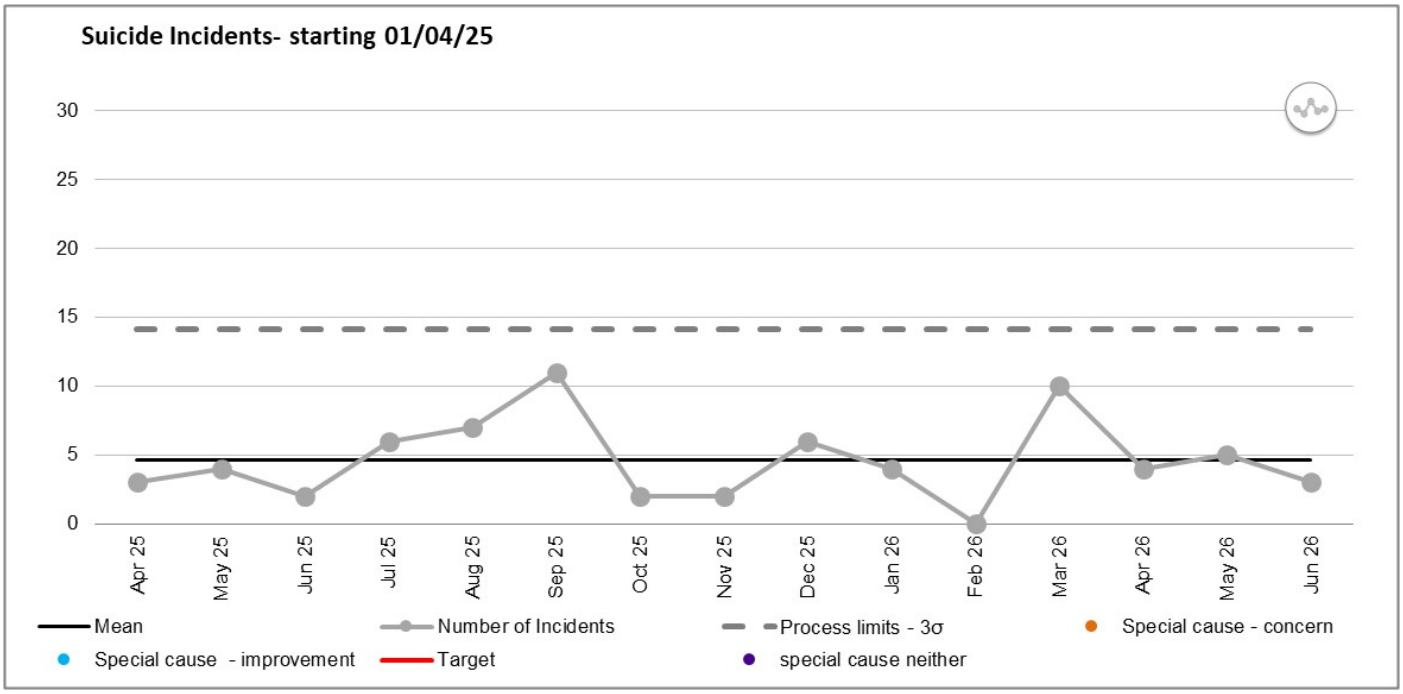
The Falls Steering group have recognised that whilst audits show relatively good compliance with process, incident investigations show that the quality of falls risk assessments and care planning could be improved. Staff feedback describes the falls risk assessment process long and cumbersome and there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

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

This work will be in line with the current initiatives around Care Planning and Frailty.

Suicide Prevention

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



Between May and June 2026, there were 3 deaths by suicide within Leicester and Leicestershire involving individuals who were known to, or had contact at some point with, Leicestershire Partnership NHS Trust (LPT) services.

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

Each death by suicide is also discussed at the LPT Rapid Review Meeting, which is attended by multiple professionals. This forum focuses on identifying any immediate learning. Where issues or

risks are identified, actions are promptly escalated and addressed to mitigate further risk and better understand how repetition may be prevented.

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

LPT have been rolling out a medicines amnesty for the last 2 years; this runs throughout March and did so this year. This amnesty is in conjunction with partner agencies, police, public health, pharmacies. The aim of the amnesty is to try to reduce the availability of unnecessary medicines in people's homes to reduce the availability and therefore the opportunity for people to take overdoses to end their lives or self-harm. It is recognised that those with social factors and serious physical illness are at increased risk of suicide and will often have access to medications most often cited in deaths by suicide. The amnesty will be evaluated, and we hope to be repeated each year.

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

Learning from Deaths

The Learning from Deaths Clinical Lead is now in post. Their early priorities include working with University Hospitals of Leicester and the Medical Examiner's Office to establish a process that enables LPT to receive the cause of death for all patients who die whilst under our care. This information will strengthen the Learning from Deaths review process and support a more comprehensive understanding of themes.

They are also leading work to improve the recording of patients' protected characteristics and enhance the Learning from Deaths dataset. This will support the identification of trends, potential health inequalities, and areas requiring further investigation, enabling more effective triangulation of information and targeted quality improvement activity.

This data is required so that they can progress in one of the key priorities which is to strengthen our thematic reviews.

LeDeR (Learning from lives and Deaths of people with a learning disability and autistic people)

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

- There were 4 notifications made by LPT staff to LeDeR related to patients with a known learning disability or autism and who have died for May (3) 2026 and June (1) 2026.
- For City and Countywide reviews, there were 7 patient death notifications in May 2026 and 6 patient death notifications in June 2026.
- Of the total 13 notifications,1 is focused and 11 are initial reviews.

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

National Patient Safety Alerts (NATPSA)

National Patient Safety Alerts remain a critical mechanism for safeguarding patients and strengthening organisational reliability. They provide a clear, standardised framework for identifying, escalating, and mitigating risks, with the alert triangle acting as a powerful visual cue that reinforces the urgency and priority of required actions. Effective management of these alerts—through timely assessment, robust governance oversight, and demonstrable implementation—ensures that learning is rapidly translated into safer clinical practice. For the Board, sustained scrutiny of alert compliance is essential, not only to meet statutory obligations but to assure that the organisation is proactively addressing system vulnerabilities and embedding a culture of continuous safety improvement.

LPT current position

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

Alert	Detail	Due for closure	Notes
NATPSA/2023/010/MHRA	Bed rails and Levers and their safe use and ongoing assessment of risk	1st March 2024 (overdue closure)	This alert remains open past its closure date due to the need to develop a process for patients who are in their own homes with levers or bedrails who are no longer on our caseload to be offered a risk assessment. The process has been agreed and implemented, and this alert will now be recommended for closure when the Group Chief Nurse/Executive Director of Nursing, Allied Health Professionals (AHPs) & Quality has reviewed the evidence.

NATPSA/2025/006/NHSPS	The incorrect recording of Penicillin Allergy as Penicillamine	20th November 2026	This alert is being led by LLRICB and involves all system partners -this is on track and all identified actions currently identified for LPT have been completed.
NATPSA/2025/008/NHSPS	risk associated with adult breathing circuits lacking a patent exhalation route	12th June	Actions taken and alert closed on time on 12th June.

LPT Outstanding patient safety reviews: As of 19th June 2026

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

Overdue learning response stage	CHS	DMH	FYPC	Corporate
Allocation	0	0	0	0
Information Gathering	0	0	0	0
Report Drafting	0	0	0	0
Awaiting specialist review	0	0	0	0
SMART Action Planning	0	0	0	0
Directorate Sign off Stages	0	0	0	3
Right to Reply Family	0	1	0	2
Right to Reply Staff	0	1	0	0
Submission to CPST	0	0	0	0
Exec Review	0	1	0	5
With ICB	0	0	0	0
Directorate Post Exec Review	0	0	0	0
Total Learning Responses Overdue	**0**	**3**	**0**	**10**

Current Position

As of **19th June 2026,** there were 49 open investigations. 15 DMH, 21 Corporate, 8 CHS and 5 FYPC/LDA.

- Of these 13 are overdue and of these 2 are in right to reply with patient or family.
- 3 DMH (20%) are overdue, 1 is the legacy STEIS (for incident December 2022) delayed by police and court process (commenced October 2023, fluctuating consent to allow family to be involved and the patient wanting to participate in the investigation, and liaison with the secure services clinical team. All staff have now reviewed, and this is expected to be signed off in the directorate in the next 2 weeks.
- 10 Corporate (47.62%) are overdue all are within the various phases of sign off.
- 0 CHS are overdue.
- 0 FYPC/LDA are overdue.

Duty of Candour

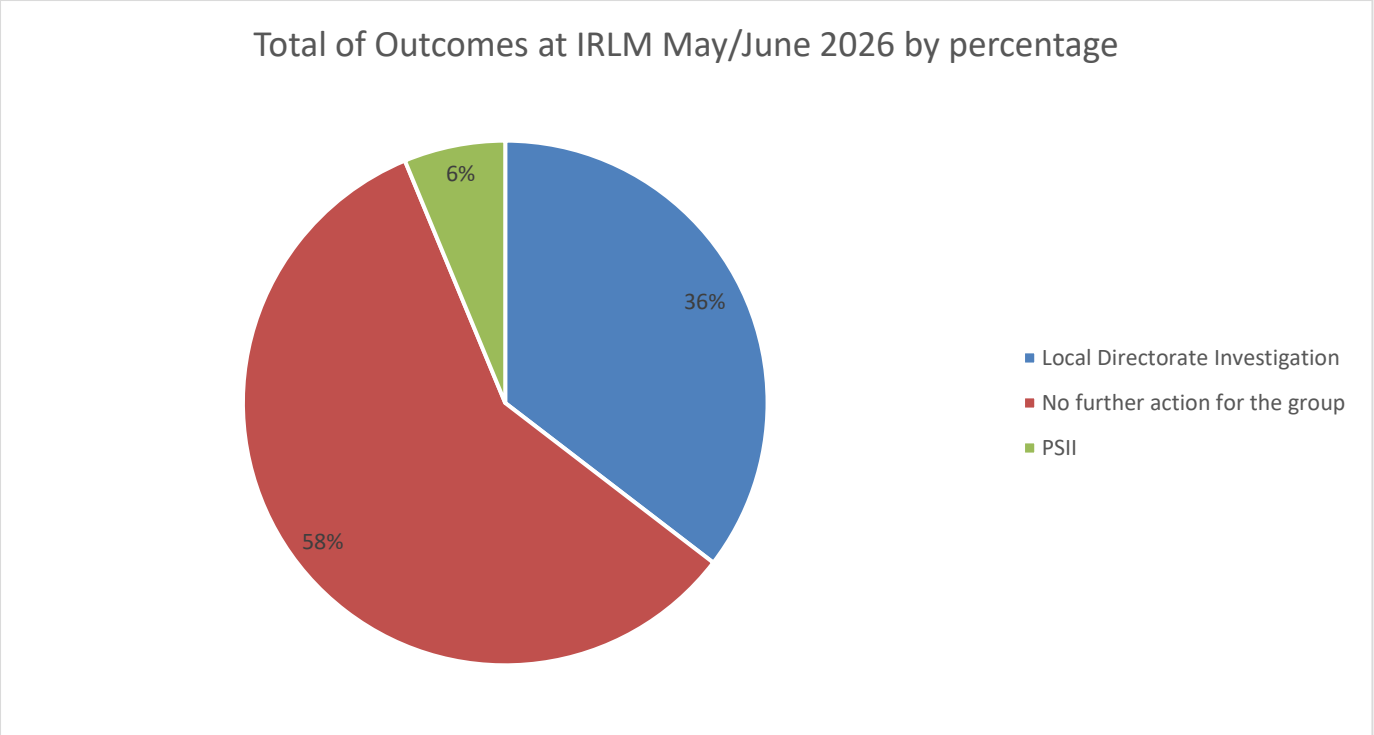
There was no statutory duty of candour breaches during this period. We continue to follow 'being open' which is inbuilt in Patient Safety Incident Response Framework (PSIRF) principles of compassionate and positive engagement with patients/families.

Never Events

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

Incident Review & Learning Meeting (IRLM)

48 cases were reviewed at IRLM during May and June 2026. 3 (6%) Patient Safety Incident Investigations (PSII) were declared during this reporting period. 28 (58%) were identified as having already identified any learning and actions put in place. There were 17 (36%) Local Directorate reviews requested to explore appropriate actions, 0 (0 %) initial service managers reviews (ISMR's) were shared with Learning from Deaths (LfD) for the themes to be aligned with their own.



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

Leicester Leicestershire and Rutland Integrated Care Board (LLRICB) patient safety team continue to be members of the IRLM and continue to feedback how assured they find the conversations and appreciate the focus on system learning.
No queries have been raised by LLR ICB or His Majesties Coroner during the reporting period.
The Care Quality Commission (CQC) are reviewing patient safety incidents reported by LPT and requesting additional information for some incidents as part of their oversight process currently asking for information for February 2026.

Patient Safety Strategy

Training: Systems Engineering Initiate for Patient Safety (SEIPS) approach to investigation training.

During March 2026, 21 staff had been trained bringing the total so far to 362 members of staff. There are further dates available throughout 2026/2027.

This training is evaluating well with staff feeding back that it feels a supportive way to learn and undertake incident reviews:

Directorate	**Numbers trained in SEIPS 2025/2026**
DMH	109

CHS	54
FYPC/LDA	73
Enabling	6
TOTAL	**242**

The CPST have provided three sessions of SEIPS training to Northampton Healthcare Foundation Trust (NHFT) colleagues, this training has been well received and is supporting NHFT to further embed Patient Safety Incident Response Framework (PSIRF).

The team have undertaken some successful reviews where partner organisations have attended so providing another perspective to the findings resulting in opportunity for system level changes. Partners have included patients General Practitioner, care home staff, Local Authority, East Midland Ambulance Service (EMAS).

National: Level one and level two National patient safety training.

This is national training delivered as E learning to support the patient safety strategy and the implementation of PSIRF. The training has been available for staff to access and is required as pre learning for the SEIPS training. The below figures are the staff who have attended so far and as part of our improvement work, we have agreed that all staff will access level 1 and have finalised the staff groups who will benefit from level 2 as band 7 and above.

Table below shows updated figures for the whole trust.

Month Year	Patient Safety Level 1	Patient Safety Level 2	Grand Total
Jan-2025	37	26	63
Feb-2025	48	32	80
Mar-2025	34	25	59
Apr-2025	4817	35	4852
May-2025	1184	12	1196
Jun-2025	459	18	477
Jul-2025	347	8	355
Aug-2025	207	6	213
Sept- 2025	199	12	211
Oct-2025	173	4	177
Nov – 2025	122	4	126

Month Year	Patient Safety Level 1	Patient Safety Level 2	Grand Total
Dec – 2025	89	8	97
Jan – Feb 2026	96	6	102
March – April 2026	134	5	139
May – June 2026	109	7	116
Total	7946	201	8079

Decision Required

Briefing – no decision required.

Governance Table

For Board and Board Committees:	Trust Board
Paper sponsored by:	Linda Chibuzor, Group Chief Nurse/ Executive Director of Nursing, Allied Health Professionals (AHPs) and Quality
Paper authored by:	Tracy Ward, Head of Patient Safety. Patient Safety Specialist
Date submitted:	16/07/2026
Name and date of other committee / forum at which this report / issue was considered:	This report is a combination of reports and prepared as a summary for Trust Board
Level of assurance gained if considered elsewhere	☒Assured ☐ Partially assured ☐ Not assured
Date of next report:	July 2026
THRIVE strategic alignment:	☐ **T**echnology ☐ **H**ealthy communities ☒ **R**esponsive ☐ **I**ncluding everyone ☐ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	**BAF 5** – 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 patients and their families
Is the decision required consistent with LPT's risk appetite:	
False or Misleading Information (FOMI) considerations:	
Positive confirmation that the content does not risk the safety of patients or the public:	
Equality considerations:	

N

Leicestershire Partnership NHS Trust

Leicestershire Partnership NHS Trust Board (Public)
28 July 2026

Freedom to Speak Up Annual Report 2025 – 2026

Purpose of the Report

This report provides an annual review of speaking up activity, to Leicestershire Partnership NHS Trust (LPT) Board of Directors, to ensure the Board is aware of the themes raised through the Freedom to Speak Up (FTSU) Guardians and the actions being taken.

It seeks to provide assurance that matters raised are effectively managed in line with current best practices and seeks to provide assurance of the effectiveness of the FTSU guardian's efforts in supporting staff members who speak up and in fostering a culture of open communication.

Finally, it aims to demonstrate that speaking up is valued and that the Trust is committed to addressing matters and acting on concerns in a timely and appropriate manner, identifying areas for improvement and sharing learning.

Although, the report intends to provide commentary on speaking up activity during the period 2025 – 2026 in LPT it will also highlight how this information and data will inform future work in the FTSU service aligning this with our (Leicestershire Partnership and Northampton Healthcare Foundation Trust) shared vision, “Together we thrive; building compassionate care and wellbeing for all” and the mission “Making a Difference Together”. The corresponding strategy is titled THRIVE and includes six strategic priorities: -

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

The key priorities that will underpin and continue to embed a healthy speaking up culture are, including everyone, when we can demonstrate we have a culture of inclusivity where everyone’s voice is heard and matters, and valuing our people, when people at all levels of the organisation, feel valued, having their voice heard and being recognised for their efforts and achievements.

Analysis of the issue

Following the Francis Inquiry 2013 and subsequent report in 2015, the NHS launched ‘Freedom to Speak Up’ (FTSU). The aim of this initiative was to foster an open and responsive environment and culture throughout the NHS.

When things go wrong, we need to make sure that lessons are learnt, and things are improved. If we think something might go wrong, it is important that we all feel able to speak up to stop potential harm. Even when things are good, but could be even better, we should feel able to say something and be confident that our suggestion will be used as an opportunity for improvement. Making Speaking Up Business as Usual (National Guardians Office (NGO), 2020).

LPT is committed to underpinning their speaking up culture with open and transparent routes by which colleagues feel safe to speak up, confidence in their voices being heard and concerns/suggestions acknowledged and acted upon and evidenced through a robust system of reporting and learning.

The Freedom to Speak Up: Speak Up, Listen Up, Follow Up policy provides detailed information and references that support the Speaking Up process. It aligns with current guidance from NHS England. The policy is currently proceeding through the review process and is on track to be ratified in September 2026.

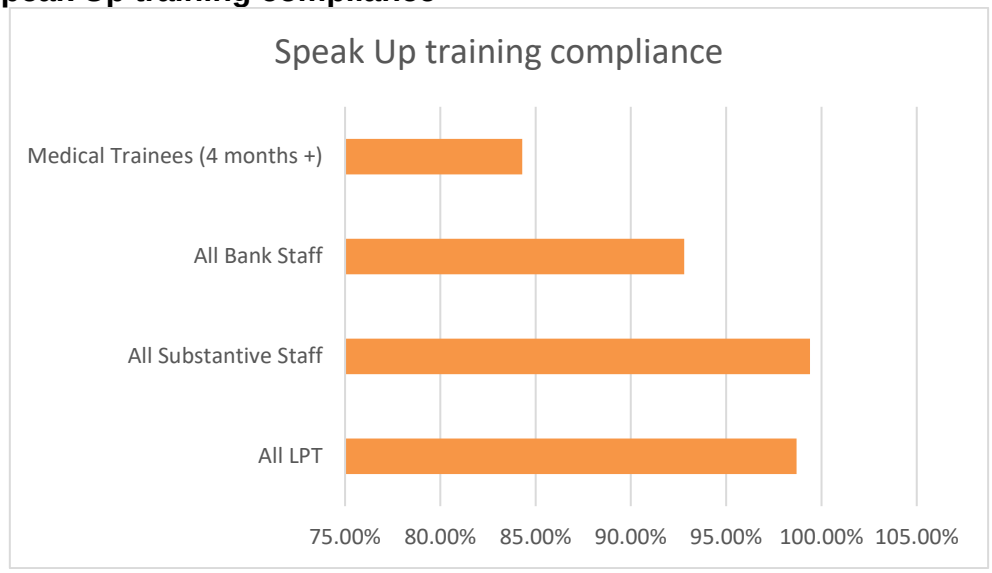
The policy identifies a variety of ways or different routes in which staff can speak up within the Trust in addition to the manager, senior leadership team or FTSU Guardian, for example, the Chaplaincy 'Listening Ear' service, AMICA counselling services, Occupational Health service, Human Resources, Patient Safety Team and Staff-side services. In addition, the policy also identifies the non-executive director with responsibility for FTSU, and other external mechanisms such as Care Quality Commission, NHS England, and other professional bodies.

Freedom to Speak Up Accountability Arrangements

The Trust is committed to providing outstanding care to service users and staff to achieve the highest standards of conduct, openness, and accountability. The Chief Executive Officer (CEO) is the named Executive Lead for FTSU and is accountable for ensuring that FTSU arrangements meet the needs of the staff across the Trust. The Non-Executive Director (NED) responsible for FTSU is available to the Guardians to seek second opinions and support as required. The Guardians have direct access to the CEO, NED, and Chair, with regular meetings scheduled to discuss all elements of FTSU activity. The Deputy Chief Executive (DCEO) is responsible for the management supervision and support to the Guardians.

The Guardians are responsible for presenting FTSU reports to the People and Culture Committee, the Audit Committee and Trust Board. In addition, monthly reports are shared within the Accountability Framework Meeting and included in Triple A reports to level one committees including Quality and Safety and Performance and Finance. Quarterly updates to the Executive Management Board provide information on themes and lessons learnt.

Table 1 - Speak Up training compliance



Freedom to Speak Up training compliance remains strong across the organisation, demonstrating continued commitment to maintaining an open, inclusive and psychologically safe culture where colleagues feel confident to raise concerns and speak up about issues affecting patient care, quality and staff experience.

Overall compliance stands at 98.7%, with 99.4% compliance among substantive staff, providing strong assurance that Freedom to Speak Up principles are well understood and embedded across the Trust. Compliance amongst bank staff also remains high at 92.8%, reflecting positive engagement across the wider workforce.

While compliance for Medical Trainees (4 months+) is 84.3%, this represents a positive level of engagement, and targeted work continues to ensure all trainees complete training at the earliest opportunity. This forms part of the Trust's routine approach to compliance monitoring and continuous improvement.

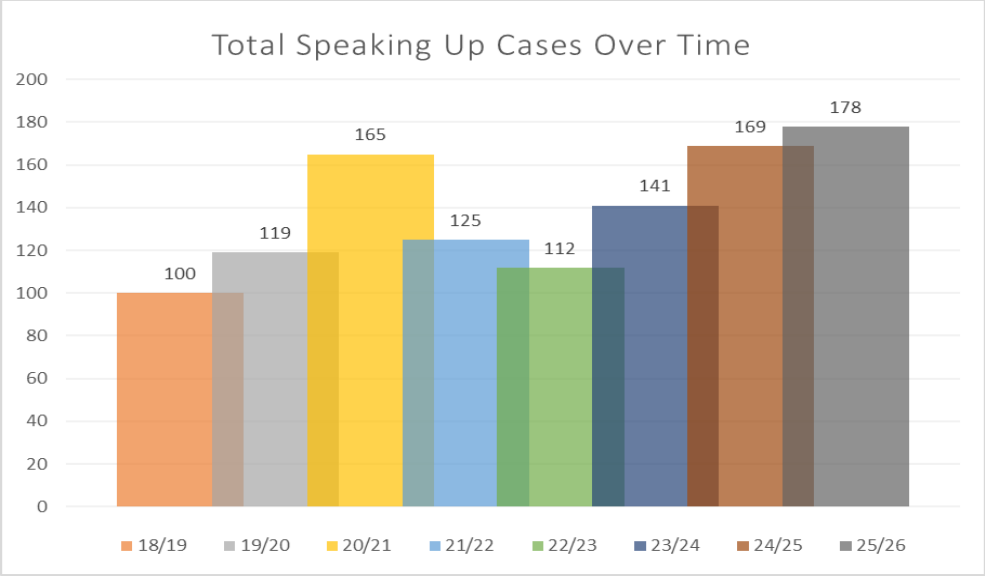
The overall position provides assurance that staff across the organisation have access to the knowledge and support required to raise concerns, contribute to organisational learning and help maintain a culture of openness, transparency and continuous improvement.

Freedom to Speak Up Data

The Trust promotes speaking up through whatever route feels right for the individual and through whatever means i.e., openly, confidentially, or anonymously. Anonymous reporting data includes contacts made to the Freedom to Speak Up (FTSU) Guardians via internal channels: the FTSU Ulysses online platform, telephone messages, letters and encrypted emails. It also covers reports sent directly to the Care Quality Commission (CQC) through external channels.

The table below illustrates the number of contacts to the FTSU Guardians since 2018 to the year end for 2025 - 2026. While the number of speak-up contacts has shown a fluctuating pattern over the years, the number of contacts this year has shown a gradual increase to its highest number. This is a positive representation of the growing confidence in the speaking up culture.

Table 2 – Comparative Summary of recorded contacts per year 2018/19 – 2025/26



In 2025–2026, the Freedom to Speak Up Guardians handled 178 cases. Where the reporter agreed, cases were escalated according to their wishes and the Speaking Up process, and issues were shared with or signposted to the relevant senior leaders. When reporters asked for no further action by the Guardians, they were given advice and directed to appropriate services, including Human Resources, Staffside and professional bodies, Occupational Health, and wellbeing support such as AMICA and Chaplaincy. Where requested, cases were flagged to the senior leadership team for intelligence only. That information is used to cross-check and inform other work on culture and safety, including patient safety, organisational development, staff engagement, health and wellbeing, human resources, and equality, diversity and inclusion.

Key observations

- Overall rise: Speaking Up activity has grown since 2018-19 and is highest in 2025-26.
- 2020-21 anomaly: the spike in 2020-21 and subsequent dip suggest an exceptional cause, likely related to pandemic pressures.
- Recent increase: the climb from 2022-23 onward suggests greater awareness or improved access to reporting routes.
- Balanced approach: Guardians both escalate when requested and signpost when reporters do not want formal action. Intelligence only reporting gives senior leaders insight without forcing formal processes.

Speaking Up Cases LPT Establishment (Permanent) vs Professional Group 2025/26

Chart 1 LPT Establishment 31st March 2026

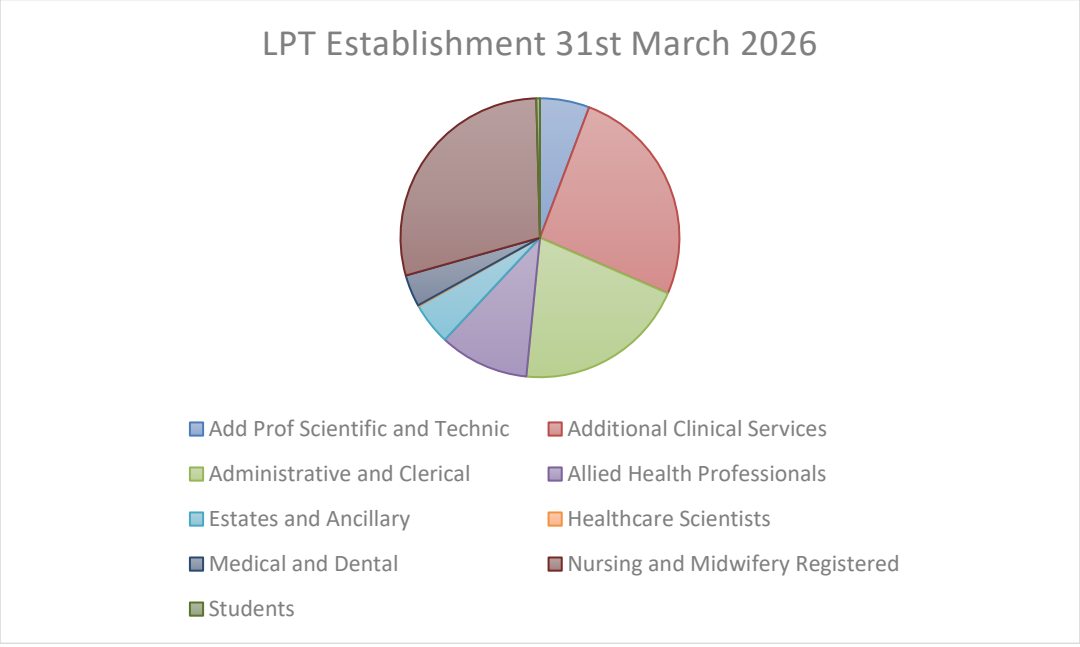
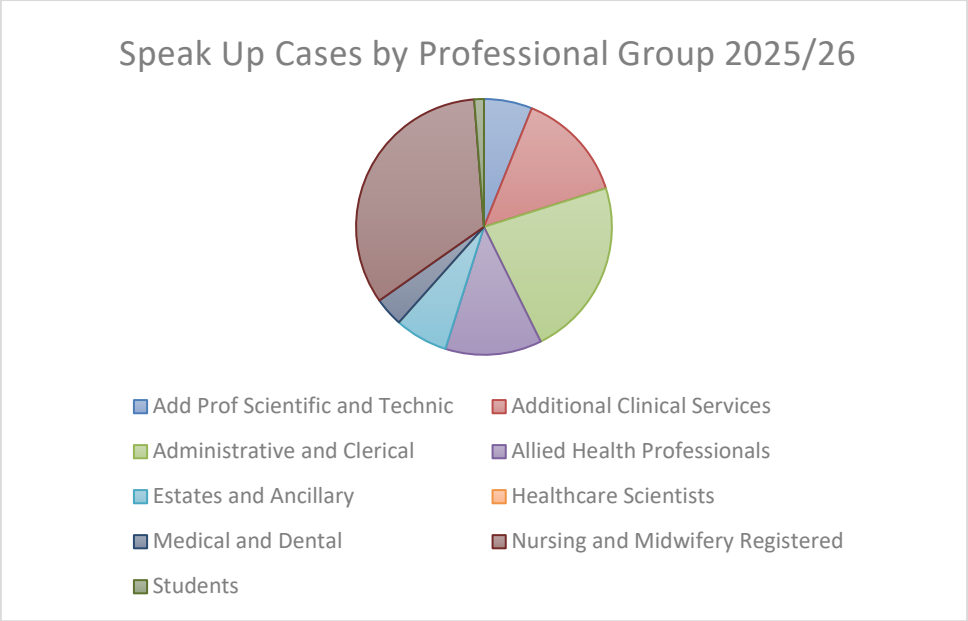


Chart 2 – Speak Up Cases by Professional Group



During 2025–2026, the Freedom to Speak Up service received 178 cases, representing 2.64% of the Trust workforce of 7127 (permanent staff 31/03/26).

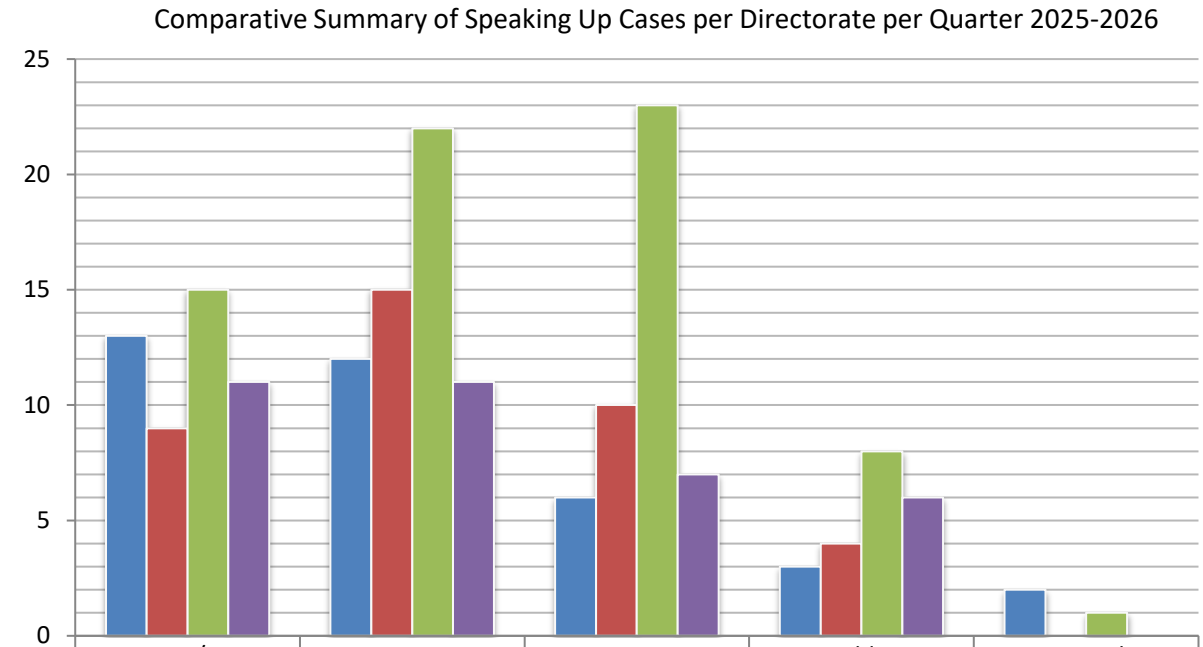
Nursing and Midwifery Registered staff accounted for the largest proportion of cases (55 cases, 30.9%), followed by Administrative and Clerical staff (37 cases, 20.8%). Additional Clinical Services and Allied Health Professionals accounted for 23 cases (12.9%) and 20 cases (11.2%) respectively.

Together, these four groups accounted for 135 cases, representing 75.8% of all Speaking Up activity during the year. This is not unexpected given the size and breadth of these staff groups across the Trust.

Activity was recorded across all professional groups, demonstrating that the Freedom to Speak Up service is being accessed by staff from a diverse range of roles and disciplines.

The 10 cases recorded as "Not Known" represent 5.6% of all cases (attributed to anonymous reports). While this remains a relatively small proportion of the overall dataset, improving the quality of workforce information recorded at the point of reporting would strengthen future analysis.

Table 3. Comparative Summary of Speaking up Cases per Directorate 2025 – 2026



	FYPC/LD	DMH	CHS	Enabling	Hosted
Q1	13	12	6	3	2
Q2	9	15	10	4	0
Q3	15	22	23	8	1
Q4	11	11	7	6	0

Reporting activity remained relatively stable during Quarters 1, 2 and 4, with a notable increase in Quarter 3, when 69 cases were recorded, representing almost 39% of all cases raised during the year. This increase coincided with National Speak up initiatives and the Trust's Speak Up Roadshows throughout October, which increased the visibility of the Freedom to Speak Up Guardians and promoted awareness of speaking up routes across the organisation. The timing suggests that the increase reflects greater staff engagement with, and confidence in, the Freedom to Speak Up process rather than a deterioration in organisational culture. Higher reporting levels can be a positive indicator that staff feel able to raise concerns and are confident that they will be listened to and supported.

At a directorate level, DMH recorded the highest overall number of cases and maintained consistently high reporting levels throughout the year. CHS and Enabling services experienced the significant increase during Quarter 3, while FYPCLDA appears to show a more consistent reporting picture throughout the year. Hosted Services reported very low levels of activity throughout the reporting period.

Key themes identified from speaking up 2025 – 2026.

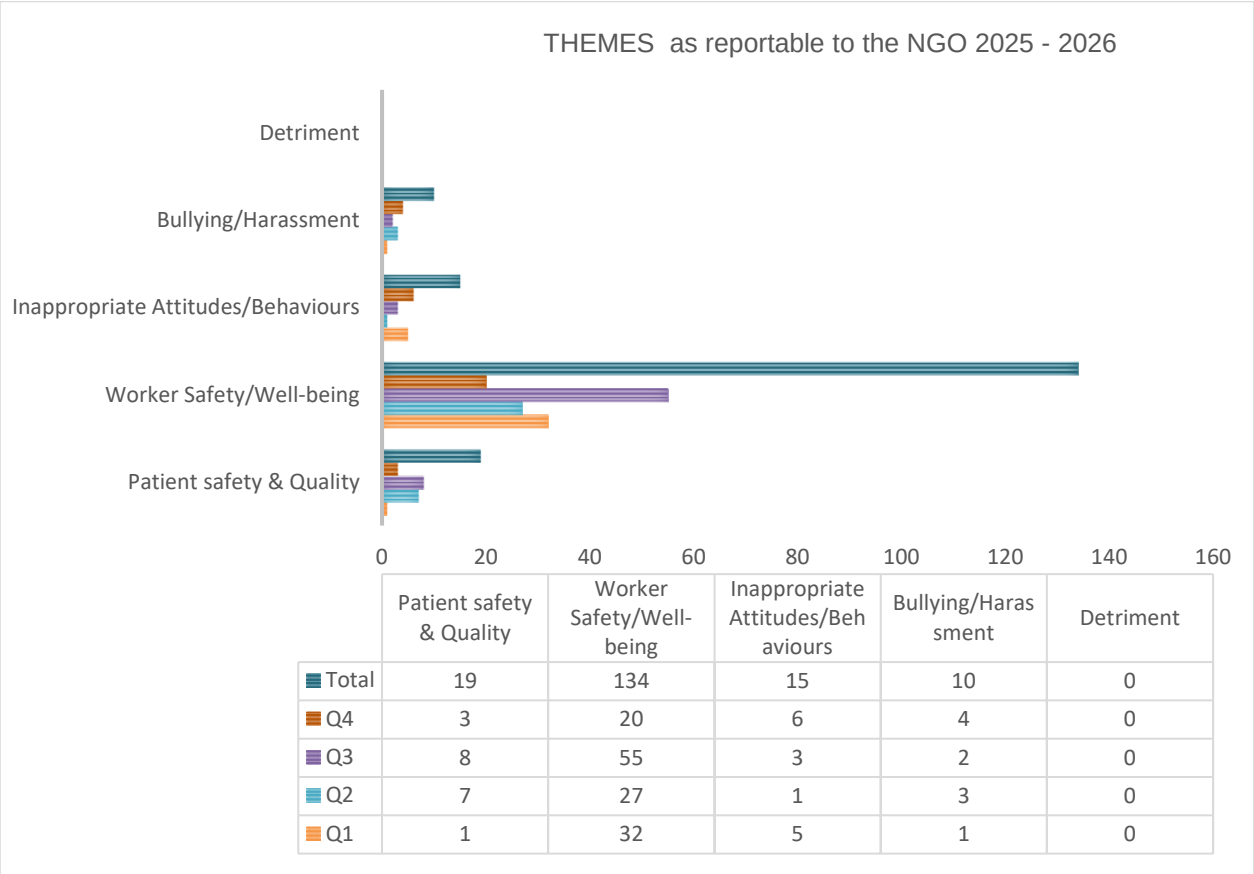
To comply with the National Guardian Office guidance on recording cases and reporting data themes are collated using the following categories;

- Patient Safety & Quality
- Bullying & Harassment,
- Worker Safety or Well-being,
- Element of other inappropriate attitudes or behaviours,

- Disadvantageous and/or demeaning treatment (Detriment) because of speaking up

Reports are recorded on the best fit according to the workers' descriptions with reference to the NGO data descriptors.

Table 4. Comparative Summary of Speaking up Themes 2025 - 2026



	Patient safety & Quality	Worker Safety/Well-being	Inappropriate Attitudes/Behaviours	Bullying/Harassment	Detriment
Total	19	134	15	10	0
Q4	3	20	6	4	0
Q3	8	55	3	2	0
Q2	7	27	1	3	0
Q1	1	32	5	1	0

** Speak-up cases often contain multiple themes; therefore, data sets do not always equate together. Reports are recorded under the workers' description and in line with National Guardian Office Guidance.*

Summary and Key Observations

During 2025–2026, the Freedom to Speak Up service received 178 cases. Worker Wellbeing remained the dominant theme, accounting for 134 cases and approximately three quarters of all concerns raised. Other themes included Patient Safety and Quality (19 cases), Inappropriate Attitudes and Behaviours (15 cases), Bullying and Harassment (10 cases), and Anonymous Reports (10 cases). No cases were recorded under the Detriment category.

Worker Wellbeing

Worker Wellbeing remained the most frequently reported theme throughout the year, potentially, reflecting sustained pressure across services and highlighting that workforce experience continues to be the most significant issue raised through Freedom to Speak Up route.

Concerns frequently related to compassionate leadership, management style, the application of policy (notably recruitment and development opportunities, disciplinary processes, flexible working and reasonable adjustments), psychological safety, workplace culture, and general health and wellbeing. Leadership behaviours were also raised where staff felt actions did not align with Trust values or expected standards.

The volume and consistency of these concerns underline the importance of continuing to invest in staff wellbeing, leadership development and supportive workplace cultures. Concerns relating to wellbeing and workplace culture can affect morale, retention and workforce resilience and, if left unaddressed, may also have an indirect impact on patient care. All concerns were managed through established Speak Up processes and escalated appropriately where action was required.

As a wider organisational response to support staff wellbeing in the workplace there is an extensive LPT Health and Wellbeing offer which is communicated through regular bulletins, StaffNet (staff intranet site), internal Facebook platform and through the network of Health and Wellbeing Champions and is often used to signpost colleagues for individual support.

The Equality Diversity and inclusion team continue to grow the Staff Support Networks and FTSUG's are active participants in each of these.

The Organisational Development team regularly communicates reminders of supportive training packages for all workers (First Steps into Leadership, Leading Great Teams, Team Development Tools, CUBE feedback model, Compassionate and Inclusive Leadership and Leadership Conversations).

Patient Safety and Quality

Patient Safety and Quality concerns accounted for 19 cases during the year, with reporting increasing during Quarters 2 and 3. Although many colleagues contacted the service primarily about leadership behaviours or wellbeing concerns, these were often linked to potential risks to patient safety and the quality of care provided.

Staff described concerns relating to workload pressures, team culture, care planning, risk assessments, documentation, multidisciplinary working and leadership oversight. Nursing colleagues highlighted issues associated with safer staffing, dignity and respect, and care planning, while Allied Health Professionals raised concerns relating to assessments, discharge planning, patient placements and role clarity within multidisciplinary teams.

All patient safety concerns were escalated through appropriate governance arrangements and reviewed by the relevant senior leaders. These reports provided valuable intelligence that support reviews, fact-finding, multidisciplinary Quality Summits, where necessary, immediate intervention. Learning from these concerns has informed improvements in staffing, training, documentation and multidisciplinary working.

Bullying, Harassment and Workplace Behaviours

Concerns relating to inappropriate attitudes and behaviours (15 cases) and Bullying and Harassment (10 cases) remained relatively low compared with other themes. A slight increase in Bullying and Harassment concerns was observed during Quarter 4 and will continue to be monitored to determine whether this reflects an emerging trend in identified work areas or isolated issues.

These concerns reinforce the importance of maintaining a culture where colleagues feel respected, included and psychologically safe. They also highlight the need for continued focus on leadership behaviours, professional conduct and early intervention when workplace relationship issues arise.

While the data in 2025/26 does not explicitly breakdown incidents by protected characteristics (e.g., race, gender, disability), the themes of bullying and harassment, inherently, raise some equality concerns. LPT focus on equality, diversity and inclusivity for all and our shared commitment to the Together Against Racism project directly supports our ambition to create a truly inclusive Trust for our colleagues, patients and service users.

Finally, the Our Future Our Way culture project team, supported by our Change Leaders are focusing on two key priorities; developing practical guidance for all staff and line managers on recognising, responding to and addressing racism and discrimination in the workplace with compassion and practical tools and guidance to support the embedding of equitable career progression. The Freedom to Speak Up Team have been active stakeholders in these projects which are, in part, an organisational response to the matters that have been raised through a variety of feedback routes including the National Staff Survey and FTSU service.

Anonymous Reports
During the year 2025 – 2026 there were 10 anonymous reports received through internal mechanisms and 7 anonymous reports to CQC understood to be from LPT workers.

Anonymous reporting remains an important route for individuals who do not feel comfortable raising concerns openly. These reports can provide valuable insight into issues that may not otherwise be reported and help identify areas where confidence and trust require further attention.

While anonymous reporting will always remain an important option, continued efforts to strengthen psychological safety and visibility of the Freedom to Speak Up service should support more colleagues to raise concerns openly where possible.

Since April 2025, a new online reporting tool provides a route for colleagues to speak up anonymously (if required). This system will record limited information relating to service and location to ensure we are able to identify potential issues or developing ‘hot spots’ increasing the potential to resolve matters at the earliest opportunity.

Overall Position
The data demonstrates continued engagement with Freedom to Speak Up processes across the Trust. The increase in reporting during Quarter 3, particularly during the period of the Speak Up Roadshows, suggests growing awareness of and confidence in the service. Worker Wellbeing remains the predominant theme and continues to require organisational focus. The increases observed in Patient Safety concerns during Quarters 2 and 3, and in Bullying and Harassment concerns during Quarter 4, warrant ongoing monitoring and thematic review. Importantly, no detriment cases were reported during the year, which is a positive indicator of psychological safety, organisational responsiveness and confidence in Freedom to Speak Up arrangements.

What Does the National Staff Survey (NSS) Tell Us About Speaking Up?

The National Guardians Office Annual report highlights the national results of the 2025 NHS Staff Survey which showed a decline in workers’ confidence in speaking up, with the Freedom to Speak Up sub-score falling to a five-year low of 6.37 (down from 6.45 in 2024). All four measures within this sub-score decreased, with three dropping by more than one percentage point. Only 55.49% of staff felt confident their organisation would address clinical safety concerns, and fewer than half (47.59%) believed their organisation would act on concerns more generally.

Nationally, while 71.1% of workers reported feeling safe to raise concerns about unsafe clinical practice, only 55.5% trusted their organisation to act on patient-safety issues. Similarly, 61.5% felt safe raising any concern, yet just 47.6% believed action would follow. This widening 'action gap' poses a significant risk to trust and engagement; a culture that encourages speaking up but fails to respond meaningfully can create disillusionment and undermine the entire framework. (extract from National Guardian's Office Annual Report 2026)

National Staff Survey Results at LPT

The 2025 NHS Staff Survey results for LPT focus on the People Promise sub-score and its four questions: Q20a, Q20b, Q25e and Q25f. These questions support the People Promise statement, "We each have a voice that counts," and measure the organisation's culture around speaking up and raising concerns.

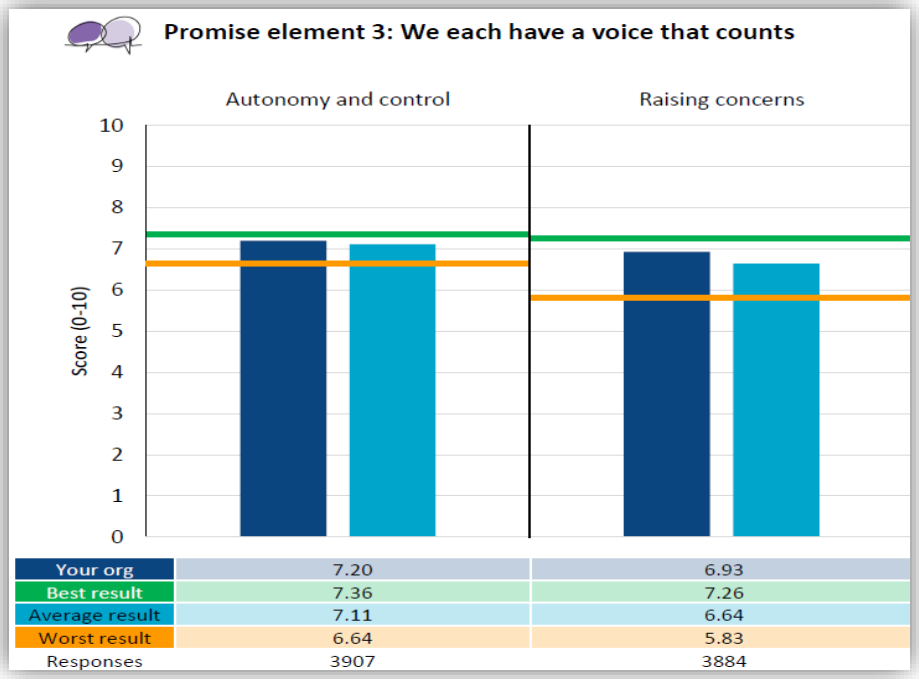
Summary of Results

LPT Raising Concerns Sub-score (0–10 scale):

- 2025: 6.93 (higher than the national sub-score of 6.37)
- Best in Benchmark: 7.26
- Benchmark Average: 6.64
- Trend: Stable since 2021 (range: 6.81–6.96)

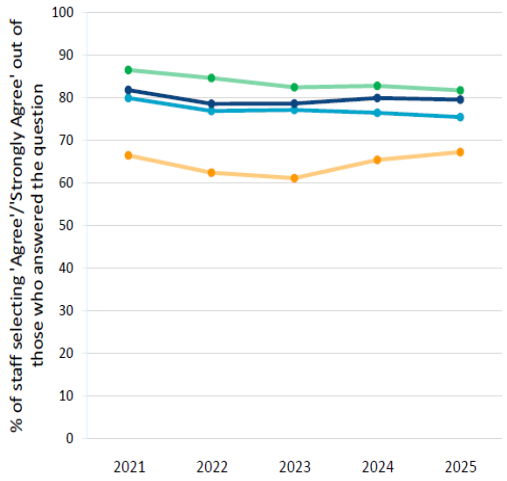
The results show a consistent, moderately positive speaking up culture with clear headroom to reach top-benchmark performance. The story that emerges is of a workforce that generally feels safe to raise issues and is more confident than peers that concerns will be acted on but still perceives gaps in how reliably and visibly concerns are addressed.

2025 NHS Staff Survey responses to statements relating to People Promise 3.



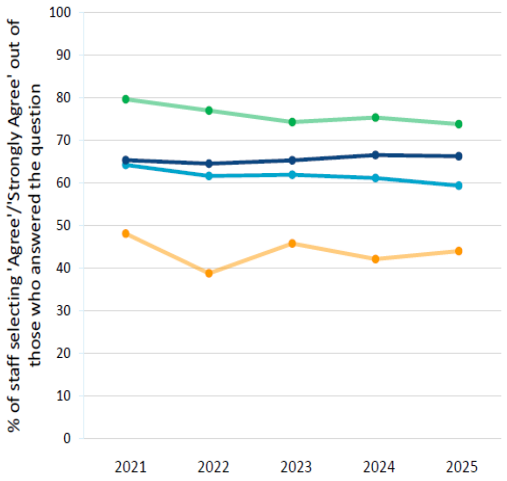
	Autonomy and control	Raising concerns
Your org	7.20	6.93
Best result	7.36	7.26
Average result	7.11	6.64
Worst result	6.64	5.83
Responses	3907	3884

Q20a I would feel secure raising concerns about unsafe clinical practice.



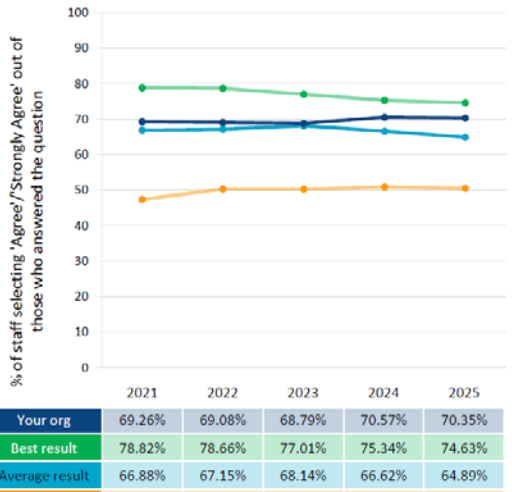
	2021	2022	2023	2024	2025
Your org	81.71%	78.49%	78.54%	79.84%	79.47%
Best result	86.42%	84.52%	82.35%	82.70%	81.64%
Average result	79.85%	76.83%	77.03%	76.38%	75.37%
Worst result	66.36%	62.35%	61.05%	65.31%	67.17%
Responses	2847	2913	3319	3941	3896

Q20b I am confident that my organisation would address my concern.



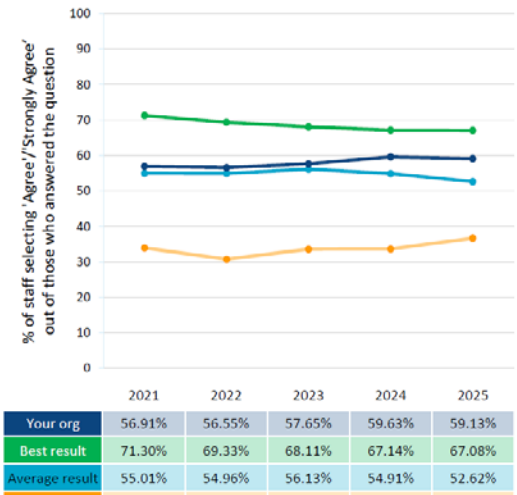
	2021	2022	2023	2024	2025
Your org	65.26%	64.45%	65.25%	66.47%	66.17%
Best result	79.56%	76.90%	74.19%	75.29%	73.72%
Average result	64.16%	61.56%	61.87%	61.07%	59.29%
Worst result	48.03%	38.71%	45.71%	42.06%	43.94%
Responses	2838	2911	3308	3932	3884

Q25e I feel safe to speak up about anything that concerns me in this organisation.



	2021	2022	2023	2024	2025
Your org	69.26%	69.08%	68.79%	70.57%	70.35%
Best result	78.82%	78.66%	77.01%	75.34%	74.63%
Average result	66.88%	67.15%	68.14%	66.62%	64.89%
Worst result	47.35%	50.28%	50.25%	50.87%	50.51%
Responses	2844	2914	3328	3933	3886

Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022	2023	2024	2025
Your org	56.91%	56.55%	57.65%	59.63%	59.13%
Best result	71.30%	69.33%	68.11%	67.14%	67.08%
Average result	55.01%	54.96%	56.13%	54.91%	52.62%
Worst result	33.93%	30.73%	33.57%	33.61%	36.67%
Responses	2844	2914	3326	3931	3881

Analysis and Interpretation

Strengths:

- The Trust consistently scores above the benchmarking average for all four questions, indicating a positive culture for raising concerns.
- Staff feel secure raising concerns about unsafe clinical practice (Q20a) and safe to speak up about anything (Q25e), both above average and close to the best in the sector.
- Confidence that the organisation would address concerns (Q20b, Q25f) is notably higher than the sector average, with a 6–7 percentage point advantage.
- Trends show stability or modest improvement since 2022, especially in confidence that concerns will be addressed.

Areas for Improvement:

- There remains a gap of 2– 8 percentage points to the best-performing organisations, especially in staff confidence that concerns will be addressed (Q20b, Q25f).
- The Trust's results, while strong, suggest that some staff still perceive inconsistency in how concerns are acted upon or communicated back.
- Operational pressures (e.g., staffing, workload) may indirectly affect staff confidence in the organisation's ability to respond to concerns.

What This Means for the Organisation

Speaking Up Culture: The Trust has established a strong foundation for speaking up, with staff generally feeling able and safe to raise concerns. This is a significant achievement and a relative strength compared to peers.

Trust in Response: The next step is to further strengthen staff confidence that concerns will be addressed reliably and visibly. This involves not only acting on concerns but also closing the feedback loop by communicating outcomes and actions taken.

Managerial Role: Managers play an important role in promoting a positive speaking up culture. Continued investment in training and supporting managers to handle, escalate, and resolve concerns consistently will help close the gap to top performance.

Operational Enablers: Addressing broader operational challenges (such as staffing and workload) will further reinforce staff trust that the organisation can act on concerns promptly and effectively.

LPT demonstrates a strong and stable speaking up culture, outperforming the sector average and showing resilience over time. To reach best in class status, the Trust should focus on making the response to concerns more consistent, visible, and timely. By enhancing feedback mechanisms and supporting managers, the organisation can further empower staff and ensure every voice truly counts.

Reporting Culture

While the Trust data give some indication of various issues or concerns, the Board may want to consider the reporting culture within the Trust, particularly the previously reported themes of fear and futility as potential barriers to speaking up. Are staff comfortable reporting concerns without fear of reprisal? Will their concern or issue be listened to and acted upon?

Ther FTSU Guardians have supported events and activities, in response to local (team level) staff survey results, including targeted listening events working alongside leaders and

managers, the Organisational Development Team and the Staff Engagement Lead. This action has enabled the FTSU Guardians to raise the profile of speaking up with the intention of building confidence in the process and enabling colleagues to speak thereby reducing the potential effects of fear and futility.

It is understood that low reporting figures in certain areas may indicate few issues or other matters that impact negatively on the speak up culture. Conversely, high reporting figures could indicate both a prevalent issue and a healthy reporting culture. The NSS results are being used to invite direct engagement with teams that may show areas for development and improvement in the People Promise element 3: We each have a voice that counts. In addition, FTSU Guardians and other engagement teams are using results to inform supportive actions where teams show a low return rate in a bid to understand the relevant data and suggest how speaking up culture and therefore level of engagement in all speaking up mechanisms can be improved.

Raising Awareness of FTSU 2025 – 2026

The Freedom to Speak Up Guardians continue to assist the Trust in developing a restorative and forward-thinking approach to addressing staff concerns based on reflective learning. They aspire to weave a strong speaking up culture across the organisation and truly make 'speaking up business as usual.

The FTSU team is tasked with raising awareness about speaking up and supporting the development of an open and transparent culture. The role of the FTSU Guardian continues to be widely promoted through internal communication routes including the Trust's weekly eNews, monthly Team Brief and social media, Trust-wide emails, posters across Trust sites, computer screen savers, face to face meetings and team presentations. The Trust's commitment to 'making speaking up business as usual' is also highlighted at all induction presentations for new staff, including corporate induction specifically for qualified and non-qualified staff, bank staff and volunteers. Bespoke presentations are delivered to medical trainees and students, nursing associates, apprentices, preceptors, international recruits and other Allied Health Professionals.

FTSUGs have taken opportunities to increase visibility and support larger engagement events throughout the year including, Black History month events, Active Bystander celebration events, wider Leicester, Leicestershire and Rutland (LLR) Allied Health Professionals (AHP) celebration conference to mark National AHP Day, and the LLR Women in Leadership conference.

The Guardians actively promote inclusive FTSU approaches, targeting seldom heard groups within the workforce, as identified by research; these include but are not limited to, those with protected characteristics, night workers, students, registrar doctors and offsite workers. Each guardian takes an active role in attending the staff Support Networks in an endeavour to further enhance confidence in the speaking up culture.

FTSU Champions

The Trust currently has 23 volunteer Freedom to Speak Up Champions who play an important role in positively promoting the key messages about speaking up and widening the reach of the FTSU agenda. Champions offer support and signpost colleagues to appropriate services as required.

There has been a recent recruitment drive and specific invitations to existing ambassador and champions networks including change leaders, health and wellbeing champions and cultural ambassadors. All Cultural Ambassadors within directorates are requested to complete the FTSU Champion training as part of their role.

FTSU Champions are offered support and supervision at regular drop-in sessions, more formal forum meetings and one to one session when requested. We also provide peer support sessions in collaboration with the Health and Wellbeing Champions.

Given the national acknowledgment of additional barriers for speaking up amongst certain groups of staff, great care has been taken to ensure the Champions network is representative of the workforce in terms of equality, diversity and inclusion and professional groups. The Trust FTSU Champions network has representatives from staff support networks and from a variety of services and disciplines including physical health and mental health teams (both registered and unregistered clinicians), volunteers, Allied Health Professionals and administrative roles across the breadth of the workforce. There is an ongoing recruitment drive to develop the FTSU Champion network further to extend the reach of the FTSU messages.

October Speak Up Month: Follow Up in Action

During October 2025 the FTSU Guardians visited 29 venues across the organisation delivering roadshow style events. These were supported by members of the Board (Executive and Non-Executive Directors), colleagues from Equality Diversity and Inclusion and, Health and Wellbeing teams and the LPT Engagement Lead when possible. This was a positive experience where FTSU team colleagues were able to share how they support the speaking up culture through these events. In addition, the feedback from the individuals that spoke up to us positively highlighted their appreciation of being able to meet members of the executive team and share their experience in person. The team have already planned a series of similar events for October 2026 further developing this model of engagement.

In addition, each member of the Board was asked to make a Speak Up pledge or to review their previous pledge indicating how they had honoured their existing pledge. These were used at many of the engagement events (as a rolling presentation) and are published on StaffNet.

The FTSU Guardians were able to present an interactive session as part of the group ‘Where I belong – every voice matters’ conference in both NHFT and LPT. The feedback collected during the session has been used to support subsequent joint Organisational Development projects including Our Future Our Way and Valuing our People – Support in Changing Times and informed the FTSU Improvement Plan.

Reflection and Planning Tool

The Freedom to Speak Up (FTSU) team continues to work in close partnership with group FTSU colleagues across the Northampton Healthcare Foundation Trust to share best practice and promote a consistent, high-quality approach to speaking up. This collaboration is underpinned by our shared vision, “Together we thrive; building compassionate care and wellbeing for all,” and our mission, “Making a Difference Together,” published in 2025.

Working collaboratively with NHFT, the FTSU Guardians facilitated the Freedom to Speak Up Reflection and Planning Tool, gathering evidence collectively and agreeing scoring levels through a collaborative Board process. NHS England advises that this tool is reviewed and updated every two years. In line with this, the group Guardians delivered an interactive Board Development session in November 2025, during which Board members again reviewed the evidence and agreed the scoring collectively. The resulting document will inform both short-

and long-term actions to strengthen FTSU arrangements and contribute to wider group culture development programmes.

National Guardian's Office Updates and Publications
In response to the Dash review and the 10-Year Health Plan it was confirmed that the role of the National Guardian will be abolished and "the functions of the National Guardian's Office should be aligned with other national staff voice functions and those in commissioner and provider organisations". The Freedom to Speak Up Guardian role will remain part of NHS Standard Contract for 2026/27. The closure of the NGO took place at the end of June 2026, and office functions have been taken over by over by NHS England, the Department for Health and Social Care (DHSC), the Care Quality Commission (CQC) and providers.

What everyone who supports speaking up needs to understand about the Public Interest Disclosure Act – aims to address any confusion in relation to what is a qualifying disclosure under Public Interest Disclosure Act and how this may affect an individual's role in supporting workers who speak up (April 2025) – this was highlighted at the Strategic Executives Board meeting – July 2025

The Annual Report of the National Guardian for the NHS, highlighting the work of Freedom to Speak Up guardians and the National Guardian's Office, was laid before Parliament on 24th November 2025. The report shares learning which indicates that more work is needed for speaking up to be described as business as usual in the healthcare sector in England - – this was highlighted at the Strategic Executives Board meeting – July 2025

In March 2026 the National Guardians Office published the Temporary Workers, Permanent Voices: A Speak Up Review which highlights the significant difficulties temporary workers face when carrying out their roles in the NHS. It acknowledges that, while not all difficulties are directly about speaking up, these factors strongly influence whether workers feel able, safe and supported to voice ideas and concerns.
The review identified three key themes:

- Workplace challenges faced by temporary workers in the NHS
- Barriers and enablers of speaking up
- Speaking up guidance, support, and gaps.

Based on these themes, the NGO has identified six recommendations to strengthen speaking up practice and improve the experience of temporary workers.

It is intended to use this report complete a gap analysis at LPT and implement the recommendations to support more consistent, effective speaking up arrangements and contribute to a safer, more inclusive environment for temporary workers.

Key Actions for 2026 – 2027

Whilst there has been a considerable amount of work undertaken in 2025 - 2026, there is more work needed to embed the FTSU programme across the Trust. This will continue to be reviewed as we work through the implications and expectations of wider guidance and recommendations of the NHS 10 -Year Plan and Dr Penny Dash's review of patient safety across the health care landscape.

Our commitment for the next 12 months is to:

- Maintain high levels of visibility to support a positive speaking up culture aligning with group strategic objectives.

- Continue to work collaboratively across the group, embed key FTSU messages aligned to the THRIVE strategy.
- Work collaboratively with other teams and services as required to support improvements and learning from NSS.
- Monitor uptake for Listen Up, Follow Up training and encourage colleagues as appropriate to complete this as part of professional development. Work with HR and OD to build in key messages into available training packages.
- Continue collaborating with the staff networks to develop action plans for addressing staff barriers to speaking up.
- Complete a gap analysis of FTSU Champions to identify existing gaps with a view to establishing a more diverse network of Champions referencing professional groups, localities, service areas and potentially protected characteristics.
- Use Temporary Workers, Permanent Voices: A Speak Up Review to complete a gap analysis at LPT and implement the recommendations to support more consistent, effective speaking up arrangements and contribute to a safer, more inclusive environment for temporary workers.

Board Assurance:
The Board can draw assurance from the THRIVE strategic objectives and additional culture projects that directly address identified key issues, particularly around enhancing psychological safety to support speaking up and prioritising workforce well-being. This shows a clear intent to provide a positive environment where staff feel safe to speak up about anything that gets in the way of them doing their job.

The current approach to supporting a positive speaking up culture aligns directly with the Trust's strategic objectives and in doing so is most likely to deliver sustainable, positive change across the Trust, however, it must be acknowledged that culture change is a long-term journey requiring sustained effort across multiple fronts.

Decision required - The Board is asked to:

1. Confirm assurance that speaking up issues and concerns are being raised and dealt with in line with the Freedom to Speak Up: Speak Up, Listen Up, Follow Up policy and that the Board is aware of themes and trends emerging in the organisation.

2. Confirm assurance that the work of the FTSUG's is supporting LPT to develop an open and transparent culture where staff are actively encouraged and enabled to speak up.

3. Confirm they are assured that the Trust has a policy and process in place for staff to safely raise concerns and as a consequence ensure action is taken on any themes emerging or areas of concern with feedback provided to those raising concerns.

4. Promote the demonstration of learning through open communication, addressing detriments, and fostering collaboration within the organisation on all matters related to speaking up.

Author – Chrispen Moyo and Pauline Lewitt
Date – 28th July 2026

Governance table

For Board and Board Committees:	Trust Board	
Paper sponsored by:	Angela Hillery, CEO	
Paper authored by:	Pauline Lewitt & Chris Moyo: FTSU Guardians	
Date submitted:	28/07/2026	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	N/A	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	N/A	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Annual	
LPT strategic alignment:	**T** - **T**echnology	
	H – **H**ealthy Communities	
	R - **R**esponsive	
	I – **I**ncluding Everyone	X
	V – **V**aluing our People	X
	E – **E**fficient & Effective	
CRR/BAF considerations *(list risk number and title of risk):*	N/A	
Is the decision required consistent with LPT's risk appetite:	N/A	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed	
Equality considerations:	None	

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Leicestershire Partnership NHS Trust

Level 1, 2 and 3 Alert, Advise and Assure (AAA) Highlight Report
LPT Committee / Group : Finance and Performance Committee
Date of Meeting: 18 June 2026
Meeting chair and Report Author: Melanie Hall / Val Glenton

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

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
			No issues to highlight.			

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

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Finance Report Month 2 2026/26	LPT/26/060	LPT Chief Finance Officer	• The CIP target was fully identified but some year to date under delivery was being seen mainly due to either the phasing of CIP schemes or late commencement. A report from one directorate would be presented to each meeting on why CIP schemes were slipping and what the barriers were to them being on track – DMH would report to the meeting in August. • Capital of £721k had been spent year to date which was below the planned value of £2.3m. Although approval had been given for all external NHS schemes, no funding had yet been received and LPT had been advised that MoU's were on pause. The issue had been escalated to the regional team who had agreed to raise the matter with the national team.	BAF10 BAF11		

ASSURE: Inform the Board where positive assurance has been received

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Board Assurance Framework	FPC/26/057	Director of Governance and Risk	Five BAF risks were mapped to FPC relating to finance, digital disruption, estates and performance. The committee received assurance that robust systems were in place to secure an effective risk framework and agreed a deep dive on the new risk BAF12 *(tighter restrictions due to NHS reforms and performance oversight framework)* at the next meeting as it had a broad content.	BAF01 BAF09 BAF10 BAF11 BAF12		N/A
Group Value Programme	FPC/26/061	NHFT Chief Finance Officer	NHS England was expecting Trusts to reduce growth in corporate service expenditure by 50% and an update on progress towards a Group corporate and enabling service efficiencies across LPT and NHFT was presented. FPC agreed that progress on the Group Value Programme would be a standing agenda item at future meetings.	BAF11		N/A
Lead Provider Governance	FPC/26/065	NHFT Chief Finance Officer	FPC had little oversight of the performance of the Adult Eating Disorder Service since quarterly reports had been stopped in 2025. FPC agreed to introduce an annual report starting with presentation in August 2026 to strengthen the governance around what was reported in the Joint Collaborative, Commissioning and Contracting Group triple A report. This approach would be reviewed after the August meeting.	BAF02		N/A
Accountability Framework Meeting	FPC/26/066	Managing Director / Deputy CEO	One alert item was reported which related to the number of people waiting over 52 and 104 weeks, the majority of which were for neurodevelopmental assessments, both children and adults. FPC was informed of the work taking place to support management of patient tracking lists across the organisation, processes were already being reviewed in CHS and DMH. The Access Delivery Group was also undertaking regular reviews of services with long waits. Six advise items were reported which included; • Length of stay in DMH. • The Mental Health Liaison Service one hour target was not being achieved.	BAF01 BAF04 BAF09 BAF11		

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
			• Access to UHL's Integrated Clinical Environment system had still not been resolved. • Concerns had been raised by a number of services about the responsiveness of the Estates Team. • Ongoing issues relating to ICB commissioned services about the lack of service specifications and the number that were out of date. • Issues with the estates and facilities software platform Invida. Assurance was received that all issues were being addressed and strong mitigations were in place.			
LHIS Annual Report 2025/26	LPT/26/067	Joint Deputy Digital Director	The Committee received overall assurance and noted in particular: • LHIS was meeting the requirements of its SLAs. • Specific focus would be given to automation and process efficiencies in the next period. • Key deliverables included the roll out of Airmid and Brigid. Also, a significant amount of work had been carried out on space utilisation which had contributed to delivery of LHIS CIP targets. • LHIS had achieved an underspend of c£250k against its core revenue budget, and CIP targets had been achieved. • Workforce and culture compliance remained strong.	BAF01		
DSPT Annual Submission 2025/26	LPT/26/070	Group Data Protection Officer	FPC noted the Trust was planning to report via the DSPT that it would attain 'Standards Met' by the deadline of 30th June which was a fantastic endorsement of the work across the teams.	BAF01		
Caldicott Guardian Annual Report	LPT/26/071	Medical Director / Group DPO	The annual update was presented on the work of the Information Governance Team who supported the Medical Director to fulfil his duties in his role of Caldicott Guardian to protect the confidentiality of people's health and care information. FPC received assurance on the work and achievements of the team's Caldicott activities.	BAF01		
Cyber Security Annual Report	LPT/26/072	Cyber Security Manager	FPC received assurance on the work of the Cyber Security Team which included; • Deployment of new systems and capabilities such as VPAM, PAM and SOC/SEIM. • Strong links with NHFT's cyber security team to ensure alignment and consolidation of approach to addressing cyber security risks and threats.	BAF01		

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
			• Close working relationships with LPT's Information Governance Team and regular reports to the Data Privacy Group. • Additional cyber awareness training was provided where relevant. A communications campaign called Cyber Force had been initiated to support users maintain their knowledge. FPC agreed it would maintain oversight of the dynamic cyber security environment through presentation of the DPG triple A report and enhanced cyber content in the 6-monthly digital plan update.			
Estates and Facilities Summary Report	LPT/26/074	NHFT Chief Finance Officer	FPC was assured by the summary of E&F performance for May 2026, key points to note were; • Estates performance compliance with statutory standards was reported at 82.77% for planned and reactive maintenance. • Facilities performance was very strong with a number of areas being reported at 100%. • Medical devices overall compliance with safety checks and planned maintenance was reported at 97% which was a huge improvement from previous years.	BAF09		
Green Plan Delivery Dashboard Proposal	LPT/26/075	NHFT Chief Finance Officer	FPC endorsed the development of a Green Plan dashboard and had a useful discussion on enhancements to enable progress-tracking and specific Trust performance within the overall Group approach. The report would show delivery performance for both LPT and NHFT at three intervals per year starting in August 2026 for LPT.	BAF09		

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

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Joint Collaborative, Commissioning and Contracting Group Triple A Report	FPC/26/064	Group Director of Strategy & Partnerships	The East Midlands CAMHS Collaborative was the regional winner of the Improving Health Outcomes category of the NHS Excellence Awards 2026, the national winner would be announced in June.	BAF02		

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Accountability Framework Meeting	FPC/26/066	Managing Director / Deputy CEO	• LPT had been reported as one of the best in the country for use of Section 136 (*emergency police power to detain*) according to national data. This was a significant achievement which highlighted the importance of partnership working between the police and mental health providers. • Mental Health Facilitators had delivered an additional 974 physical health checks beyond target.	BAF02		
	FPC/26/078	CFO	• A celebrating outstanding item was reported from DQG relating to the external audit of the Clinical Coding Team in accordance with requirements of the DSPT. The team had achieved 92% accuracy for primary diagnosis and 89% for secondary diagnosis which was a fantastic achievement.	BAF01		

Decision Escalations: Level 2 Group decisions to escalate to EMB [decisions L2 were unable to make]

Agenda Item:	Reference:	Lead:	Decision Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
			N/A			

ALERT Tracker: Progress against previously alerted items [until closure]

Date of Alert:	Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
				N/A			

Leicestershire Partnership NHS Trust

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

For presentation at the **TRUST BOARD** **28 July 2026**

Contents

Executive dashboard - overall performance against targets

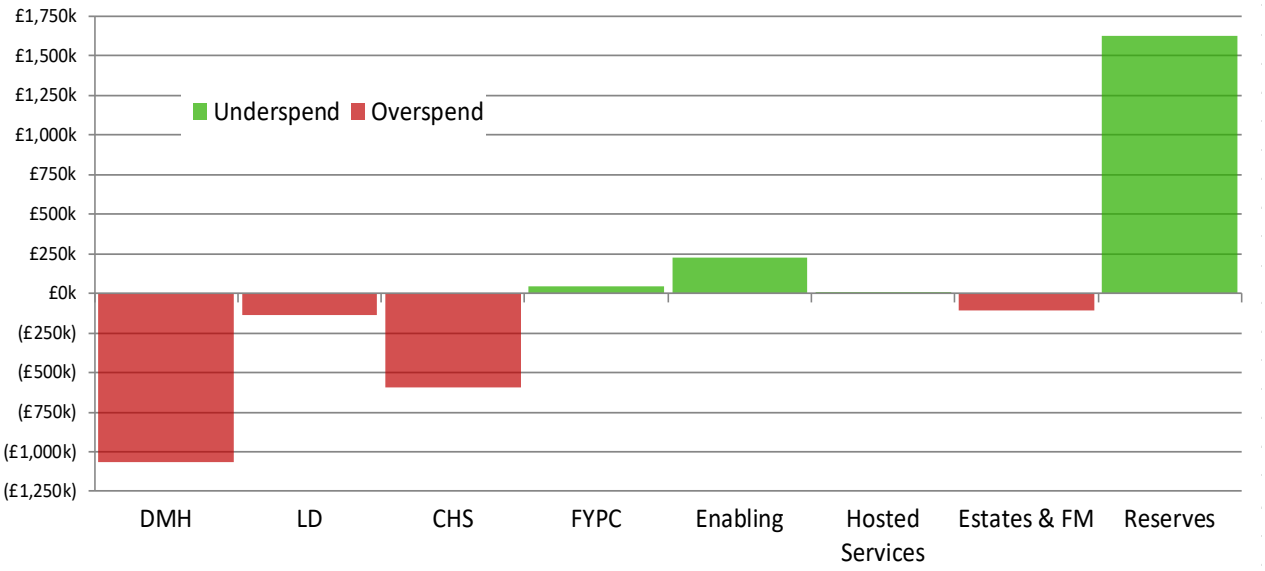
Statutory targets	Year to date	Year end f'cast	Comments	Further detail
1. Income and Expenditure break-even.	A	G	The Trust is reporting a YTD deficit of £1.42m at the end of June (in line with plan). The forecast year end position is currently a breakeven, also in line with plan.	APP. A
2. Remain within Capital Resource Limit (CRL).	G	G	The YTD capital spend for June is £1,685k, which is within funding limits.	APP. F
3. Capital Cost Absorption Duty (Return on Capital).	G	G	The capital cost absorption duty of 3.5% net assets has been achieved	N/A
Secondary targets	**Year to date**	**Year end f'cast**	**Comments**	**Further detail**
4. Deliver I&E performance in line with plan.	G	G	The reported YTD I&E deficit for June is in line with plan. The planned breakeven is forecast to be achieved.	SUMMARY REPORT
5. Achieve Efficiency Savings targets.	G	A	Savings at the end of Month 3 (June) are £4.5m, on plan. The £27.6m target for the year is expected to be delivered, however further development of directorate schemes is required to assure full delivery of their individual targets.	APP. B
6. Manage agency staff spend in line with plan	A	G	YTD agency spend at the end of June is £1,456k. This is higher (£63k) than planned YTD spend, but remains within the NHSE agency spend cap (on pro-rata basis).	APP. C
7. Comply with Better Payment Practice Code (BPPC).	G	G	Cumulatively and in month the Tust achieved all of the 4 BPPC targets.	APP. D
Internal targets	**Year to date**	**Year end f'cast**	**Comments**	**Further detail**
8. Achieve retained cash balances in line with plan	G	G	The cash balance is £18.9m at the end of June. This is £4.2m above planned cash levels. The planned cash forecast for the year is £13m.	APP. F
9. Maintain cash levels to cover at least 11 days of operating expenditure	G	G	The trust has set an internal target of having cash availability to cover at least 11 days of operating expenditure, or £13m. June's cash level of £18.9m was 16 days.	APP. F
10. Deliver capital investment in line with plan	A	G	YTD capital expenditure is £1,685k. This is below planned spend for the month. See 'Capital Section' in summary report.	APP. E

Summary report – financial position as at 30 June 2026

YEAR TO DATE POSITION

- The overall year-to-date income and expenditure plan (being a planned YTD deficit of £1,421k) has been achieved at the end of June.
- Within the wider position, the collective year-to-date operational budget position shows an overspend (£1,627k).
- Central reserves are underspent by £1,627k, offsetting the operational overspends and delivering the overall balanced position for the Trust. The individual directorate variances can be seen in the table below:

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



DIRECTORATE POSITION SUMMARY

- **The Mental Health Directorate** is overspending by £1,064k at the end of month 3. This includes medical locum pressures of £420k (14 locums currently utilised). Out of area beds budgets are overspending by £188k due to increased demand over May and June. Bank and agency costs also increased by £90k (primarily within Watermead, Beaumont and Heather Wards). A specific drug shortage nationwide has required a shift to a more expensive brand and there is a further overspend within FP10 budgets.
- **The Community Health Service** is reporting an overspend of £594k for the first 3 months of the year – a £179k negative YTD movement from month 2. The overspend

predominantly relates to the carry forward of CIPs delivered non-recurrently last year. In addition there is some slippage on delivery of current year CIPs. There are also pressures within non-pay relating to drugs and mattress rental, and although further inflation funding was received in month 3 to support the continence products spend, a residual pressure remains.

- **The FYPC** month 3 position was a £45k underspend, a favourable movement from month 2. The pay position reported a break-even whilst non-pay reported an overspend - the main pressures being linked to Medical Equipment purchases, VPN costs and the purchase of Healthcare Services. Income reported an over recovery due to high occupancy on Welford ward. CIPs are delivering as planned within the first quarter and agency costs were less than the previous financial year.

- **The LDA** month 3 position was a £140k overspend which was a small adverse movement from last month. The main pressures continue to relate to the Agnes Unit and in particular the costs associated with one patient for whom an alternative placement is being sought. Pressures are also being felt in terms of CIPs where actual cost savings (as opposed to budget reductions) are proving challenging.

- **Enabling budgets** are underspent by £222k as at month 3. This is a positive movement of £123k compared to month 2. There was an additional one-off gain (above the underlying run-rate) due to the correcting of medical staff recharges from DMH and FYPC.

- **Estates budgets** are overspent by £106k as at month 3. This is an adverse movement of £46k compared to month 2. This relates to a technical financial adjustment made in month 3 for the Agnes Unit PFI scheme, where additional information has resulted in costings being revised.

- **The Central Reserves position** is underspent by £1,627k. The reserves year-to-date budget for month 3 (aligned to our plan phasing across the year) is a £1,421k deficit - meaning that £1,421k of the operational budget overspend was built into our plan for month 3. Reserves budgets also have a further net underspend of £206k which includes a temporary year to date over-achievement of corporate CIPs (where actual savings are able to be released sooner than the budget / plan monthly phasing).

INCOME AND EXPENDITURE YEAR END FORECAST POSITION

- The reported forecast for the end of the year remains in-line with plan (I&E break-even) at this stage of the year. However as a result of material emerging financial pressures – particularly within DMH - the reported forecast is based on a best case scenario that factors in recovery actions that have not yet been fully worked up. As such it is critical that robust recovery plans are implemented as a matter of urgency.

- A best/likely/worst case risk adjusted forecast outturn is included in **appendix G**.

- The expectations underpinning the financial plan for the year assumed that initial monthly deficits would be managed down, with the position improving to show monthly surpluses in the second half of the year (see table below). However, it should be noted that the current directorate overspend is already exceeding the surplus/deficit profile in the plan, with the difference only able to be offset by the bringing forward of temporary gains in central reserves. If the rate of directorate overspend does not reducepromptly, the central reserves gains will be fully utilised and the overall Trust position will need to be supported by trust wide recovery plan actions.

	Actual M1 £'000	Actual M2 £'000	Actual M3 £'000	Forecast M4 £'000	Forecast M5 £'000	Forecast M6 £'000	Forecast M7 £'000	Forecast M8 £'000	Forecast M9 £'000	Forecast M10 £'000	Forecast M11 £'001	Forecast M12 £'000	Year 26/27 £'000
Monthly surplus / (deficit)	(522)	(477)	(422)	*(362)*	*(202)*	*(100)*	*118*	*218*	*323*	*398*	*486*	*542*	***0***
Cuml. YTD surplus / (deficit)	(522)	(999)	(1,421)	*(1,783)*	*(1,985)*	*(2,085)*	*(1,967)*	*(1,749)*	*(1,426)*	*(1,028)*	*(542)*	*0*	***0***

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

APPENDICES

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 30 June 2026	YTD Actual M3 £000	YTD Budget M3 £000	YTD Var. M3 £000
Revenue			
Total income	112,440	109,341	3,100
Operating expenses	(112,697)	(109,598)	(3,099)
Operating surplus (deficit)	**(257)**	**(257)**	**0**
Investment revenue	150	150	0
Other gains and (losses)	0	0	0
Finance costs	(495)	(495)	0
Surplus/(deficit) for the period	**(602)**	**(602)**	**0**
Public dividend capital dividends payable	(705)	(705)	0
I&E surplus/(deficit) for the period (before tech. adjs)	**(1,307)**	**(1,307)**	**0**
NHS Control Total performance adjustments			
IFRIC 12 adjustment (PFI interest adj - excl. from Con.Total)	(114)	(114)	0
NHS I&E control total performance	**(1,421)**	**(1,421)**	**0**
Other comprehensive income (Exc. Technical Adjs)			
Impairments and reversals	0	0	0
Gains on revaluations	0	0	0
Total comprehensive income for the period:	**(1,307)**	**(1,307)**	**0**
Trust EBITDA £000	**1,715**	**1,715**	**0**
Trust EBITDA margin %	**1.5%**	**1.6%**	**0.0%**

APPENDIX B – Efficiency savings performance

At the end of month 3, CIP performance is reported in line with the year-to-date plan which is delivery of £4.5m total savings. There is a minor net shortfall of £123k within directorate schemes however this offset by a temporary gain within corporate schemes. Note also that DMH schemes appearing to be over-delivering against the year to date plan. This is due to an overly conservative assessment of quarter 1 CIP delivery reflected in the original CIP plan. Despite the over delivery against specific schemes, the favourable CIP position is not sufficient to offset the pressures in the wider DMH position.

Forecast savings for the year are reported in line with the planned £27.6m savings target. The gap in directorate schemes (net £0.4m) has reduced significantly since month 2 (where it stood at £1.6m) and it is anticipated that the remaining gap will be eliminated.

CIP year-to-date performance and forecast by directorate

	M3 YTD PERFORMANCE (£000)			FORECAST (£000)		
Directorate	YTD plan	YTD actual	YTD variance	Annual target / plan	FOT	Variance
DMH	1,156	1,442	286	6,795	6,795	0
CHS	1,201	943	(257)	5,434	4,977	(456)
FYPCLDA	917	907	(10)	4,980	4,980	(1)
Enabling	415	415	0	1,630	1,660	30
Hosted (HIS)	214	214	(0)	489	509	20
Estates	606	464	(142)	2,574	2,574	(0)
Corporate Schemes	0	123	123	5,726	5,726	(0)
Unallocated Trust plans-in-progress	0	0	0	0	408	408
Total	**4,508**	**4,508**	**(0)**	**27,628**	**27,628**	**0**

Leicestershire Partnership NHS
NHS Trust

APPENDIX C – Agency expenditure

Dir.	2026/27 Agency Expenditure	25/26 Outturn £000s Actual	25/26 Avg mth £000s Actual	26/27 M1 £000s Actual	26/27 M2 £000s Actual	26/27 M3 £000s Actual	26/27 M4 £000s F'cast	26/27 M5 £000s F'cast	26/27 M6 £000s F'cast	26/27 M7 £000s F'cast	26/27 M8 £000s F'cast	26/27 M9 £000s F'cast	26/27 M10 £000s F'cast	26/27 M11 £000s F'cast	26/27 M12 £000s F'cast	26/27 YTD £000s Actual	26/27 Yr end £000s F'cast
DMH	Consultant Costs	-3,671	-306	-276	-259	-224	-193	-198	-230	-230	-230	-206	-218	-212	-230	-759	-2,706
	Nursing - Qualified	-1,419	-118	-65	-48	-74	-55	-55	-55	-55	-55	-55	-55	-55	-55	-187	-682
	Nursing - Unqualified	-79		0	0	-1	0	0	0	0	0	0	0	0	0	-1	-2
	Other clinical staff costs	-19	-2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sub-total - DMH	**-5,188**	**-426**	**-341**	**-306**	**-299**	**-248**	**-253**	**-285**	**-285**	**-285**	**-261**	**-273**	**-267**	**-285**	**-947**	**-3,390**
LD	Consultant Costs	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0
	Nursing - Qualified	-104	-9	-45	4	-35	-25	-3	-3	-3	-3	-3	-3	-3	-3	-76	-125
	Nursing - Unqualified	-19		-7	6	6	-5	-1	-1	-1	-1	-1	-1	-1	-1	5	-8
	Other clinical staff costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sub-total - LD	**-123**	**-9**	**-52**	**10**	**-29**	**-30**	**-4**	**-4**	**-4**	**-4**	**-4**	**-4**	**-4**	**-4**	**-71**	**-133**
CHS	Consultant Costs	-118	-10	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Nursing - Qualified	-2,719	-227	-103	-95	-85	-80	-75	-75	-75	-70	-80	-65	-65	-65	-284	-934
	Nursing - Unqualified	-179		-16	-11	-5	-8	-8	-5	-5	-5	-5	-5	-5	-5	-33	-84
	Other clinical staff costs	-112	-9	-5	-7	-7	-7	-7	-7	-7	-7	-7	-7	-7	-7	-19	-78
	Sub-total - CHS	**-3,127**	**-246**	**-125**	**-113**	**-98**	**-95**	**-90**	**-87**	**-87**	**-82**	**-92**	**-77**	**-77**	**-77**	**-336**	**-1,096**
FYPC	Consultant Costs	-139	-12	0	-20	-22	-42	-42	0	0	0	0	0	0	0	-42	-126
	Nursing - Qualified	-601	-50	-29	-1	-25	-24	-24	-6	-6	-6	-6	-6	-6	-6	-54	-144
	Nursing - Unqualified	-29		-3	-1	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-6	-24
	Other clinical staff costs	-4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sub-total - FYPC	**-773**	**-62**	**-32**	**-21**	**-49**	**-68**	**-68**	**-8**	**-8**	**-8**	**-8**	**-8**	**-8**	**-8**	**-102**	**-294**
ENAB/ ESTS/ HOST	Consultant Costs	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Nursing - Qualified	41	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Nursing - Unqualified	5		0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Other clinical staff costs	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Non clinical staff costs	-224	-19	-2	2	0	0	0	0	0	0	0	0	0	0	0	0
	Sub-total - Enab/Host	**-172**	**-16**	**-2**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL TRUST	Consultant Costs	-3,927	-327	-276	-279	-247	-235	-240	-230	-230	-230	-206	-218	-212	-230	-802	-2,833
	Nursing - Qualified	-4,803	-400	-242	-139	-219	-184	-157	-139	-139	-134	-144	-129	-129	-129	-600	-1,885
	Nursing - Unqualified	-300	-25	-26	-6	-2	-15	-11	-8	-8	-8	-8	-8	-8	-8	-35	-118
	Other clinical staff costs	-130	-11	-5	-7	-7	-7	-7	-7	-7	-7	-7	-7	-7	-7	-19	-78
	Non clinical staff costs	-224	-19	-2	2	0	0	0	0	0	0	0	0	0	0	0	0
	Total actual/forecast	**-9,383**	**-782**	**-552**	**-429**	**-475**	**-441**	**-415**	**-384**	**-384**	**-379**	**-365**	**-362**	**-356**	**-374**	**-1,456**	**-4,913**
	Total plan:			**-476**	**-465**	**-452**	**-440**	**-427**	**-415**	**-403**	**-390**	**-377**	**-366**	**-351**	**-339**	**-1,393**	**-4,901**
	Variance to plan:			**-76**	**36**	**-23**	**-1**	**12**	**31**	**19**	**11**	**12**	**4**	**-5**	**-35**	**-63**	**-12**
	Var' to annual cap of £6,749k (monthly in12ths):			**11**	**133**	**87**	**122**	**148**	**179**	**179**	**184**	**198**	**201**	**207**	**189**	**231**	**1,836**

Agency spend for June (month 3) is £0.48m. This is slightly higher than the planned spend of £0.45m.

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

LPT planned spend for the year is £4.9m. The current year end forecast is marginally higher than plan.

The NHSE agency spend cap is £6.7m for the year, and so the current forecast spend would be well within this target.

Phased in equal 12ths the cap would equate to monthly spend of £0.56m, putting the M3 YTD spend also well within the cap if applied on an equal 12ths basis.

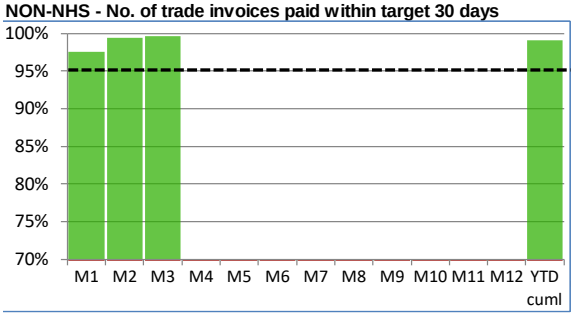
APPENDIX D – BPPC performance

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

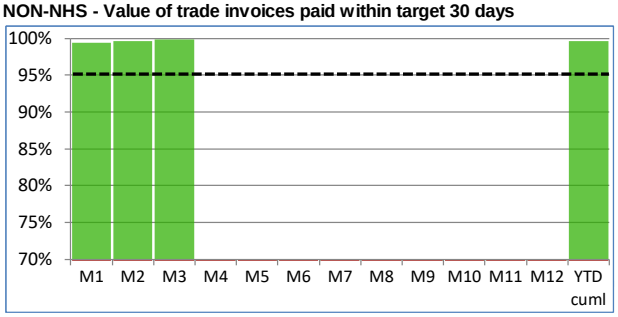
Better Payment Practice Code	June (Cumulative)		May (Cumulative)	
	Number	£000's	Number	£000's
Total Non-NHS trade invoices paid in the year	7,768	39,815	4,652	26,634
Total Non-NHS trade invoices paid within target	7,700	39,670	4,595	26,508
% of Non-NHS trade invoices paid within target	**99.1%**	**99.6%**	**98.8%**	**99.5%**
Total NHS trade invoices paid in the year	168	17,681	108	7,156
Total NHS trade invoices paid within target	165	17,654	107	7,155
% of NHS trade invoices paid within target	**98.2%**	**99.8%**	**99.1%**	**100.0%**
Grand total trade invoices paid in the year	7,936	57,496	4,760	33,790
Grand total trade invoices paid within target	7,865	57,324	4,702	33,663
% of total trade invoices paid within target	**99.1%**	**99.7%**	**98.8%**	**99.6%**

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

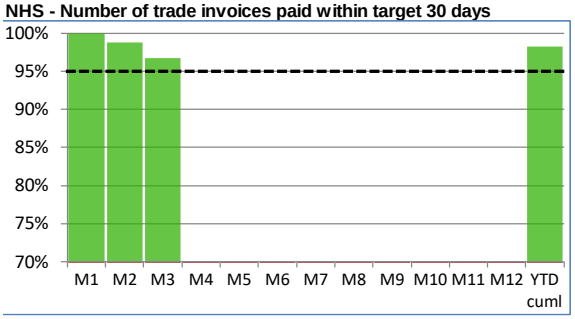
NON-NHS - No. of trade invoices paid within target 30 days



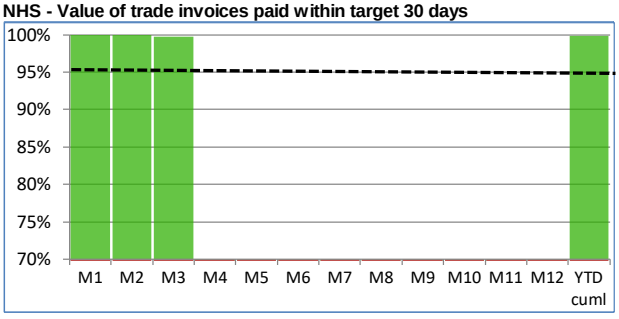
NON-NHS - Value of trade invoices paid within target 30 days



NHS - Number of trade invoices paid within target 30 days



NHS - Value of trade invoices paid within target 30 days



APPENDIX E - Capital Programme 2026/27 update

At the start of the year Trust Board approved an opening capital plan of £19.8m. This includes £8.5m operational capital, £1m lease capitalisation, £6.8m PDC funding to support Constitutional Standards & Left Shift schemes, and Estates Safety Critical Infrastructure Risk (CIR) funding of £1.6m. The plan also includes the Mental Health Out of Area Placements (OAPs) funding of £1.8m, deferred from 2025/26.

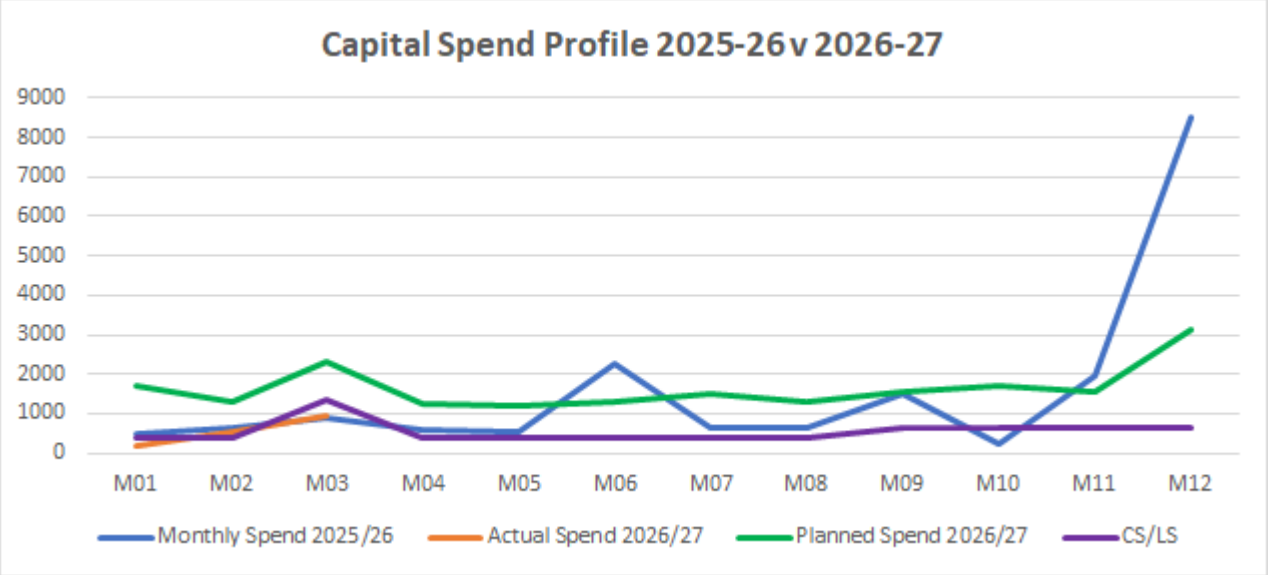
	Annual Revised Plan	June Actual	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation	11,817	2,954	11,817	0
Cash reserves	779	(1,320)	779	0
Capital borrowings repayments	(4,117)	0	(4,117)	0
Capital grants	0	0	188	188
Total System operational capital	**8,479**	**1,634**	**8,667**	**188**
IFRS-16 new leases	**1,040**	**0**	**1,040**	**0**
MH OAPS - Deferral from 2025/26	1,800	0	1,800	0
Constitutional Standards/Left Shift	6,821	0	6,821	0
Estates Critical Infrastructure Risk (CIR)	1,550	0	1,550	0
National Programmes (PDC)	**10,171**	**0**	**10,171**	**0**
PFI capital lifecycle costs	**131**	**51**	**131**	**0**
Total Capital funds	**19,821**	**1,685**	**20,009**	**188**
Application of Funds				
Estates	**£'000**	**£'000**	**£'000**	**£'000**
Strategic schemes	0	(1)	(1)	(1)
Capital staffing	(510)	(69)	(571)	(61)
Estates backlog programme	(3,784)	(737)	(3,693)	91
Estates rolling programme	(1,420)	(24)	(1,447)	(27)
Medical devices	(170)	0	(170)	0
Directorate investment	(11,010)	(125)	(11,230)	(220)
PFI Agnes Unit capital lifecycle costs	(131)	(51)	(131)	0
	(17,025)	**(1,007)**	**(17,243)**	**(218)**
IM&T investment	**(1,756)**	**(678)**	**(1,726)**	**30**
Operational Capital	**(18,781)**	**(1,685)**	**(18,969)**	**(188)**
IFRS16 - Right of Use Leases	**(1,040)**	**0**	**(1,040)**	**0**
Total Capital Expenditure	**(19,821)**	**(1,685)**	**(20,009)**	**(188)**
(Over)/underspend	**0**	**0**	**0**	**0**

Capital expenditure to date:

Capital expenditure up to the end of June totals £1.685m. This is £3.6m below planned spend of £5.3m at Month 3. The underspend reflects lower-than-expected spend on work-in-progress projects carried forward from 2025/26 and delays in commencing Public Dividend Capital (PDC) schemes pending receipt of the funds, including Constitutional Standards/Left Shift schemes (CS/LS). Spend will increase when funding is received and delivery progresses. The Capital team are continuing to actively review programme phasing and re-profiling schemes, to ensure all capital duties are met.
The following table shows the current status of all schemes over £500k, the current spend and the annual forecast against each one:

Schemes over £500k	M03 Planned Spend £'000	M03 Actual Spend £'000	M03 Variance £'000	Opening Plan £'000	Annual Forecast £'000	Current Status
Capital Staffing	(127)	(69)	(58)	(510)	(571)	Slow start on schemes therefore Principal designer/Cost advisor costs are currently lower than planned
Estates Backlog - Valentine Roof	(159)	(685)	526	(630)	(806)	Valentine roof construction progressing during June, with solar panels being installed. Costs in excess of plan.
Estates Backlog - Site Electrical Supply	(129)	0	(129)	(500)	(500)	High voltage Cable installation for supply to New MH Hospital - 26/27 works not yet commenced
Estates Backog - Lough Generator replacement	0	0	0	(500)	(500)	Generator replacement phased in late 26/27
Estates Rolling Programmes	(261)	(24)	(237)	(1,420)	(1,447)	£250k Replacement taps at Hinckley Hospital commencing July, Fire stopping scheme at Bradgate being checked, Patient staff call system due to commence installations
IM&T - IT Rolling Replacements	(261)	(489)	228	(1,040)	(1,040)	Spend in excess of plan
IM&T - On-going configurations	(180)	(219)	39	(716)	(716)	
Directorate Schemes						
Soundproofing Audiology Hynca Lodge	(165)	0	(165)	(656)	(656)	Scope and drawings being completed
Acacia Full refurbishment	(393)	0	(393)	(1,570)	(1,570)	Signing off drawings
Thornton Ward Refurbishment	(324)	0	(324)	(1,300)	(1,300)	Signing off drawings
Wakerley Ward Refurbishment	(90)	0	(90)	(900)	(774)	Phased in from June - likely late 26/27 due to relocation of staff from Valentine
Coalville Ward 3 Refurbishment	(234)	0	(234)	(930)	(930)	Scope to be determined
24/7 Neighbourhood MH Centre (City)	0	0	0	(925)	(925)	Scope to be determined - phased in late 26/27
MH Emergency Department	0	0	0	(1,000)	(1,000)	Scope to be determined - phased in late 26/27
IFRS16 Leases	(408)	0	(408)	(1,040)	(1,040)	Costs will transfer in Q2
Other Schemes value less than £500k	(2,648)	(199)	(2,449)	(6,184)	(6,234)	66 schemes
	(5,379)	**(1,685)**	**(3,694)**	**(19,821)**	**(20,009)**	

Capital expenditure is historically slow at the beginning of each financial year, with a significantly higher spend in month 12. The 2026/27 spend is continuing to track slightly lower than in 2025/26, noting the National CS/LS schemes which are largely yet to be scoped / designed with services.



CS/LS = Constitutional Standards/Left Shift schemes

Capital changes since last month:

The overall capital programme increased by £188k this month, due to the inclusion of a National Institute for Health and Care Research (NIHR) capital grant to support the purchase of a mobile research unit.

There were additional allocation virements between schemes, resulting in an increase to the risk managed shortfall pot of £339k, which now amounts to £677k.

	Opening Plan	Changes	Revised Plan	Comments
	£'000	£'000	£'000	
M03 Position	**(19,821)**	**(188)**	**(20,009)**	
Changes to Plan over £100k				
IM&T Equipment - MaST (Management & Supervision Tool)	(140)	(369)	(509)	Increase in scheme value - not started 25/26 due to delays so 26/27 should have been full value of scheme
Mobile Research Unit (R&D)	0	(188)	(188)	Funded by NIHR capital grant
Valentine Roof works	(630)	(176)	(806)	Increase in scheme value
Cooling for Bradgate	(310)	260	(50)	Value reduced - expect to be completed in 27/28, planning costs only this year
Increase in Risk Managed Shortfall	338	339	677	increased Risk to fully fund MaST
Net Change in month		(134)		
Net Change in month < £100k		134		
Net Change in month		**0**		

APPENDIX F SoFP, cash and working capital

PERIOD: June 2026	2025/26 31/03/26 Draft £'000's	2026/27 31/05/26 June £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	135,011	134,600
Intangible assets	3,310	2,950
IFRS16 - Right of use (ROU) assets	19,421	18,829
Trade and other receivables	821	821
Total Non Current Assets	**158,563**	**157,200**
CURRENT ASSETS		
Inventories	461	461
Trade and other receivables	7,155	13,864
Short term investments	0	0
Cash and Cash Equivalents	20,941	18,856
Total Current Assets	**28,557**	**33,182**
Non current assets held for sale	**0**	**0**
TOTAL ASSETS	**187,120**	**190,382**
CURRENT LIABILITIES		
Trade and other payables	(26,927)	(34,769)
Borrowings	(4,958)	(4,926)
Provisions	(5,031)	(4,940)
Other liabilities	(7,701)	(5,587)
Total Current Liabilities	**(44,617)**	**(50,222)**
NET CURRENT ASSETS (LIABILITIES)	**(16,060)**	**(17,040)**
NON CURRENT LIABILITIES		
Borrowings	(39,040)	(38,118)
Provisions	(704)	(704)
Total Non Current Liabilities	**(39,744)**	**(38,822)**
TOTAL ASSETS EMPLOYED	**102,759**	**101,338**
TAXPAYERS' EQUITY		
Public Dividend Capital	112,834	112,834
Retained Earnings	(28,595)	(30,016)
Revaluation reserve	18,520	18,520
Other reserves	0	0
TOTAL TAXPAYERS EQUITY	**102,759**	**101,338**

Non-current assets

Property, plant, and equipment (PPE) amounts to £134.6m, and includes capital additions of £1,685k, offset by depreciation charges.

Right of Use (ROU) leased assets total £18.8m.

Current assets

Current assets of £33.2m mainly includes cash of £18.9m, and receivables of £13.9m.

Current Liabilities

Current liabilities amount to £50.2m with trade and other payables making up £34.8m of this balance.

Other liabilities of £5.6m mainly relate to deferred income carried over from 2025/26.

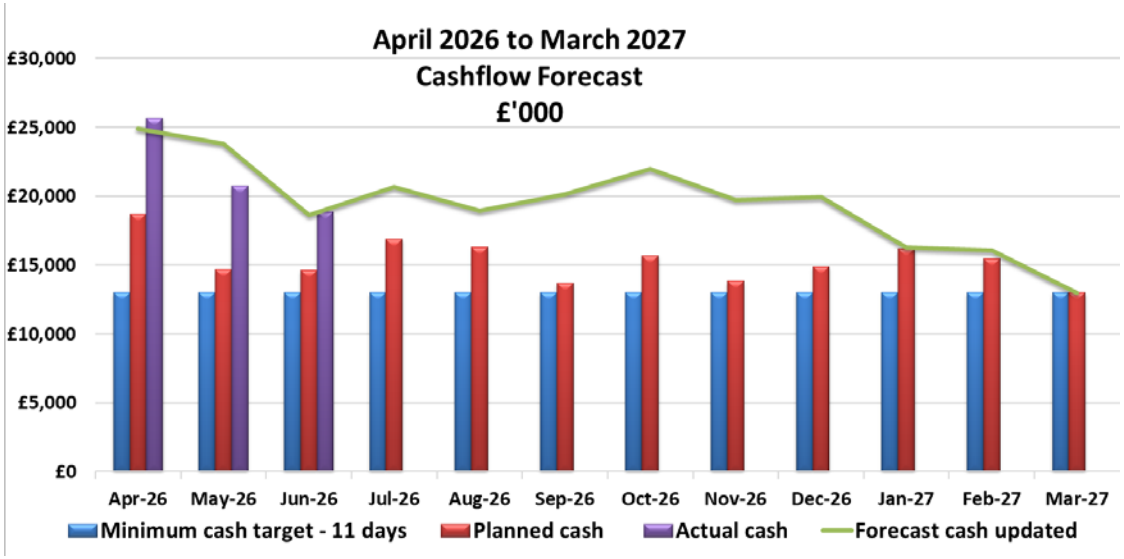
Net current assets / (liabilities) show net liabilities of £17m.

Taxpayers' Equity

June's deficit of £1.42m is reflected within retained earnings.

The Public dividend capital balance is £113m at the end of June. This is expected to increase by a further £10m during the year following additional capital investment support from NHSE.

Cash



The closing cash balance at the end of June is £18.9m; a decrease of £2.1m since the start of the year and an additional £4.2m compared to June's planned cash of £14.6m. This delivers 16 operating cash days - 4 days above the planned level of 12 days for Month 3. Favourable working capital movements have resulted in this improved cash position compared to plan.

The forecast closing cash balance as at the 31st of March 2027 remains at £13m. This is an £8m reduction compared to the previous year's closing cash balance of £21m. The in-year reduction is due to cash utilisation related to last year's provisions and deferred income, the release of cash reserves to support capital investment, and other working capital movements.

The Trust continues to work to a minimum of 11 operating cash days as its internal cash target. The cashflow forecast is monitored closely to ensure any deviations against the I&E

Cashflow Forecast - by value and days:

£000	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Minimum cash target - 11 days	13,009	13,009	13,009	13,009	13,009	13,009	13,009	13,009	13,009	13,009	13,009	13,009
Planned cash	18,685	14,668	14,631	16,881	16,292	13,704	15,676	13,843	14,912	16,221	15,489	13,000
Forecast cash updated	24,896	23,773	18,642	20,964	19,371	19,592	21,902	20,186	19,783	16,654	16,935	13,000
Actual cash	25,664	20,760	18,856									

Days	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Minimum cash target - 11 days	11	11	11	11	11	11	11	11	11	11	11	11
Planned cash days	16	12	12	14	14	12	13	12	13	14	13	11
Forecast cash days	21	20	16	18	16	17	19	17	17	14	14	11
Actual cash days	22	18	16									

Receivables

Current receivables (debtors) total £13.9m, an increase of £6.7m since the start of the year. The increase mainly relates to accruals and prepayments; higher values are expected in the first quarter of the financial year.

Receivables	Current Month June 2026					
	NHS	Non	Emp's	Total	% Total	% Sales Ledger
	£'000	£'000	£'000	£'000		
Sales Ledger						
30 days or less	2,468	2,016	4	**4,488**	**30.56%**	**76.3%**
31 - 60 days	34	934	3	**971**	**6.61%**	**16.5%**
61 - 90 days	48	17	3	**68**	**0.46%**	**1.2%**
Over 90 days	117	28	208	**353**	**2.40%**	**6.0%**
	2,667	2,995	218	**5,880**	**40.04%**	**100.0%**
Non sales ledger	3,617	4,367	0	**7,984**	**54.37%**	
Total receivables current	**6,284**	**7,362**	**218**	**13,864**	**94.41%**	
Total receivables non current		821		821	**5.59%**	
Total	**6,284**	**8,183**	**218**	**14,685**	**100.00%**	**0.0%**

Debt greater than 90 days stands at £353k; this is an increase of £51k since the previous month. Receivables over 90 days should not account for more than 5% of the overall total receivables balance. The proportion at month 3 is 2.40% (last month: 2.28%).

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

Payables

The current payables position in month 3 is £34.8m – an increase of £7.8m since the start of the year. As with receivables, payables balances are always higher at the start of the financial year. Other liabilities of £5.6m relate to deferred income carried over from 2025/26 (of which the majority relates to Provider Collaborative income and Secure Digital Environment (SDE) funding).

APPENDIX G Risk adjusted forecast outturn

The table below shows a range of risk adjusted forecasts under best, likely and worst case assumptions. Forecasting at this early stage of the year is challenging and so the positions below should be viewed in this context. It should be noted in particular that actions to address the significant DMH estimated deficit are currently at a very early stage. An adjustment has been included to reflect the impact of a level of DMH recovery, however considerable further work will be required in order to firm up these assumptions. It is anticipated that a more comprehensive update will be provided in the month 4 report.

DIRECTORATES	VARIANCE		
	BEST CASE	**LIKELY FOT**	**WORST CASE**
	£000	**£000**	**£000**
DMH	(3,732)	(3,732)	(4,000)
CHS	(1,200)	(1,840)	(2,800)
FYPC	300	0	(100)
LD	(100)	(200)	(400)
ESTS	0	(196)	(946)
ENABLING	1,038	748	500
HOSTED	150	50	(200)
TOTAL DIRECTORATE FOT VARIANCE:	**(3,544)**	**(5,170)**	**(7,946)**

CORPORATE / NOT ALLOCATED	**BEST CASE**	**LIKELY FOT**	**WORST CASE**
	£000	**£000**	**£000**
Delivery against orginal plan gap mitigations / contingencies			
£2.0m NON-REC EXP GAINS TARGET (over or under achieved):	762	0	(500)
Release of Transformation funding*:	0*	1,000	1,000
--			
Sub-total - position re: original plan gap mitigations:	**762**	**1,000**	**500**
Other mitigations			
Interest receivable gain over budget:	250	100	(50)
Indicative directorate recovery actions target (to be confirmed)	*2,532*	*1,332*	*0*
--			
Sub-total mitigations position:	**3,544**	**2,432**	**450**
Other Corporate/Trust wide pressures			
Pay award funding shortfall (TBC):	0	0	(1,000)
Nursing band 5 job eveluation (TBC):	0	0	(1,000)
TOTAL CORPORATE PRESSURES / MITIGATIONS:	**3,544**	**2,432**	**(1,550)**
TOTAL TRUST	**0**	**(2,738)**	**(9,496)**

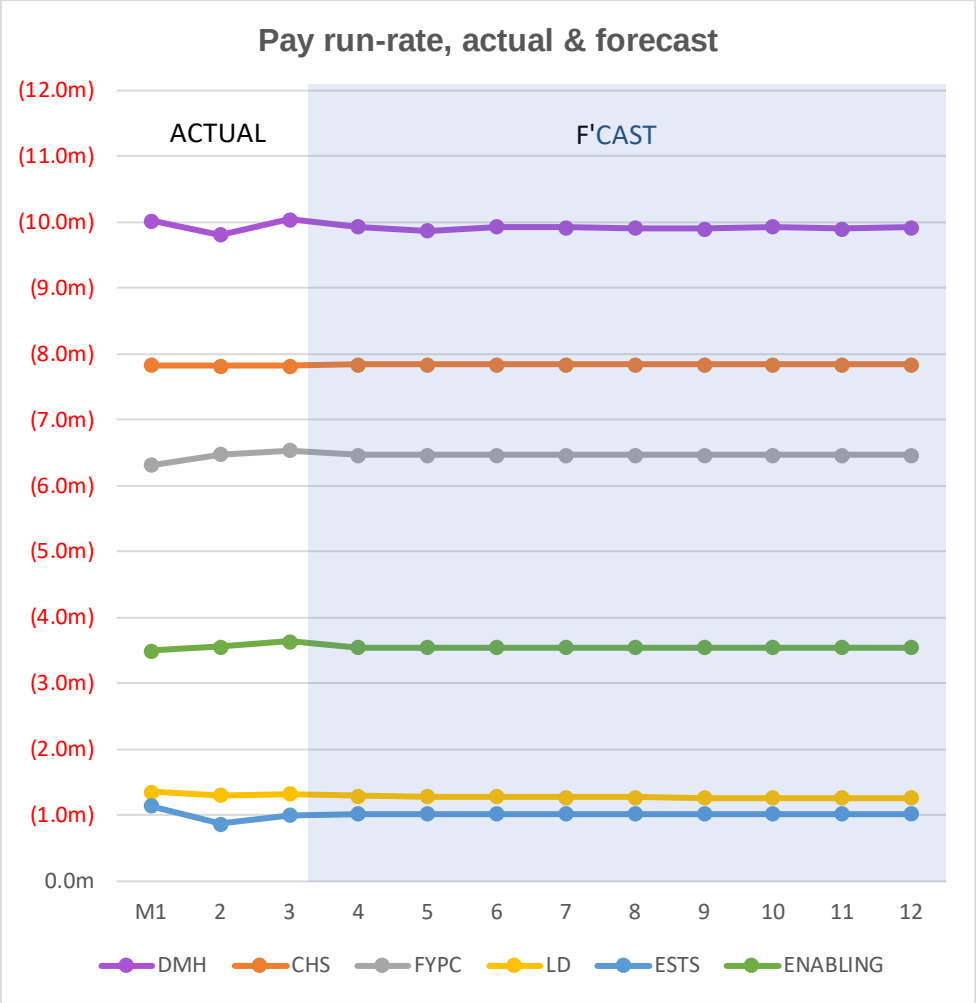
In a best case scenario, any available transformation funding would likely be utilised to provide for future year costs subject to satisfying accounting requirements for financial provisions

APPENDIX H - Forecast pay expenditure run-rate analysis

The vast majority of controllable Trust expenditure is related to staff pay costs. Given the expectation of continued cost improvement, an analysis of monthly pay run-rates across the year is a useful indicator of wider financial performance.

The chart below shows actual and forecast monthly pay costs by directorate across the 26/27 financial year (note that these are the run-rates reflected in the LIKELY risk-adjusted forecast outturn position – see **appendix G,** previous page).

It is evident that costs are relatively static in the likely forecast which supports the view that further financial recovery actions will be required in order to meet the assumptions reflected in the financial plan (whereby the position improves across the year as, for example, CIPs come on line).



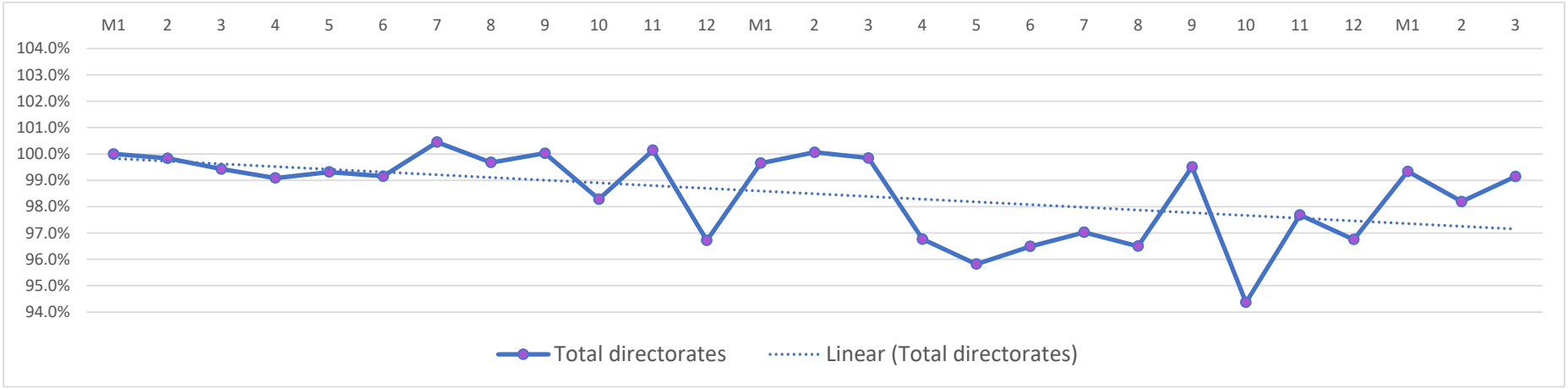
APPENDIX H2 - Historical pay expenditure run-rate analysis

The graph below shows total directorate pay costs over the past 27 months (from the start of financial year 2024/25). Month 1 in year 2024/25 has been set as the base year (100%) - percentages have been used to allow a clearer understanding of movements.

To enable a proper comparison of costs over this period, **the costs have been adjusted for the effects of pay inflation and funded growth.** Whilst there will have been other factors that cause pay costs to fluctuate, this approach provides a broadly consistent basis for the analysis of cost trends.

Plotting a linear trend line affords a clear view of the general direction of travel and this shows that we have reduced underlying costs by c. 3% in the last 2 years. This is broadly in line with the external / mandatory recurrent CIP target over the 2024 - 2026 period (1.1% in 24/25 and 2.0% in 25/26).

However, it is apparent that for the first 3 months of the current year 2026/27, pay costs appear to have increased compared with those reported at the end of the previous year. Further work to understand these initial findings is required, and the adjustments to exclude pay inflation and funded growth create further challenges. However this initial analysis does concur with the emerging picture whereby costs are not reducing at the rate required to deliver our plan.



APPENDIX I – Deconstructing the Block update

The Trust is currently undertaking work relating to NHSE's national exercise to *deconstruct block contracts* for non-acute services - primarily mental health and community care. Block contracts pay a fixed sum regardless of activity or quality, and the national direction of travel is toward payment mechanisms that are more focussed on activity, quality, and outcomes.

The 2026/27 exercise uses indicative prices derived from the 2024/25 National Cost Collection to compare 2026/27 block contract values with an activity × price assessment. National guidance acknowledges that *'the deconstruction of block contract values provided in the return template may be lower or higher than the contract value'*. Whilst no contract / value changes will occur in 2026/27, the results will inform payment policy from 2027/28 onward (although the extent to which this approach will be applied has not yet been confirmed).

Clearly an activity x price assessment of contract values could present a material financial risk for the Trust where this is lower than the current block value. Conversely it may also present financial opportunity.

Scope of the Exercise

The exercise collects 2026/27 contract values and estimated activity value for all relevant ICB-commissioned non-acute block contracts.

In scope

- Core ICB-commissioned mental health and community service block contracts, including those delivered by NHS trusts, integrated trusts, IS providers, CICs, and VCSE organisations.
- Activity grouped into national currencies: mental health inpatient spells, care contacts, talking therapies, community care, ADHD/autism.
- Contracts ≥ £1.5m.

Out of scope

- Delegated specialised mental health services (will be subject to a stand-alone exercise)
- Retained specialised mental health services commissioned by NHSE.
- Block contracts < £1.5m.
- IS/CIC/VCSE services paid on an activity or outcomes basis.
- Hospice-based services.
- Ambulance services.

Key Dates

- **Interim submission:** *27 August 2026*
- **Final submission:** *17 September 2026*

ICBs will be responsible for collating and submitting returns on behalf of their system. One system in each region will submit an interim submission to support early issue-spotting and guidance updates. For the Midlands region the NHS Birmingham and Solihull system/ICB has been selected.

Governance Table

For Board and Board Committees:	Trust Board, 28th July 2026
Paper sponsored by:	Sharon Murphy, Chief Finance Officer
Paper authored by:	Chris Poyser - Head of Corporate Finance; Jackie Moore – Financial Controller; Dawn Bennett – Finance Manager (Capital & Technical); Hasmita Thakkar – Assistant Finance Manager (Corporate).
Date submitted:	20th July 2026
Name and date of other committee / forum at which this report / issue was considered:	None
Level of assurance gained if considered elsewhere	☐ Assured ☐ Partially assured ☐ Not assured
Date of next report:	Trust Board standing agenda item
THRIVE strategic alignment:	☐ **T**echnology ☐ **H**ealthy communities ☐ **R**esponsive ☐ **I**ncluding everyone ☐ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	BAF 11 - Inadequate control, reporting and management of each Trust's 2026/27 financial position could mean we are unable to deliver our financial plan resulting in a breach of our statutory duties and medium-term financial plan.
Is the decision required consistent with LPT's risk appetite:	Yes
False or Misleading Information (FOMI) considerations:	N/A
Positive confirmation that the content does not risk the safety of patients or the public:	Yes
Equality considerations:	None

Q

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Public Trust Board – 28th July 2026

Integrated Performance Report – June 2026 (Month 3)

Purpose of the Report

To provide the Trust Board with an overview of Trust performance against an agreed set of KPI's for June 2026 (M3 of 2026/27).

Analysis of the Issue

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

Proposal

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

- A query has been identified in relation to the longest waiter in the Dynamic Psychotherapy Service which has increased above expected level. This is being investigated and an update will be provided next month.
- Referral numbers reported within the Exception Pages remain under investigation, as some continue to show higher levels of variance than expected. Analysis is ongoing, and a further update will be provided in a future reporting cycle once the review has been completed.
- The Delayed Transfers of Care metric for CHS remains under review. Work is ongoing to understand the reported position, and a further update will be provided in a future reporting period.
- Further work is required at service level to include all remaining trajectories – these will be included in the next report.
- 2026/27 NOF metrics are not yet available pending publication of the national technical specification; therefore, 2025/26 metrics will remain in the report until the new measures can be reported in line with national definitions. The previous 'Percentage of adult inpatients with a length of stay over 60 days at discharge' metric is no longer available in the Mental Health

Core Data Pack and therefore is 'greyed out' in the attached report. All other metrics remain unchanged.

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

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

- From *special cause improving higher values* to *common cause*
  - Childrens Audiology (6 week wait for diagnostic procedures) - Incomplete pathway
- From *special cause improving lower values* to *common cause*
  - Occupancy Rate - Mental Health Beds
- From *special cause concerning higher values* to *common cause*
  - No. of episodes of prone (Unsupported) restraint
- *From special cause concerning lower values to common cause*
  - *ADHD (18 week* local RTT) - Incomplete pathway
  - Adult Psychiatry - Neighbourhood Mental Health Teams - Assessments waits over 52 weeks - No of Waiters

The Exception Report Summary and individual Exception Reports contain analytical and operational commentary covering performance and improvement actions for services demonstrating a special cause concern against an agreed target.

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

Decision Required

The Trust Board is asked to:

- Approve the Performance Report.

Governance Table

For Board and Board Committees:	Trust Board
Paper sponsored by:	Jean Knight, Managing Director and Deputy Chief Executive Anne Rackham, Group Chief Integration and Delivery Officer
Paper authored by:	Pardeep Dhami, Information Analyst Prakash Patel, Head of Information Anne Senior, Associate Director
Date submitted:	21.07.2026
Name and date of other committee / forum at which this report / issue was considered:	This report will be presented to the July Accountability Framework Meeting prior to sharing at Trust Board.
Level of assurance gained if considered elsewhere	☐Assured ☐ Partially assured ☐ Not assured
Date of next report:	
THRIVE strategic alignment:	☐ **T**echnology ☒ **H**ealthy communities ☒ **R**esponsive ☒ **I**ncluding everyone ☒ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	BAF3.2 - Without timely access to services, we cannot provide high quality safe care for our patients which will impact on clinical outcomes.
Is the decision required consistent with LPT's risk appetite:	Yes
False or Misleading Information (FOMI) considerations:	None
Positive confirmation that the content does not risk the safety of patients or the public:	Yes
Equality considerations:	None identified

NHS
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NHS Trust

Integrated Board Performance Report

June 2026 (Month 3)

Our group strategy

CONTENTS

TRUST EXCEPTION REPORTS MATRIX SUMMARY

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

TRUST EXCEPTION REPORTS SUMMARY - Consistently Failing Target

Operational Performance - Waiting Times						
Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	SPC Assurance	SPC Trend
Adult Psychiatry - Neighbourhood Mental Health Teams Access (6 weeks routine) - Incomplete pathway	>=95%	May-26	79.3%	72.5%	F	H
Memory Clinic (18 week Local RTT) - Incomplete pathway	>=92%	May-26	46.1%	45.6%	F	L
ADHD (18 week local RTT) - Incomplete pathway	>=92%	May-26	4.9%	4.7%	F	
CINSS (6 weeks) - Incomplete Pathway	>=95%	May-26	53.0%	54.0%	F	H
Speech Therapy - Voice, Respiratory and Dysfluency - Routine (6 weeks) - Incomplete Pathway	>=95%	May-26	29.6%	24.6%	F	
Community Paediatrics (18 weeks) - Incomplete pathway	>=92%	May-26	8.1%	8.3%	F	L
Childrens Audiology (6 week wait for diagnostic procedures) - Incomplete pathway	>=99%	May-26	29.4%	28.8%	F	

Patient Flow						
Delayed Transfers of Care	<=3.5%	Jun-26	6.7%	6.0%	F	H

Quality & Safety						
Safe staffing - No. of wards not meeting >80% fill rate for RNs - Day	0	Jun-26	2	1	F	

Workforce						
Vacancy Rate	<=10%	Jun-26	9.7%	9.7%	F	L
Sickness Absence	<=5.0%	May-26	5.7%	5.5%	?	

Operational Performance - Treatment Waits (over 52 weeks)						
Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	SPC Assurance	SPC Trend
Adult Psychiatry – Neighbourhood Mental Health Teams – Treatment waits	0	Jun-26	0	0	F	L
Cognitive Behavioural Therapy	0	Jun-26	25	21	F	L
Dynamic Psychotherapy	0	Jun-26	1	0	F	L
Therapy Service for People with Personality Disorder	0	Jun-26	1	7	F	L
Medical/Neuropsychology	0	Jun-26	46	52	F	L
ADHD (18 week local RTT) - assessment waits	0	May-26	7951	7860	F	H
MHSOP Memory Clinics (18 week local RTT) - assessment waits	0	May-26	19	18	F	
Community Paediatrics - assessment waits	0	May-26	7684	7604	F	H
Community Paediatrics Treatment (excl ND)	0	Jun-26	13	25	F	L
All Neurodevelopment (inc CAMHS, SALT, PAEDS)	0	Jun-26	1578	1544	F	H
CAMHS - Treatment waits (excl ND)	0	Jun-26	62	53	F	
All LD - Treatment waits	0	Jun-26	0	3	?	
Children's Physiotherapy	0	Jun-26	0	0	F	L

TRUST EXCEPTION REPORTS SUMMARY - Consistently Achieving Target

NHS Oversight						
Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	SPC Assurance	SPC Trend
MRSA Infection Rate	0	Jun-26	0	0	P	
Clostridium difficile infection rate	<=12	Jun-26	0	1	P	

Workforce						
Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	SPC Assurance	SPC Trend
Normalised Workforce Turnover (Rolling previous 12 months)	<=10%	Jun-26	6.4%	6.3%	P	L
Core Mandatory Training Compliance for substantive staff	>=85%	Jun-26	98.6%	98.6%	P	H
Staff with a Completed Annual Appraisal	>=80%	Jun-26	95.1%	95.1%	P	
% of staff from a BME background	>=22.5%	Jun-26	34.0%	34.0%	P	H
% of staff who have undertaken clinical supervision within the last 3 months	>=85%	Nov-25	94.2%	94.4%	P	

Trust Headlines

Overall CQC rating (provision of high-quality care) = 2 **CQC Well Led rating = 2** **Q4 Overall NOF Rating = 2**

Operational Performance - Waiting Times	Operational Performance - Over 52 week waits (access / treatment)	Quality & Safety	Workforce	NHS Oversight - Operational Planning
All services with waiting times identified as a priority for improvement have plans in place to deliver improved compliance with contractual and / or operational planning targets and trajectories added to the report support visibility of delivery. Trajectories are fixed for the full year with variance addressed in individual exception reports. Improvement in performance remains variable across the services. Consistent positive change continues in Adult Neighbourhood Mental Health teams with compliance steadily improving. Compliance in Adult Speech and Language Therapy and Community Integrated Stroke and Neurology Services continue to show a longer-term positive trend albeit with some month by month variance. Plans are in place to continue this improvement in 2026/27. Paediatric Audiology compliance is delivering above trajectory in terms of reducing numbers waiting in excess of 6 weeks whilst maintaining its position in relation to overall compliance. Compliance is expected to continue to improve as the year progresses, delivering the required 6 week wait by March 2027. Community Paediatrics, Memory Service, Adult ADHD although seeing a deteriorating position with demand continuing to outstrip capacity, the rate of deterioration is slowing with actions to improve productivity and deliver transformation starting to have an effect. All services continue to implement transformation plans and productivity improvements including system-wide approaches for Adult ADHD and community paediatrics where wider change is needed to address growth in demand alongside maximising available capacity and are supported by a strong productivity focus. All services hold regular PTL meetings to ensure effective management of their waiting lists and compliance with the Trust's Access Policy. Detailed actions for each service are contained in individual exception reports.	Work continues to drive reductions in the number of patients waiting over 52 weeks for access and /or treatment. Reviews of reported waits continue to ensure all waits are appropriately categorised. This work has reduced numbers waiting in some services and further improvement is expected as review programmes are rolled out. Robust mechanisms are in place within services to monitor follow-up waits with clear routes for escalation where these become a concern. Psychological therapies continue to make good progress in reducing the number of over 52 week waiters. Therapy Services for People with Personality Disorder (TSPPD) have implemented a revised pathway working closely with the neighbourhood teams enabling the service to focus on reducing the numbers of long waits. Medical Psychology, Dynamic Psychotherapy (DPS) and Cognitive Behavioural Therapy (CBT) continue to balance assessment and treatment activity to reduce numbers of over 52 week waiters. Treatment waits over 52 weeks are now at zero for Learning Disability and are expected to sustain zero waits this position in the longer-term. Overall numbers waiting over 52 weeks, and the longest wait within this, continue to increase due to numbers waiting in services relating to adults and children with neurodevelopmental disorders where achieving sustainable change in these services requires a system-wide transformation programme. These long-term programmes are under development with system partners in ICB, education, VCSE and primary care, in the interim internal transformation activities are in place deliver improvements to the LPT element of the wider offer.	Work to address data quality / assurance processes issues have supported a third consecutive month of 100% compliance with gatekeeping standards on mental health inpatient wards. Whilst June saw an overall increase in the number of patient safety incidents, there was a reduction in the number and % of these resulting in severe harm or death. Performance against the 72 hour follow-up standard continues to be above target and improving (this data is extracted from the national mental health core data pack and is reported in arrears) The number of complaints and concerns increased in the month, however the number of compliments increased. These changes are within the expected variance. The numbers of wards not meeting safer staffing standards remains above the target of zero with 2 wards non-compliant for day shifts (up from 1 last month) and 3 wards for night shifts (up from 1 last month). Numbers of seclusions increased from 8 to 16, with the number of restrictive practices, also rising from reducing from 254 to 350. No restraints (prone and unsupported) were reported in month. Numbers of pressure ulcers developed in LPT care (all categories) remained stable. Numbers of repeat falls increased from 43 in May to 48 in June. The 'clock' for annual health checks restarts on 1 April each year and compliance, whilst the % appears low this is in line with plan and is not a performance concern.	Performance against workforce standards continues to be high with sickness absence the only area where standards are consistently not met. Further detail and actions in place to address this are contained within the individual exception reports. There is a continued increase in the costs associated with sickness absence which reflects the costs incurred in order to cover higher level of absence in month.	Delivery against MH length of stay (3 month rolling average) was below trajectory for adult and PICU beds in June with an increased length of stay up from 50.8 days in May to 52.9 days against a target of 52.5. Performance for beds for older people showed a significant improvement in performance in June with an ALOS of 86.3 compared to 97 days in May, however this remains above our target of 77.9 days. Inappropriate out of area placements remained at 1 in June with a total of 14 occupied bed days. This remains above the target of zero. Compliance with the target for adults to wait no more than 18 weeks for community services remained high at 98.6%. However the position for children remains low with compliance at 22.8% compared to 25% in May. This low compliance is driven by the long waits for children requiring audiology or neurodevelopmental interventions – all other CYP community services are fully compliant with this national target. The number of CAMHS patients not meeting the 104 week meaningful help standard is above trajectory and expected to continue this downward trend as data quality issues are addressed. The percentage of children waiting over 6 weeks for a diagnostic test (audiology) is moving positively with performance above plan as recovery measures are put in place. Numbers waiting over 52 weeks (all children waiting for ND interventions) were above plan. Performance was marginally below expected levels for community contacts for adults but above plan for children.

NHS Oversight Framework 2025-26

Section	Source	Reporting Frequency	Indicator	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	Q4 Published Score	Q3 Published Score
Access to services	Trust	*Monthly*	Percentage of patients waiting over 52 weeks for community services	**Jun-26**	**37.0%**	**37.5%**		2.8	2.94
	Trust	*Monthly (in arrears) (12-month rolling, year-on-year)*	Annual percentage change in the number of children and young people accessing NHS funded mental health services	**Apr-26**	**15.0%**	**13.7%**			
Effectiveness and experience of care	Trust	*Monthly (in arrears) (3-month average)*	Percentage of adult inpatients with a length of stay over 60 days at discharge	**Apr-26**	**N/A**	**25.0%**		2.19	2.25
	Trust	*Annual Survey*	CQC community mental health survey satisfaction rate	**2024/25**	**2**				
	Trust	*Monthly*	Percentage of Urgent Community Response patients seen within two hours	**Jun-26**	**88.0%**	**87.9%**			
Finance and productivity	Trust	*Annual Plan*	Planned surplus/deficit	**2025/26**	**£313k**	**n/a**		1.39	1.39
	Trust	*Monthly (Year to date)*	Variance year-to-date to financial plan	**Jun-26**	**£0**	**£0**			
	Trust	*Annual*	Relative Difference in Costs	**2024/25**	**95.1%**	**105.2%**			
Patient safety	Trust	*Annual*	Staff survey – raising concerns sub-score	**2024/25**	**6.96**			2.18	2.47
	Trust	*Monthly (in arrears)*	Percentage of crisis response patients to receive face to face contact within 24 hours	**Apr-26**	**82.0%**	**73.0%**			
People and workforce	Trust	*Annual*	NHS Staff survey engagement theme sub-score	**2024/25**	**7.20**			2.27	2.47
	Trust	*Monthly (in arrears) (Rolling twelve months)*	Sickness Absence Rate	**May-26**	**0.0%**	**5.5%**			

Operational Planning Dashboard

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Operational Planning	TRUST	Monthly (3 month rolling)	Average Length of Stay in Adult Acute & PICU MH Beds	<=52.5	Jun-26	52.9	50.8				
	TRUST	Monthly (3 month rolling)	Average Length of Stay in Older Adult Acute MH Beds	<=77.9	Jun-26	86.8	97.0				
	TRUST	Monthly	Active inappropriate adult acute mental health out of areas placements (OAPs)	0	Jun-26	1	1				
	TRUST	Monthly	Percentage of people on waiting lists per system who are waiting 18 weeks or less - Adult Community Services	Plan=97.0%	Jun-26	98.6%	98.3%				
	TRUST	Monthly	Percentage of people on waiting lists per system who are waiting 18 weeks or less - CYP Services	Plan=19%	Jun-26	22.8%	25.0%				
	TRUST	Monthly	Community Services Waiting List over 52 weeks	Target =0 Plan=7777	Jun-26	7836	7713				
	TRUST	Monthly	Attended Community Care Contacts - CHS	Plan=86372	Jun-26	85769	81971				
	TRUST	Monthly	Attended Community Care Contacts - FYPC	Plan=11198	Jun-26	11326	9306				
	TRUST	Monthly	Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period	Target =0 Plan=350	Jun-26	286	388				
	TRUST	Monthly	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	Target = 0% Plan=88%	Jun-26	37.4%	65.8%				
	TRUST	Monthly	Reliance on specialist inpatient care for adults with a learning disability and/or autism		Jun-26	26	25				
	TRUST	Monthly	Reliance on specialist inpatient care for children with a learning disability and/or autism		Jun-26	5	5				

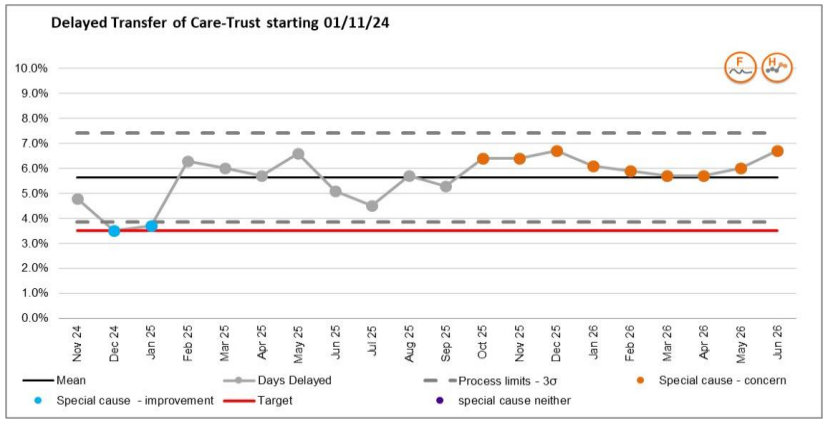
Patient Flow Dashboard

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Patient Flow	TRUST	Monthly	Daily discharges as % of patients who no longer meet the criteria to reside in hospital		Jun-26	25.0%	23.5%				
	TRUST	Monthly	Out of Area Placement - Inappropriate Bed Days	0	Jun-26	14	28				
	TRUST	Monthly	Occupancy Rate - Mental Health Beds (excluding leave)	<=85%	Jun-26	86.5%	80.0%				
	TRUST	Monthly	Occupancy Rate - Community Beds (excluding leave)	>=93%	Jun-26	92.5%	94.3%				
	TRUST	Monthly	Delayed Transfers of Care	<=3.5%	Jun-26	6.7%	6.0%				
	TRUST	Monthly	Delayed Transfers of Care - DMH	<=3.5%	Jun-26	13.2%	12.3%				
	TRUST	Monthly	Delayed Transfers of Care - CHS	<=3.5%	Jun-26	0.1%	0.0%				
	TRUST	Monthly	Admissions to adult facilities of patients under 18 years old	0	Jun-26	0	0				

EXCEPTION REPORT - Delayed Transfers of Care

	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
TRUST	3.5%	4.5%	5.7%	5.3%	6.4%	6.4%	6.7%	6.1%	5.9%	5.7%	5.7%	6.0%	6.7%
DMH		8.0%	10.2%	9.0%	12.0%	12.8%	13.7%	13.7%	12.9%	11.1%	11.8%	11.9%	13.2%
CHS		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%

Mean	Lower Process Limit	Upper Process Limit
5.6%	4.0%	7.0%



Trajectory graph to be inserted here

Analytical Commentary

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

Operational Commentary

Actions	Timescales	Consequences	RAG
Undertake a focused review of all patients contributing to CRFD delays to identify common themes, barriers and opportunities for earlier escalation.	Within 1 month	Improved understanding of delay drivers and identification of quick wins.	
Establish fortnightly system-level review of patients delayed >14 and >21 days, involving Adult Social Care, ICB and provider exec level partners.	Within 1 month	Increased oversight and earlier resolution of complex discharge barriers.	
Escalate sustained market capacity concerns through existing system governance arrangements, supported by analysis of unmet demand and delayed discharge trends.	Within 2 months	Supports strategic commissioning decisions and capacity planning.	
Work with Adult Social Care colleagues to define enhanced escalation arrangements for periods of extreme pressure, including consideration of actions beyond existing operational responses. This should be an output action from Action 3.	Within 2.5 months	Creation of additional interventions during periods of significant flow pressure.	

Achievements

Quality & Safety Dashboard

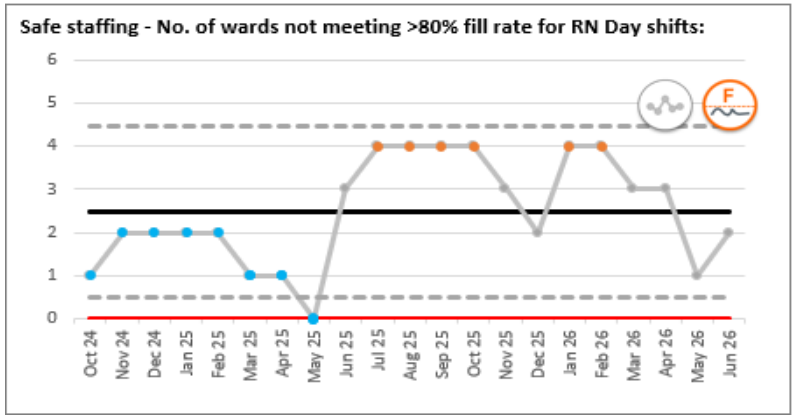
Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Quality Account	TRUST	Monthly	The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period	>=95%	Jun-26	100.0%	100.0%				
	TRUST	Yearly	The Trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period		24/25	6.6	6.3				
	TRUST	Monthly	The percentage of inpatients discharged with a subsequent inpatient admission within 30 days - 0-15 years		Jun-26	0.0%	0.0%				
	TRUST	Monthly	The percentage of inpatients discharged with a subsequent inpatient admission within 30 days - 16+ years		Jun-26	5.8%	5.0%				
	TRUST	Monthly	The number of patient safety incidents reported within the Trust during the reporting period		Jun-26	2194	1872				
	TRUST	Monthly	The rate of patient safety incidents reported within the Trust during the reporting period		Jun-26	70.8%	67.7%				
	TRUST	Monthly	The number of such patient safety incidents that resulted in severe harm or death		Jun-26	14	20				
	TRUST	Monthly	The percentage of such patient safety incidents that resulted in severe harm or death		Jun-26	0.6%	1.1%				
	MHSDS	Monthly (a quarter in arrears)	72 hour Follow Up after discharge (Aligned with national published data)	>=80%	Apr-26	93.0%	91.0%				
Quality & Safety	TRUST	Monthly	No. of Complaints		Jun-26	35	31				
	TRUST	Monthly	No. of Concerns		Jun-26	60	44				
	TRUST	Monthly	No. of Compliments		Jun-26	256	219				
	TRUST	Monthly	Safer staffing - No. of wards not meeting >80% fill rate for RNs - Day	0	Jun-26	2	1				
	TRUST	Monthly	Safer staffing - No. of wards not meeting >80% fill rate for RNs - Night	0	Jun-26	3	1				
	TRUST	Monthly	Care Hours per patient day		Jun-26	11.1	11.0				
	TRUST	Monthly	No. of Long term Segregations		Jun-26	1	1				

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
	TRUST	Monthly	No. of episodes of seclusions		Jun-26	16	8				
	TRUST	Monthly	No. of episodes of prone (Supported) restraint		Jun-26	0	3				
	TRUST	Monthly	No. of episodes of prone (Unsupported) restraint		Jun-26	0	1				
	TRUST	Monthly	Total number of Restrictive Practices		Jun-26	350	254				
	TRUST	Monthly (In Arrears)	No. of Category 2 pressure ulcers developed or deteriorated in LPT care		May-26	128	128				
	TRUST	Monthly (In Arrears)	No. of Category 3 pressure ulcers developed or deteriorated in LPT care		May-26	12	11				
	TRUST	Monthly (In Arrears)	No. of Category 4 pressure ulcers developed or deteriorated in LPT care		May-26	8	10				
	TRUST	Monthly (In Arrears)	No. of repeat falls		May-26	48	43				
	TRUST	Monthly	No. of Medication Errors		Jun-26	111	104				
	TRUST	Monthly	LD Annual Health Checks completed - YTD		Jun-26	14.5%	7.8%				
	MHRA	Monthly	National Patient Safety Alerts not completed by deadline		Jun-26	1	1				
	TRUST	Monthly	MRSA Infections	0	Jun-26	0	0				
	TRUST	Monthly	Clostridium difficile infections	Annual <=12	Jun-26	0	1				
	UHL	Monthly (In Arrears)	E.coli bloodstream infections		May-26	0	0				
	GOV	Monthly (YTD)	Percentage of people aged 65 and over who received a flu vaccination		Jun-26						

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

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

Mean	Lower Process Limit	Upper Process Limit
2	0	4



Trajectory graph to be inserted here

Analytical Commentary

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

Operational Commentary

Actions	Timescales	Consequences	RAG
FYPCLDA The GRANGE - offers planned respite care and staffing model dependent on individual patient need, presentation and associated risks. As a result, this fluctuates the fill rate for RNs on days. Staffing is supported by Agnes Unit and Gillivers. Work is in progress to align the LD Short Breaks Service (The Gillivers and The Grange) fill rate analysis. Options have been considered at Directorate DMT to enable joint reporting going forward, additional data requested and wil be revisited at DMT in July/August. AGNES UNIT - low fill rate due to reduction in number of patients, the service is exploring adjusted planned staffing levels to support accurate fill rate reporting which is based on patient numbers.	30.08.2026	Will improve accuracy and consistency of reporting	

Achievements

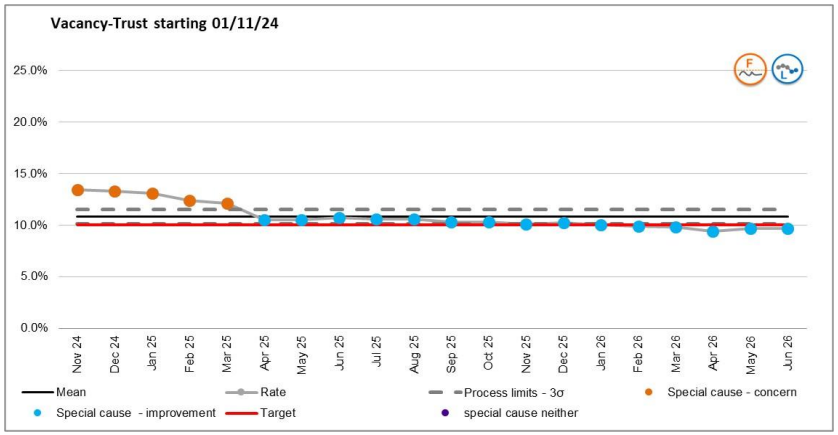
Workforce Dashboard

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Workforce	TRUST	Monthly	Normalised Workforce Turnover (Rolling previous 12 months)	<=10%	Jun-26	6.4%	6.3%				
	TRUST	Monthly	Vacancy Rate	<=10%	Jun-26	9.7%	9.7%				
	TRUST	Monthly (In Arrears)	Sickness Absence	<=5.0%	May-26	5.7%	5.5%				
	TRUST	Monthly (In Arrears)	Sickness Absence Costs		May-26	£1,296,434	£1,214,139				
	TRUST	Monthly (In Arrears)	Sickness Absence - YTD	<=5.0%	May-26	5.6%	5.5%				
	TRUST	Monthly	Core Mandatory Training Compliance for substantive staff	>=85%	Jun-26	98.6%	98.6%				
	TRUST	Monthly	Staff with a Completed Annual Appraisal	>=80%	Jun-26	95.1%	95.1%				
	TRUST	Monthly	% of staff from a BME background	>=22.5%	Jun-26	34.0%	34.0%				
	TRUST	Monthly	Staff flu vaccination rate (frontline healthcare workers)		Jun-26						
	TRUST	Monthly	% of staff who have undertaken clinical supervision within the last 3 months	>=85%	Jun-26	93.3%	94.2%				

EXCEPTION REPORT - Vacancy Rate

	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
TRUST	<=10%	10.6%	10.6%	10.3%	10.3%	10.1%	10.2%	10.0%	9.9%	9.8%	9.4%	9.7%	9.7%
DMH		12.3%	12.4%	13.1%	13.2%	13.3%	12.7%	12.8%	12.4%	12.4%	12.2%	12.1%	12.0%
CHS		10.0%	10.1%	9.9%	9.3%	8.5%	8.9%	8.4%	8.2%	7.9%	8.2%	8.2%	8.3%
FYPCLDA		10.6%	10.0%	9.3%	9.1%	9.3%	9.7%	9.5%	9.8%	9.5%	9.2%	10.8%	10.7%

Mean	Lower Process Limit	Upper Process Limit
10.8%	10.0%	12.0%



Trajectory graph to be inserted here

Analytical Commentary

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

Operational Commentary

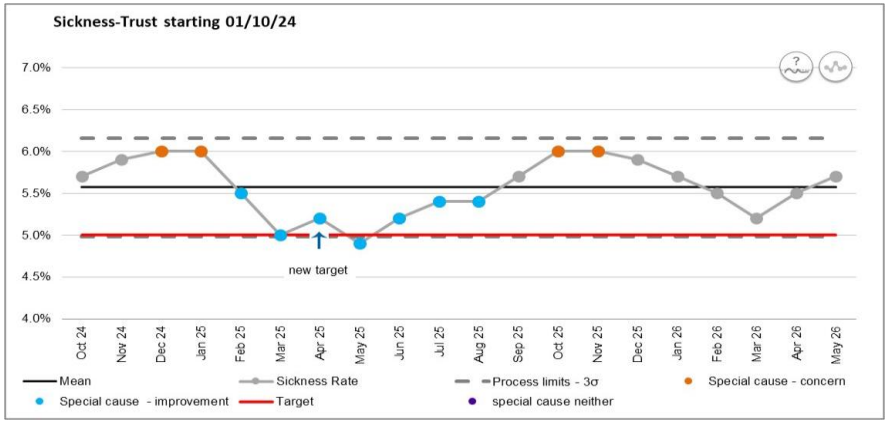
Actions	Timescales	Consequences	RAG
Workforce plan in place. This includes plans to recruit substantively to some vacancies in order to reduce the need to fill vacant post with bank or agency staff.	Mar-27	By the end of 26/27, we plan for a vacancy rate of 8.5%. This is based on an assumption there will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

Achievements

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

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

Mean	Lower Process Limit	Upper Process Limit
5.6%	5.0%	6.0%



Trajectory graph to be inserted here

Analytical Commentary

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

Operational Commentary

Actions	Timescales	Consequences	RAG
360 Assurance audit to take place focusing on: - Are expected working practices for managing attendance being applied promptly, consistently, and fairly across the Trust - Are colleagues appropriately supported to enable them to safely return to work following long term sickness absence at the earliest opportunity.	Jul-26	Identification areas for development and actions required to improve the management of sickness absence. Identification of best practice for wider learning/sharing.	
Ongoing support from HR Advisory Team to ensure sickness absence is managed in accordance with policy timescales and signposting staff to LPT's extensive health and wellbeing offer.	TBC	Managers have clarity on their role and responsibilities for managing sickness absence. Staff feel supported, are treated equitably and are supported to return to work at the earliest opportunity.	

Achievements

Finance Dashboard

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Finance	TRUST	Monthly	Variance to Plan - I&E (£000)	>=0	Jun-26	£0	£0				
	TRUST	Monthly	Variance to Plan – efficiency (£000)	>=0	Jun-26	£0	£0				
	TRUST	Monthly	Variance to Plan – capital spend (£000)	£0	Jun-26	£835k	£774k				
	TRUST	Monthly	Variance to Plan – agency spend (£000) - YTD	>=0	Jun-26	£-23k	£36k				
	TRUST	Monthly	Agency Spend % of Total Pay - YTD	<=1.87%	Jun-26	1.5%	1.4%				
	TRUST	Monthly	Agency annual expenditure cap – FOT performance	<=6,749,000	Jun-26	£4,913,000	£5,009,000				
	TRUST	Monthly	Bank annual expenditure cap – FOT performance	<=20,361,000	Jun-26	£20,160,000	£20,160,000				

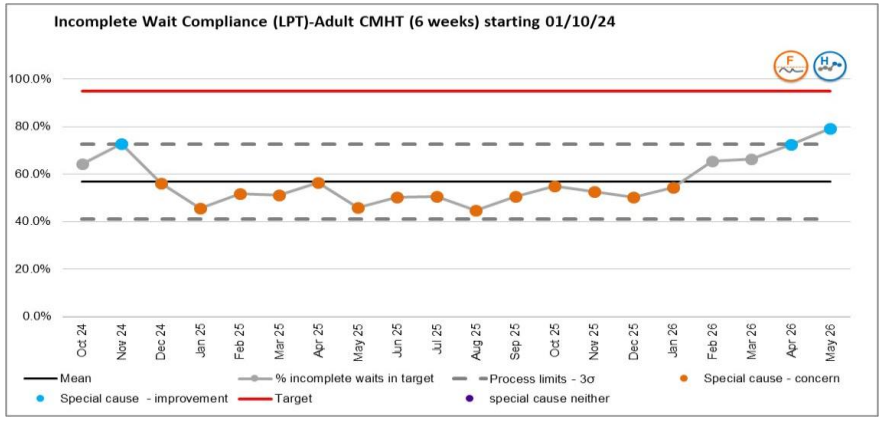
Operational Performance - DMH Waiting Times Dashboard

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Operational Performance - Access Waiting Times	TRUST	Monthly (In Arrears)	Adult Psychiatry - Neighbourhood Mental Health Teams - Access (6 weeks routine) - Incomplete pathway	>=95%	May-26	79.3%	72.5%				
	TRUST	Monthly (In Arrears)	Memory Clinic (18 week Local RTT) - Incomplete pathway	>=92%	May-26	46.1%	45.6%				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - Incomplete pathway	>=92%	May-26	4.9%	4.7%				
	TRUST	Monthly (In Arrears)	Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral - complete pathway	>=60%	May-26	66.7%	61.5%				
Operational Performance - 52 Week Waits	TRUST	Monthly (In Arrears)	Adult Psychiatry - Neighbourhood Mental Health Teams - Assessments waits over 52 weeks - No of waiters	0	May-26	2	6				
	TRUST	Monthly (In Arrears)	Adult Psychiatry - Neighbourhood Mental Health Teams - Assessments waits over 52 weeks - Longest waiter (weeks)		May-26	63	61				
	TRUST	Monthly	Adult Psychiatry – Neighbourhood Mental Health Teams – Treatment waits - No of Waiters	0	Jun-26	0	0				
	TRUST	Monthly	Adult Psychiatry – Neighbourhood Mental Health Teams – Treatment waits - Longest Waiter		Jun-26	22	20				
	TRUST	Monthly	Cognitive Behavioural Therapy - Treatment waits - No of waiters	0	Jun-26	25	21				
	TRUST	Monthly	Cognitive Behavioural Therapy- Treatment waits - Longest waiter (weeks)		Jun-26	81	77				
	TRUST	Monthly	Dynamic Psychotherapy - Treatment waits - No of waiters	0	Jun-26	1	0				
	TRUST	Monthly	Dynamic Psychotherapy - Treatment waits - Longest waiter (weeks)		Jun-26	82	24				
	TRUST	Monthly	Therapy Service for People with Personality Disorder - Treatment waits - No of waiters	0	Jun-26	1	7				
	TRUST	Monthly	Therapy Service for People with Personality Disorder - Treatment waits - Longest waiter (weeks)		Jun-26	187	182				
	TRUST	Monthly	Medical/Neuropsychology - Treatment waits - No of Waiters	0	Jun-26	46	52				
	TRUST	Monthly	Medical/Neuropsychology- Treatment waits - Longest Waiter		Jun-26	115	123				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	May-26	7951	7860				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - assessment waits over 52 weeks - Longest waiter (weeks)		May-26	381	376				
	TRUST	Monthly (In Arrears)	MHSOP Memory Clinics (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	May-26	19	18				
	TRUST	Monthly (In Arrears)	MHSOP Memory Clinics (18 week local RTT) - assessment waits over 52 weeks -Longest waiter (weeks)		May-26	66	72				

EXCEPTION REPORT - Adult Neighbourhood Mental Health Teams Access (six weeks routine) - Incomplete pathway *(Month in arrears)*

DMH	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
	>=95%	50.2%	50.5%	44.6%	50.5%	54.9%	52.5%	50.4%	54.4%	65.5%	66.2%	72.5%	79.3%
No of Referrals		314	448	344	439	539	474	476	520	598	659	511	531

Mean	Lower Process Limit	Upper Process Limit
56.8%	41.0%	72.0%



Trajectory graph to be inserted here

Analytical Commentary

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

Operational Commentary

Actions	Timescales	Consequences	RAG
Substantive recruitment to Consultant posts. Job descriptions and recruitment plan in place. 3 substantive Consultants have been recruited to date.	Aug-26	Increase capacity and reduce waiting times.	
Additional actions put in place to increase capacity and improve flow include: • Additional dedicated medic time week 24th, 25th and 26th August with B7 nurse to further support caseload reviews in North-West Leicestershire • Additional nurse clinics in North West and South teams to support medic capacity and caseload management. • Band 7 nurse supporting caseload reviews in North West Leicestershire. • Band 7 Non-Medical Prescriber facilitating annual reviews for stable depot patients in city teams which will increase medic capacity (extent to be confirmed). • Senior medical/operational and clinical group reviewing all workstreams to support phased plan for 26/27 • Reviewing caseloads to identify patients open to multiple team members and ensure remains appropriate.	Timescales for individual actions TBC	Improve flow through the Neighbourhood Mental Health Teams. Sustained reduction in waiting times. Ensure patients are seen for follow up as planned. Impact of these actions to be monitored at weekly Community Waiting Times Meetings.	
City West has identified a small number of patients breaching a 52 week wait for assessment. This is due to historical ways of working and medic capacity and has been escalated and appointments booked.	Jun-26	Patients will be seen, enabling them to be removed from the waiting list.	

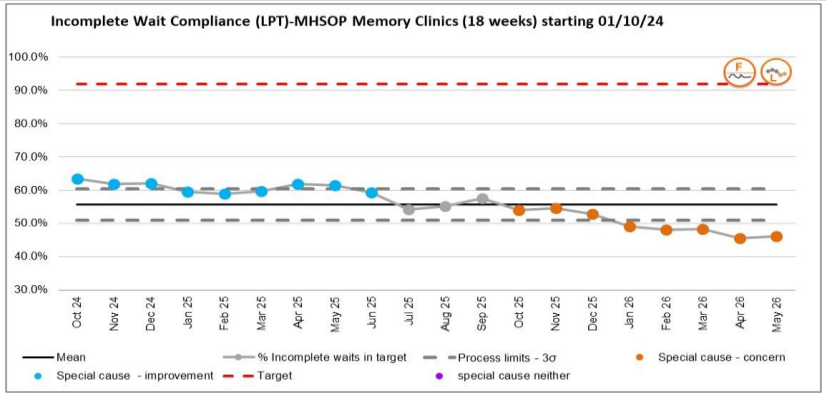
Achievements

% compliance is moving upwards with a signficant improvement seen in last two quarters

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

DMH	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
	>=95%	59.2%	54.1%	55.1%	57.6%	54.0%	54.6%	52.9%	49.1%	48.1%	48.3%	45.6%	46.1%
No of Referrals		240	184	203	279	267	224	230	234	227	267	184	184

Mean	Lower Process Limit	Upper Process Limit
55.7%	51.0%	60.0%



Trajectory graph to be inserted here

Analytical Commentary

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

Operational Commentary

Actions	Timescales	Consequences	RAG
Implementation of One Stop Clinic and Advanced Pathway Review undertaken to assess impact of One Stop Clinic and Advanced Pathway has indicated overwhelming support to continue with both. Findings to be shared with Quality and Safety DMT for sign off prior to becoming business as usual. Workforce review to be carried out to ensure the right capacity and skill mix in the service.	Sep-26	Increase efficiency, flow and patient experience. Reduction in waiting times. Assessment, diagnosis and treatment within one clinic for those over 85 with suspicion of established dementia will improve patient experience.	
Gaps in the medical capacity in the team is limiting delivery of One Stop Clinics. The Lead Consultant and Clinical Director are identifying options to address. Medic capacity update – service capacity reduced by equivalent of 1wte medic. 2 days of GP with Special interest working on the bank and 2 days of locum cover in place. GP is unable to supervise One Stop clinics and the nurses. The lead consultant is working with the clinical director to resolve this capacity gap. A ST is starting with the team in August 2026. Due to sickness in the nursing team, existing staff have to cover duty and triage more frequently. Saturday clinics have been organised until end of August to increase assessment capacity. Half day session held on 7 July to agree the expansion of One Stop and Advanced Pathway. Current capacity is approximately 28 One Stop appointments per week (impacted by staff absence), with a planned increase to around 40 appointments per week from September 2026, subject to consultant/medical availability, and an ultimate ambition of 52 appointments per week when fully operational.	Sep-26	Increase capacity enabling waiting times / number of over 52 waits to be reduced.	

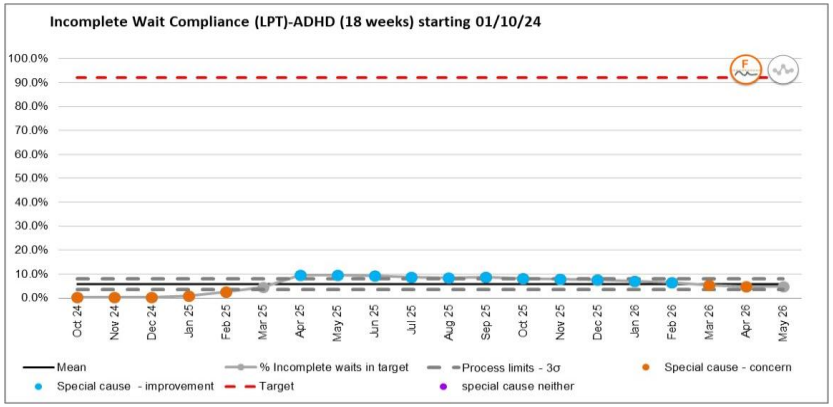
Achievements

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

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

DMH	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
	>=95%	9.4%	8.7%	8.4%	8.8%	8.2%	7.8%	7.6%	7.1%	6.6%	5.4%	4.7%	4.9%
No of Referrals		268	266	239	299	251	257	222	197	216	221	53	55

Mean	Lower Process Limit	Upper Process Limit
5.8%	4.0%	8.0%



Trajectory graph to be inserted here

Analytical Commentary

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

Operational Commentary

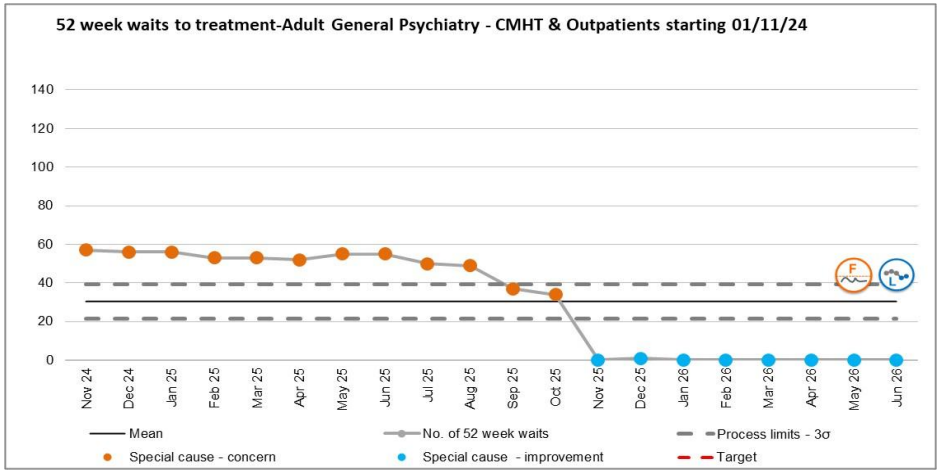
Actions	Timescales	Consequences	RAG
Transformation of the ADHD pathway to improve access and reduce waiting times. System group established to take forward transformation of the pathway, co-chaired by the Director of Mental Health and ICB Associate Director of Mental Health and LD. Piloting AI Scribe to support improved efficiency across the pathway. Work to commence with ICB and HEIM to consider pathway remodelling using local learning alongside that from other Trusts nationally. We are on the priority list for rollout of AI scribe (HEIDI), implementation date yet to be confirmed. This will support with reducing clinical admin time and increase clinical appointments.	Sep-26	Improved access and reduction numbers waiting in excess of 52 weeks. Improved service productivity. Improved patient experience. Improved staff experience.	
Improved recording and reporting of waiting times and pathways. Consider recommendations in the NHS ADHD National Improvement Plan. Discussions with SystmOne, Integrated Information and Business Teams to progress. Workshop held with Service Leads, LHIS, Business Team and Integrated Information Team to review SystmOne configuration and reporting and actions are being progressed. SystmOne optimisation taking place to ensure information correctly logged to track patient's journey through the pathway. New templates being created.	Jul-26	Waiting times data is consistent across all reports and systems.	
New provider (COGS AI) has been commissioned to provide pre and post diagnostic support to patients. Data sharing agreement is in the process of being signed off so we can refer identified patients for this support.	Jun-26	To provide psychological and psychoeducation support to patients whilst they are waiting.	

Achievements

EXCEPTION REPORT - Adult Psychiatry - Neighbourhood Mental Health Teams (treatment) - No of waiters over 52 weeks

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

Mean	Lower Process Limit	Upper Process Limit
30.4	21.3	39.5



Trajectory graph to be inserted here

Analytical Commentary

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

Operational Commentary

Actions	Timescales	Consequences	RAG
Sustaining this position will be supported by the actions identifed in the exception report for NMHT 6 week waits	N/A		

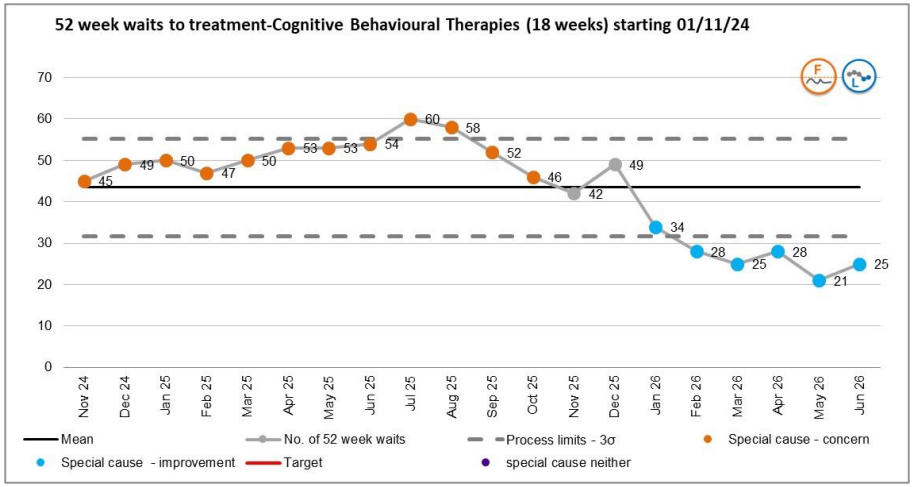
Achievements

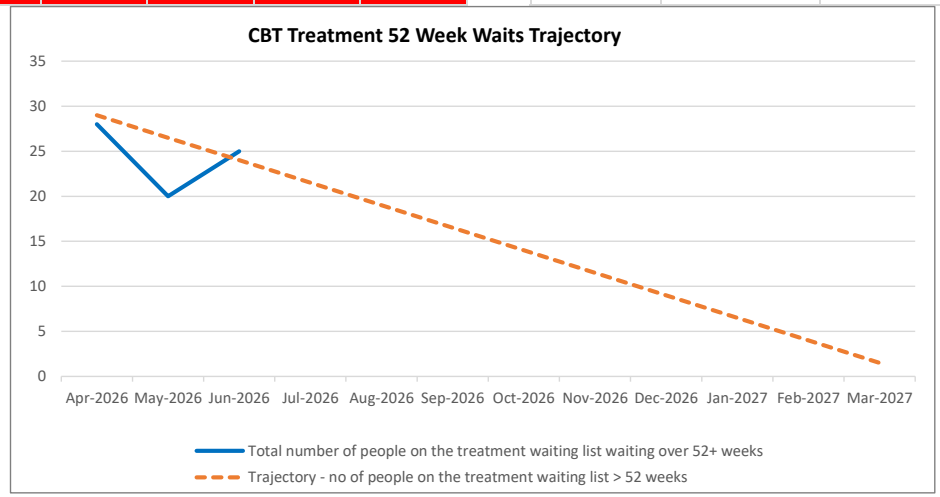
As a result of work to review waiting lists, clinical activity and data recording, treatment waits in excess of 52 weeks are expected to be eliminated going forward with 0 waits reported since Dec 2025.

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

DMH	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
	0	60	58	52	46	42	49	34	28	25	28	21	25

Mean	Lower Process Limit	Upper Process Limit
43.5	31.7	55.2





Analytical Commentary

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

Operational Commentary

5 of the 25 showing as waiting longer that 52 weeks- have been taken into treatment since the report was issued and have had appointments recently or are due to be seen this week.

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

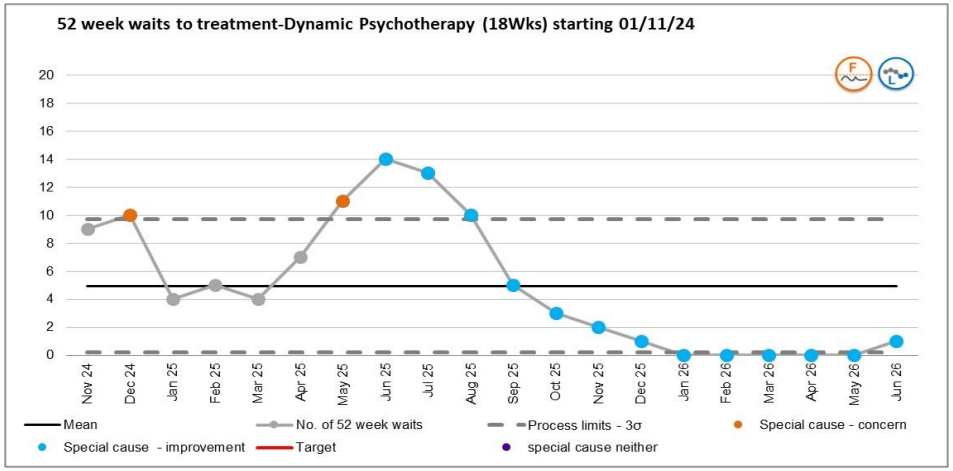
Achievements

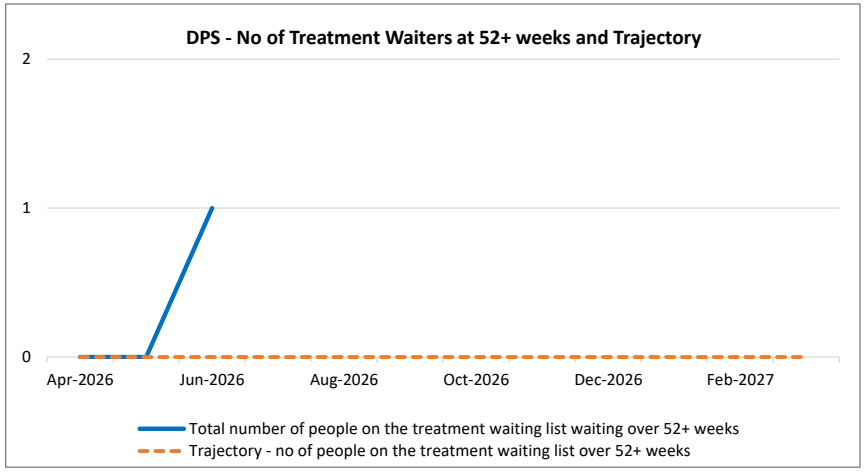
Maintaining 100% compliance for access KPI for past 12 months and maintaining progress with continual reduction of numbers of 52 weeks waiters in line with current trajectory.

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

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

Mean	Lower Process Limit	Upper Process Limit
5.0	0.2	9.7





Analytical Commentary

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

Operational Commentary

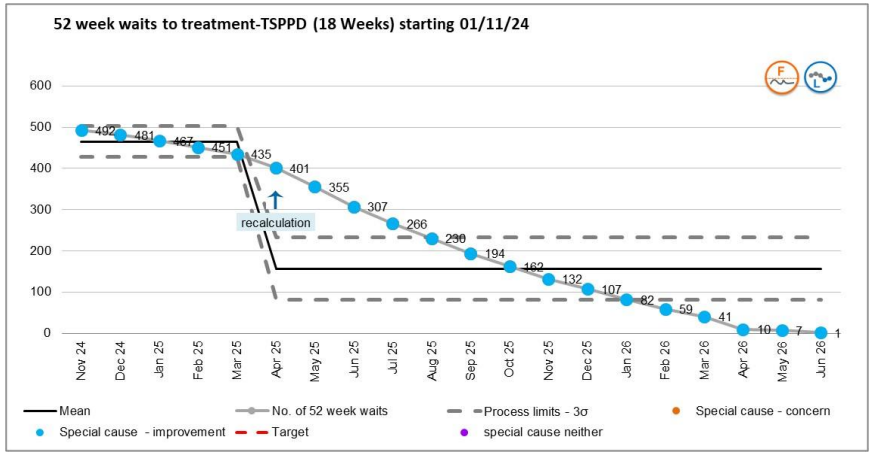
Actions	Timescales	Consequences	RAG
All referrals to DPS will go through Neighbourhood Mental Health Teams, the new front door process for those teams, and may be picked up either at the huddle or following discussion in the consultor meeting. Agree implementation plan at Steering Group Meeting, this is still being worked through to ensure agreement at NMHT level and service level in ensuring the correct clinical processes in place. To be discussed in the CRG, with plan for referrals to come through huddles as well as consulter meetings.	July/Aug 2026	A joined-up approach across services is in development, which will improve flow and ensure that patients are being seen by the most appropriate service at the earliest point in referral.	
Reviewing recording of clinical interventions in 1:1 sessions prior to group therapy to ensure patient pathway is captured accurately in SystmOne. This is in place now with waits for MBTi groups correctly recorded and reported.	Complete	Ensure accurate reflection of activity is reflcted on the waiting list and within performance reports. Action now complete - impact to be assessed.	

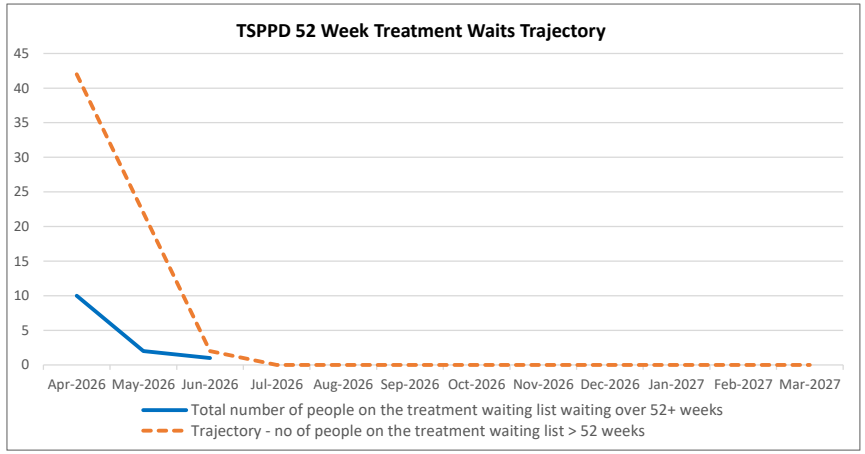
Achievements

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

DMH	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
	0	266	230	194	162	132	107	82	59	41	10	7	1

Mean	Lower Process Limit	Upper Process Limit
156.9	80.9	232.9





Analytical Commentary

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

Operational Commentary

Actions	Timescales	Consequences	RAG
Development of consultation and training support to community services to enhance the primary care offer (small scale). ICB funding no longer available for 25/26. Develop foundational training in Trauma Informed Care. Advertisement of training sent to City East and City West, with start dates in September 2026. To clarify training dates for other neighbourhood areas for 2027.	Dec-27	Provide support to VCSE/primary care to prevent referrals for low level support entering secondary care services.	
All TSPPD referrals to come through Neighbourhood Teams and fit directorate wide secondary care referral criteria. Business as usual will be provided by the Mental Health Neighbourhood Teams during the transition period. Operational plans to be discussed in weekly Personality Disorder" transformation working group.	Oct-26	Reduced waiting time for secondary mental health input as we focus on the severity of need best served.	
Agree and implement a clinical model for the current TSPPD waiting list and governance processes to work through waiting list before transforming provision. Complete waiting list initiative.	Dec-26	Improved service offer, increased efficiency and reduced waits.	
Design new Neighbourhood Team clinical model to be tailored to meet the needs personality difficulties. Part of IN2 and reporting through that project structure.	Oct-26	Model for working with people with moderate personality difficulties within Neighbourhood Team.	
Establish the 'Personality Disorder Hub. Model in development through weekly "Personality Disorder" transformation meeting and organisational development sessions in TSPPD.	Jan-27	Improve service offer, increase efficiency, and reduce waits.	

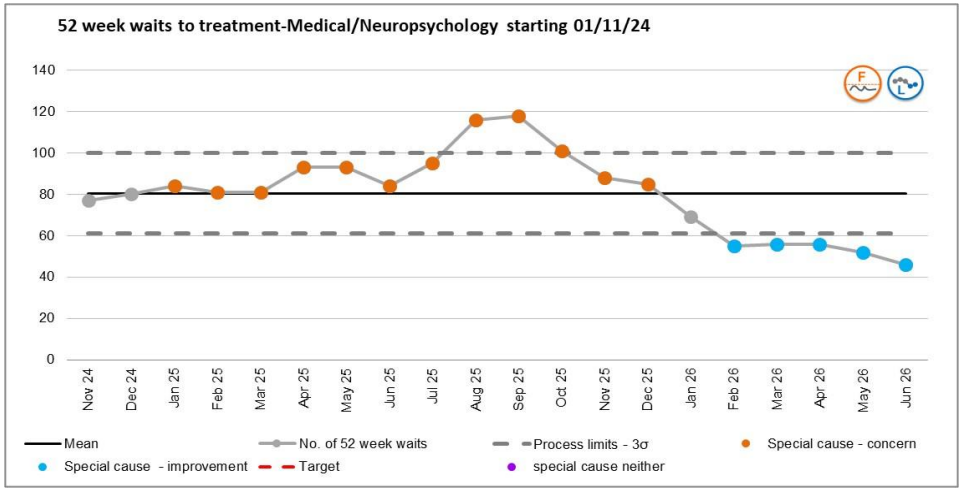
Achievements

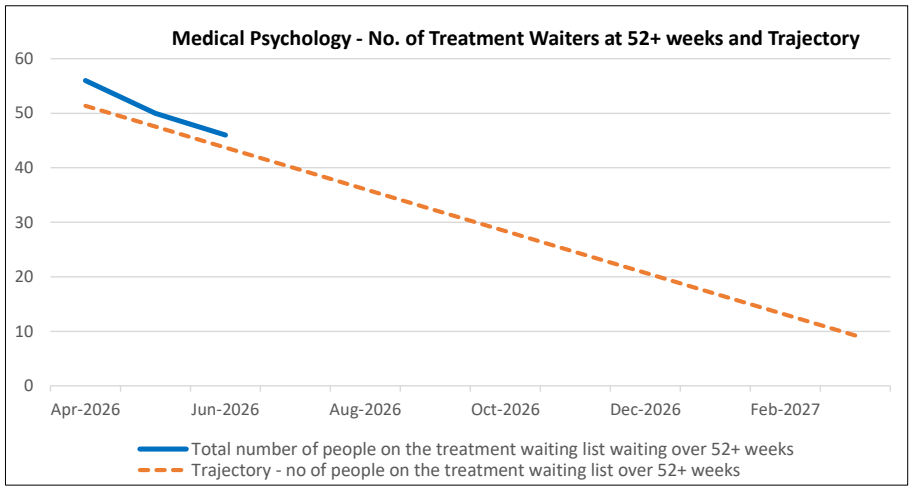
Signficant and sustained reduction in numbers waiting over 52 weeks over the last 12 months.

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

DMH	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
	0	95	116	118	101	88	85	69	55	56	56	52	46

Mean	Lower Process Limit	Upper Process Limit
80.5	61.0	100.0





Analytical Commentary

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

Operational Commentary

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

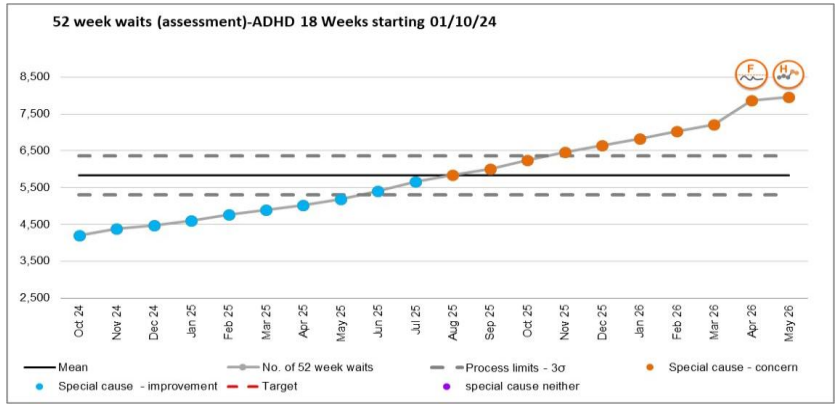
Achievements

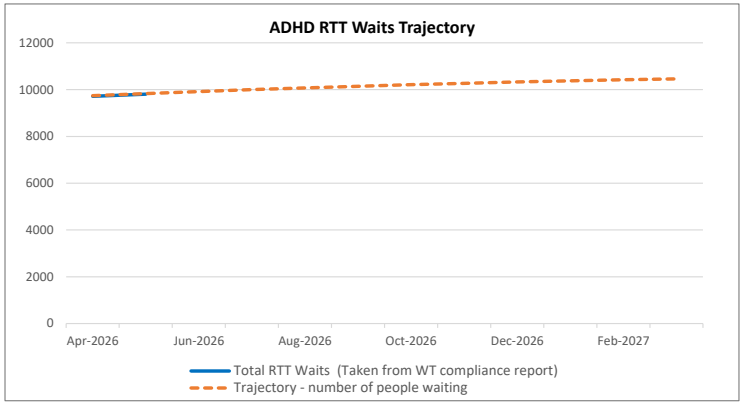
Number of over 52 week waits continue to fall with a significant reduction over the past 12 months.

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

DMH	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
	0	5398	5661	5833	6006	6250	6464	6639	6830	7023	7211	7860	7951

Mean	Lower Process Limit	Upper Process Limit
5831.2	5305.1	6357.3





Analytical Commentary

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

Operational Commentary

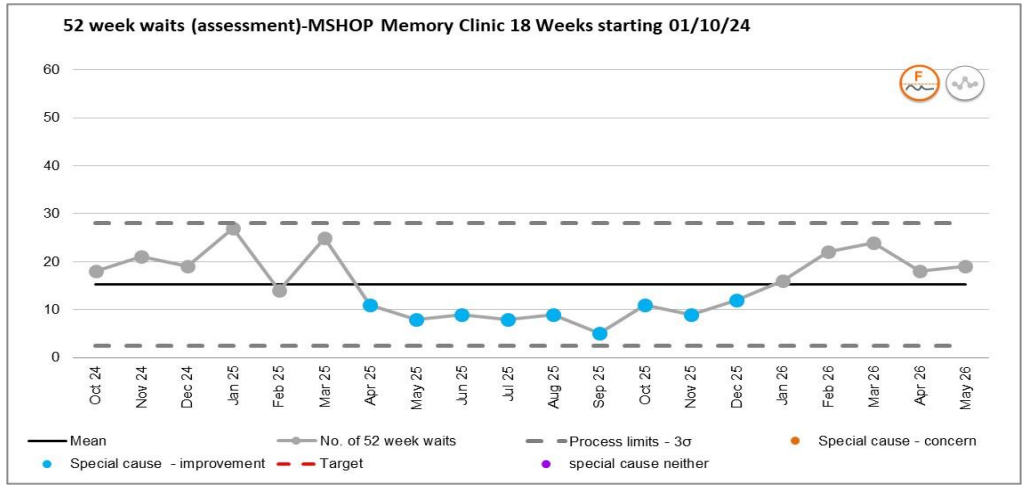
Actions	Timescales	Consequences	RAG
Transformation of the ADHD pathway to improve access and reduce waiting times. A system group has been established to take forward transformation of the pathway, co-chaired by the Director of Mental Health and ICB Associate Director of Mental Health and LD. Piloting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

Achievements

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

DMH	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
	0	9	8	9	5	11	9	12	16	22	24	18	19

Mean	Lower Process Limit	Upper Process Limit
15.3	2.5	28.0



Trajectory graph to be inserted here

Analytical Commentary

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

Operational Commentary

Actions	Timescales	Consequences	RAG
Implementation of One Stop Clinic and Advanced Pathway Review undertaken to assess impact of One Stop Clinic and Advanced Pathway has indicated overwhelming support to continue with both. Findings to be shared with Quality and Safety DMT for sign off prior to becoming business as usual. Workforce review to be carried out to ensure the right capacity and skill mix in the service.	Sep-26	Increase efficiency, flow and patient experience. Reduction in waiting times. Assessment, diagnosis and treatment within one clinic for those over 85 with suspicion of established dementia.	
Gaps in the medical capacity in the team is limiting delivery of One Stop Clinics. The Lead Consultant and Clinical Director are identifying options to address.	Jul-26	Increase capacity to assess more patients	

Achievements

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

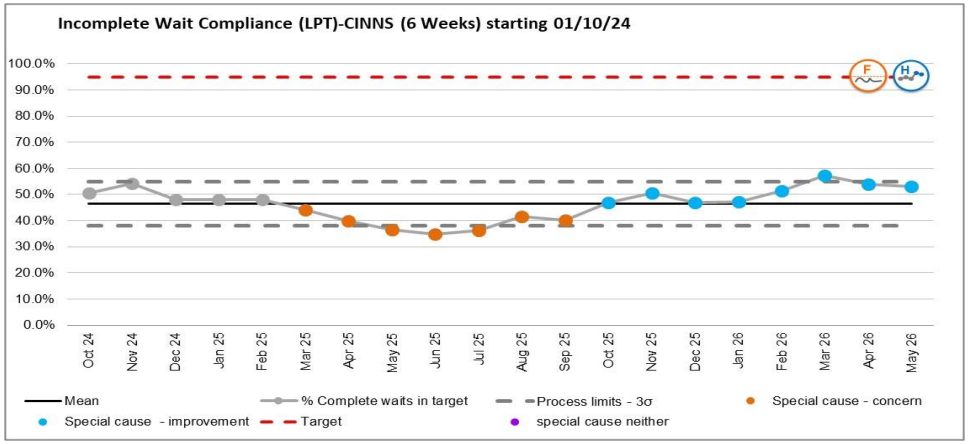
Operational Performance - CHS Waiting Times Dashboard

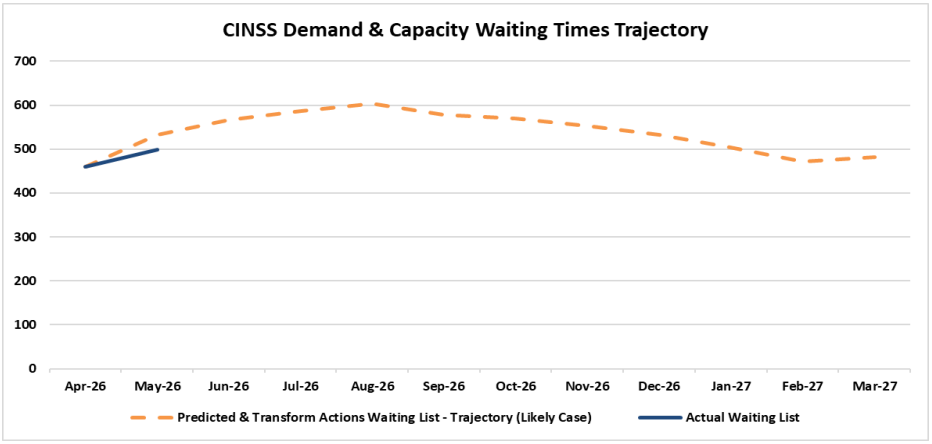
Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Operational Performance - Access Waiting Times	TRUST	Monthly (In Arrears)	CINSS (6 weeks) - Incomplete Pathway	>=95%	May-26	53.0%	54.0%				
	TRUST	Monthly (In Arrears)	Speech Therapy - Voice, Respiratory and Dysfluency - Routine (6 weeks) - Incomplete Pathway	>=95%	May-26	29.6%	24.6%				

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

CHS	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
	>=95%	34.9%	36.3%	41.5%	40.2%	46.9%	50.6%	46.9%	47.3%	51.4%	57.4%	54.0%	53.0%
No of Referrals		180	189	205	165	188	178	180	174	169	212	181	178

Mean	Lower Process Limit	Upper Process Limit
46.5%	38.0%	55.0%





Analytical Commentary

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

Operational Commentary

Significant reduction in available capacity due to maternity leave and long term sickness.

Actions	Timescales	Consequences	RAG
Energy Management Group to be rolled out	Sep-26	Increase capacity and throughput of patients; reduce numbers waiting	
Student workforce allocation has been reviewed and standardised across the Trust.	Aug-26	Releasing Time to Care	
Dictation software options being explored - awaiting trustwide progress and funding	TBC	Releasing Time to Care	
SystmOne holistic templates to be reviewed	TBC	Releasing Time to Care	
Trusted assessor equipment list to be reviewed	TBC	Releasing Time to Care	
Review alternative options for safeguarding & social care related work / liaison	TBC	Releasing Time to Care	
Weekly monitoring of new patient appointments & prospective bookings	TBC	Reduce waiting list; reduce longest waiters	

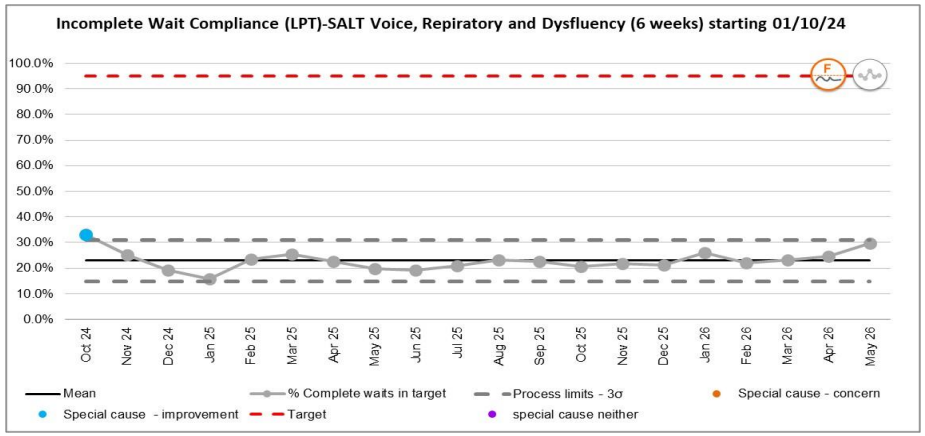
Achievements

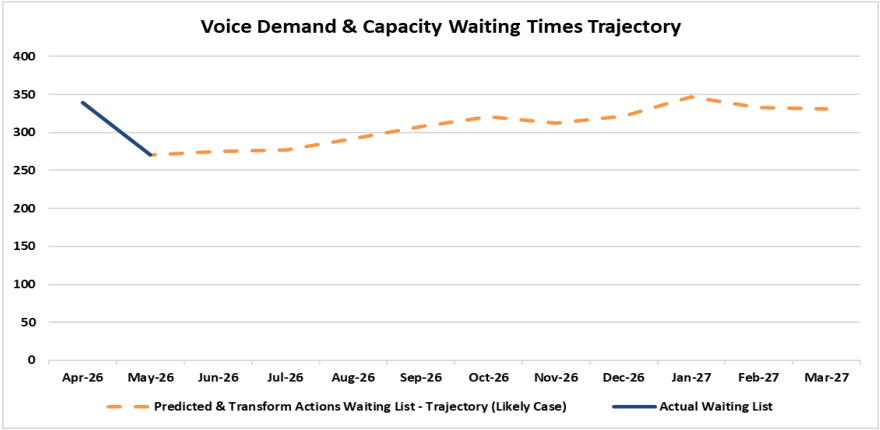
95th percentile waiting list has decreased to 15 weeks. There are only 9 patients waiting above 18 weeks; and only 4 that do not have an appointment book yet due to capacity. 97.5% of patients are waiting within 18 weeks.

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

CHS	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
	>=95%	19.3%	20.8%	23.2%	22.5%	20.7%	21.9%	21.2%	25.9%	22.0%	23.1%	24.6%	29.6%
No of Referrals		58	63	81	81	72	56	74	88	45	63	69	57

Mean	Lower Process Limit	Upper Process Limit
23.0%	15.0%	31.0%





Analytical Commentary

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

Operational Commentary

Incomplete and complete compliance will not increase significantly until the longest waiters are seen.

Actions	Timescales	Consequences	RAG
Recruitment to 0.4 w.t.e. Voice Therapist	Oct-26	Increase clinical capacity; reduce waiting list.	
Individual Job Planning	Aug-26	Validated trajectory in place	
Consider increased use of digital communication for appointments & self-help	Sep-26	Releasing Time to Care; Increase capacity	
Increase use of video & telephone follow-ups	Aug-26	Reduce cancellations; increase capacity; reduce waiting list	
Set up next cohort of group patients	Sep-26	Reduce waiting list; reduce longest waiters	
Weekly monitoring of new patient appointments & prospective bookings	TBC	Reduce waiting list; reduce longest waiters	

Achievements

Significant reduction in numbers waiting. Improvement in waiting times compliance. Over -achieving on likely case waiting list trajectory with 95th percentile wait decreasing (from 34 weeks to 28 weeks). PTL processes strengthened to support compliance with Access and DNA Policies.

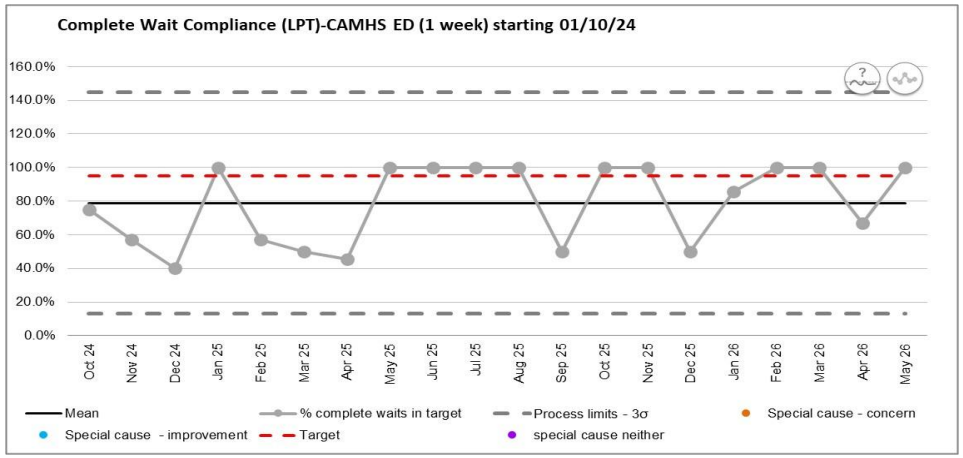
Operational Performance - FYPCLDA Waiting Times Dashboard

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Operational Performance - Access Waiting Times	TRUST	Monthly (In Arrears)	CAMHS Eating Disorder (one week) - Complete pathway	>=95%	May-26	100.0%	66.7%		?		
	TRUST	Monthly (In Arrears)	CAMHS Eating Disorder (four weeks) - Complete pathway	>=95%	May-26	100.0%	92.9%		?	H	
	TRUST	Monthly (In Arrears)	Community Paediatrics (18 weeks) - Incomplete pathway	>=92%	May-26	8.1%	8.3%		F	L	
	TRUST	Monthly (In Arrears)	Childrens Audiology (6 week wait for diagnostic procedures) - Incomplete pathway	>=99%	May-26	29.4%	28.8%		F		
Operational Performance - Looked After Children	TRUST	Monthly	Percent of IHA plans sent to LA in month by 19th working day of being taken into care (City/County/Rutland)		Jun-26	66.0%	50.0%				
	TRUST	Monthly	(5-18yrs) Percent of RHAs sent to LA in month within 12 months of previous assessment (City/County/Rutland)		Jun-26	95.5%	94.8%				
	TRUST	Monthly	(0-4yrs) Percent of RHAs sent to LA in month within 6 months of previous assessment (City/County/Rutland)		Jun-26	100.0%	97.1%				
Operational Performance - 52 Week Waits	TRUST	Monthly (In Arrears)	Community Paediatrics - assessment waits over 52 weeks - No of waiters	0	May-26	7684	7604		F	H	
	TRUST	Monthly (In Arrears)	Community Paediatrics - assessment waits over 52 weeks - Longest waiter (weeks)		May-26	229	225				
	TRUST	Monthly	Community Paediatrics Treatment (excl ND) - No of waiters	0	Jun-26	13	25		F	L	
	TRUST	Monthly	Community Paediatrics Treatment (excl ND) - Longest waiter		Jun-26	82	112				
	TRUST	Monthly	All Neurodevelopment (inc CAMHS, SALT, PAEDS) - Treatment waits - No of waiters	0	Jun-26	1578	1544		F	H	
	TRUST	Monthly	All Neurodevelopment (inc CAMHS, SALT, PAEDS) - Treatment waits - Longest waiter (weeks)		Jun-26	233	291				
	TRUST	Monthly	CAMHS - Treatment waits (excl ND) - No of waiters	0	Jun-26	62	53		F		
	TRUST	Monthly	CAMHS - Treatment waits (excl ND) - Longest waiter (weeks)		Jun-26	73	75				
	TRUST	Monthly	All LD - Treatment waits - No of waiters	0	Jun-26	0	3		?		
	TRUST	Monthly	All LD - Treatment waits - Longest waiter (weeks)		Jun-26	51	56				
	TRUST	Monthly	Children's Physiotherapy - No of waiters	0	Jun-26	0	0		F	L	
	TRUST	Monthly	Children's Physiotherapy - Longest waiter		Jun-26	44	40				
	TRUST	Monthly	Audiology - No of waiters	0	Jun-26	0	0		?		
	TRUST	Monthly	Audiology - Longest waiter		Jun-26	49	46				
	TRUST	Monthly	Adult Eating Disorders Community - Treatment waits - No of waiters	0	Jun-26	1	3		?	L	
	TRUST	Monthly	Adult Eating Disorders Community - Treatment waits - Longest waiter (weeks)		Jun-26	57	57				

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

FYPCLDA	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
	>=95%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	50.0%	85.7%	100.0%	100.0%	66.7%	100.0%
No of Referrals		2	3	3	4	5	1	3	10	4	1	3	1

Mean	Lower Process Limit	Upper Process Limit
78.9%	13.0%	145.0%



Trajectory graph to be inserted here

Analytical Commentary

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

Operational Commentary

Actions	Timescales	Consequences	RAG
Monthly review PTL in place supported by the Business Team, in addition to service led daily PTL's.	TBC	Early intervention where children at risk of breaching target so improving adherence to KPI	

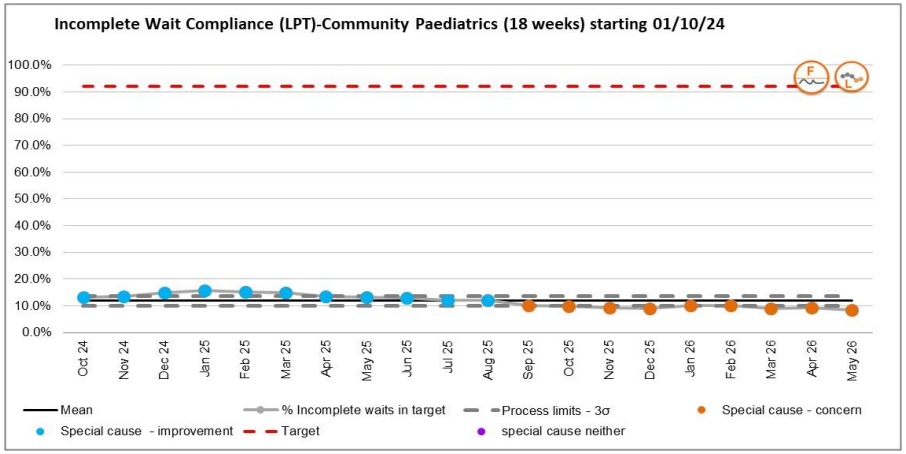
Achievements

Target achieved for 8 out of last 10 months.

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

FYPCLDA	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
	>=92%	13.0%	12.0%	10.2%	9.8%	9.3%	9.0%	10.1%	10.0%	9.1%	9.4%	8.3%	8.1%
No of Referrals		286	290	137	215	295	226	278	299	377	446	176	191

Mean	Lower Process Limit	Upper Process Limit
11.6%	10.0%	13.0%



Trajectory graph to be inserted here

Analytical Commentary

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

Operational Commentary

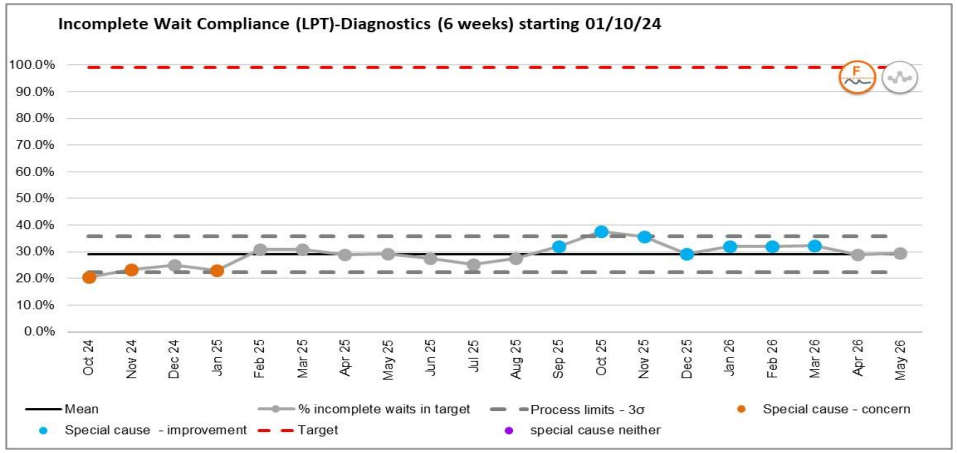
Actions	Timescales	Consequences	RAG
Commence capacity and demand work	Jun-26	Understanding of current capacity and demand and identification of potential areas for improvement	Complete
Pathway review- workshop with NHFT	Jun-26	Shared learning and opportunities for improvement	Complete
Exploration of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

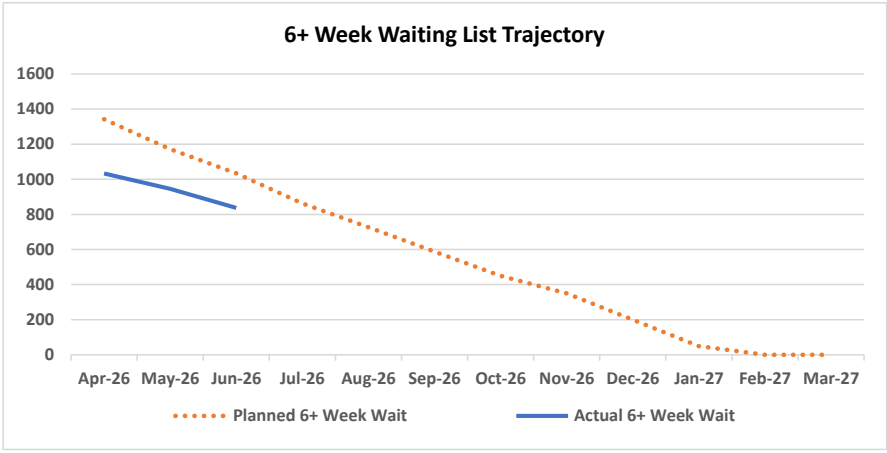
Achievements

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

FYPCLDA	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
	>=99%	27.5%	25.3%	27.5%	32.0%	37.6%	35.7%	29.2%	32.0%	32.0%	32.4%	28.8%	29.4%
No of Referrals		243	206	201	246	271	205	166	238	255	292	243	179

Mean	Lower Process Limit	Upper Process Limit
29.1%	22.0%	36.0%





Analytical Commentary

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

Operational Commentary

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

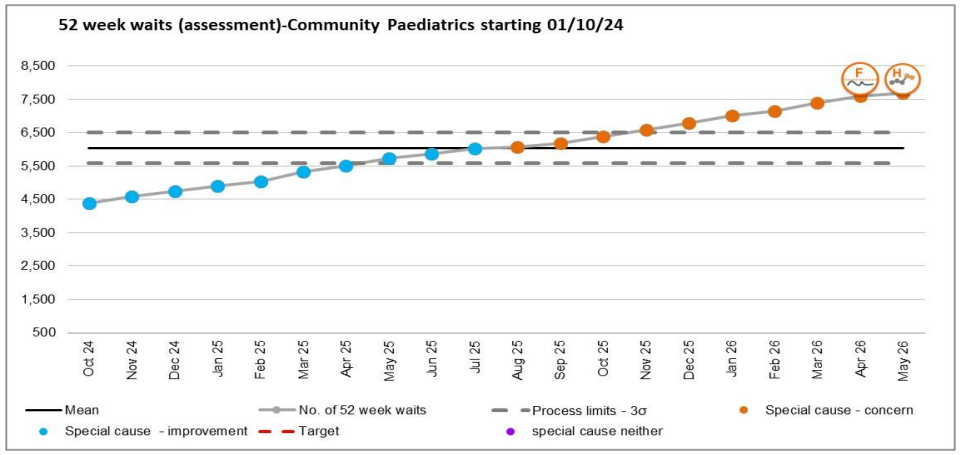
Achievements

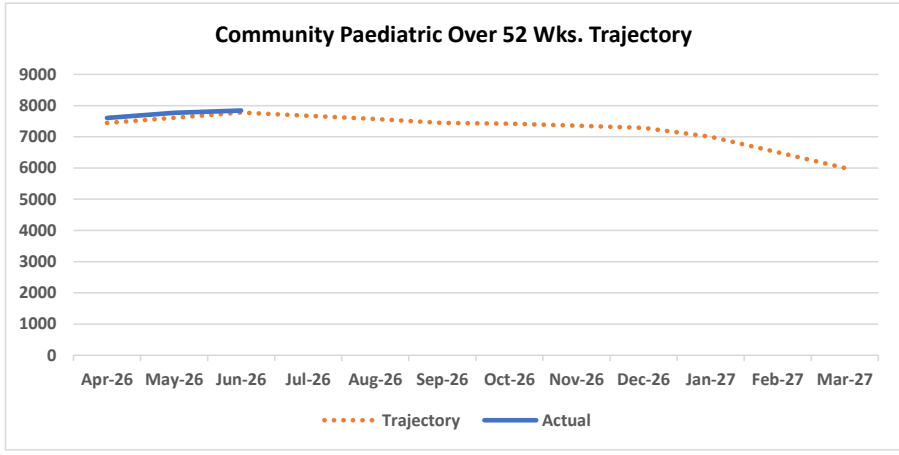
No +52 week waits for past 2 months.

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

FYPCLDA	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
	0	5858	6022	6067	6182	6380	6585	6782	7003	7154	7385	7604	7684

Mean	Lower Process Limit	Upper Process Limit
6046.5	5585.62	6507.38





Analytical Commentary

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

Operational Commentary

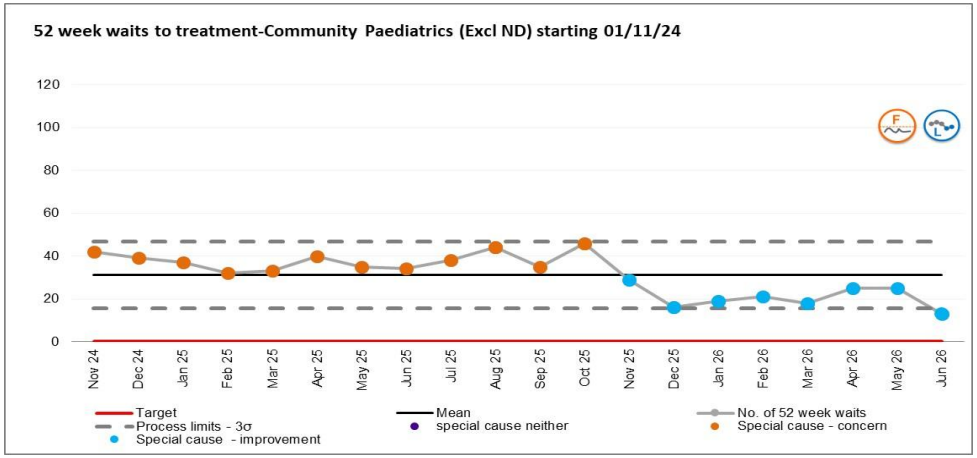
Actions	Timescales	Consequences	RAG
Commence of capacity and demand work	Jun-26	Understanding of current capacity and demand and identification of potential areas for improvement	Complete
Pathway review- workshop with NHFT	Jun-26	Shared learning and opportunities for improvement.	Complete
Exploration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

Achievements

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

FYPCLDA	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
	0	38	44	35	46	29	16	19	21	18	25	25	13

Mean	Lower Process Limit	Upper Process Limit
31.1	15.51	46.59



Trajectory graph to be inserted here

Analytical Commentary

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

Operational Commentary

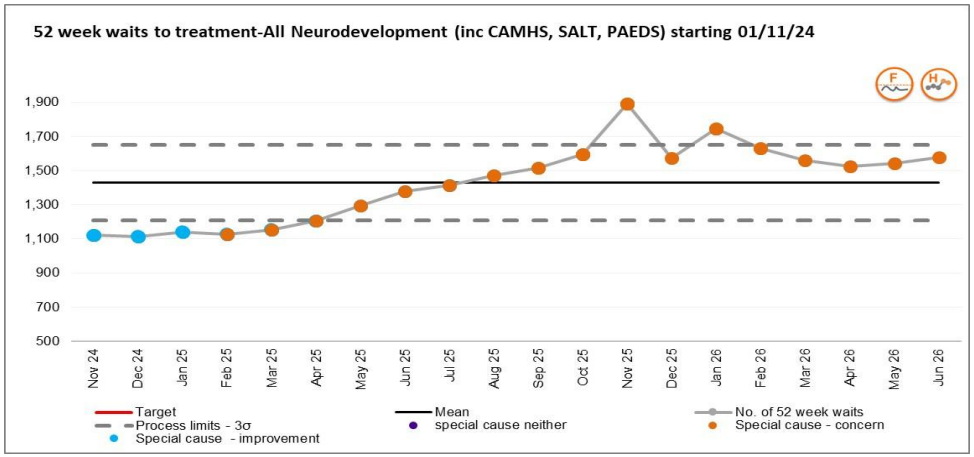
Actions	Timescales	Consequences	RAG
Review waiting list to ensure all patients are correctly categorised by wait type.	Jul-26	Waits are correctly categorised ensuring patients appropriately supported. Reporting accurately reflects waits	
Completion of waiting list validation exercise to identify follow up and treatment waits.	Sep-26	Waiting list validated	
Establish an options appraisal for a single ND front door	Sep-26	Streamline service provision	

Achievements

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

FYPCLDA	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
	0	1415	1473	1518	1597	1893	1575	1747	1632	1562	1523	1544	1578

Mean	Lower Process Limit	Upper Process Limit
1429.6	1208.21	1650.89



Trajectory graph to be inserted here

Analytical Commentary

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

Operational Commentary

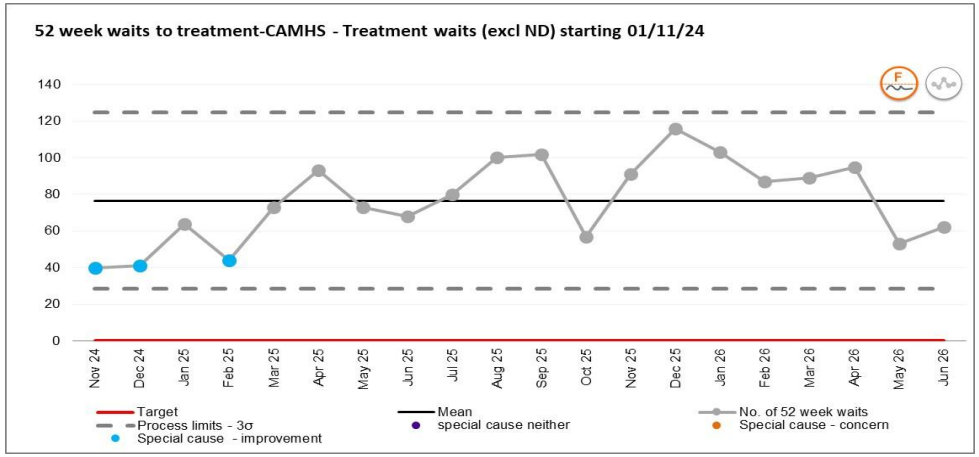
Actions	Timescales	Consequences	RAG
Recruitment and onboarding of non-medical prescriber for CAMHS	Sep-26	Increased capacity enabling increased throughput to enable waiting times to be reduced.	
Exploration of digital health contact - sign off EQIA	Jul-26	Support waiters and identify CYP who may no longer require assessment and clock can be stopped / patient discharged.	
Participation in piloting the ND profiling tool	Nov-26	Provide support at early identification stage, which may reduce demand for specialist assessment and treatment.	
Establish an options appraisal for a single ND front door	Sep-26	Streamline service provision	

Achievements

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

FYPCLDA	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
	0	80	100	102	57	91	116	103	87	89	95	53	62

Mean	Lower Process Limit	Upper Process Limit
76.6	28.39	124.71



Trajectory graph to be inserted here

Analytical Commentary

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

Operational Commentary

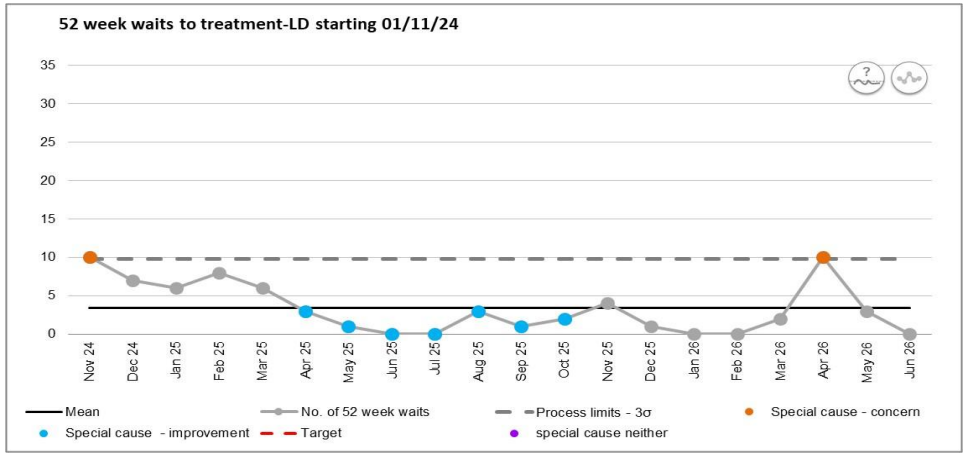
Actions	Timescales	Consequences	RAG
Deep dive into waiting lists to validate and confirm wait is for treatment not secondary follow up.	Jun-26	Confirmation of wait types to ensure CYP on appropriate lists and these are reported through the appropraite governance route	Complete
CAMHS Clinical and Operational Teams to explore ongoing enhanced validation of waits	Jun-26	Confirmation of waits and more accurate reporting of treatment waits and understanding of other potential delays in pathway.	Complete
Commencement of additional groups to increase capacity.	Jun-26	Reduction of long waiters as increased places available on groups	Complete
Validation of patients and capacity, including identification of requirement for urgent slots, based on current CYP needs.	Jun-26	Confirmation of true waiters and reduction in wait times.	Complete
Present paper at EMB in July 2026 to present findings of deep dives and identification of follow-up waits inappropriately reported.	Sep-26	Ensure waits are correctly recorded, reported and managed.	

Achievements

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

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

Mean	Lower Process Limit	Upper Process Limit
3.4	-3.09	9.79



Trajectory graph to be inserted here

Analytical Commentary

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

Operational Commentary

Actions	Timescales	Consequences	RAG
Validation of the wait type	Jun-26	To confirm wait type and ensure patient recorded on appropriate treatment pathway	
Develop AHP priority action plan (SaLT & OT)	Jun-26	Reduce number of waiters	
Deep dive into waits to ensure reasons for waits are understood.	Jun-26	To identify rationale and implement focused actions to reduce waits	

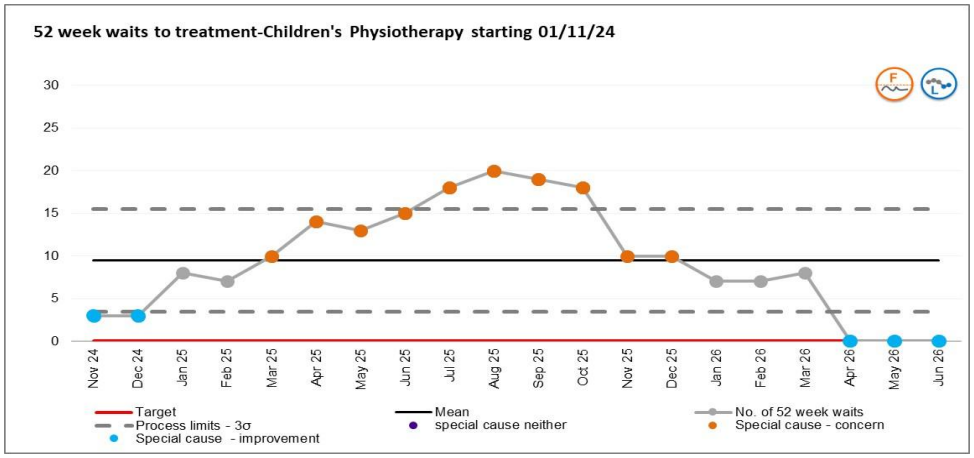
Achievements

Validation work has commenced and is showing a reduction in long waits. Current positon is 0 +52 week waits.

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

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

Mean	Lower Process Limit	Upper Process Limit
9.5	3.48	15.52



Trajectory graph to be inserted here

Analytical Commentary

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

Operational Commentary

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

Achievements

SPC Business Rules

Assurance: Failing

Assurance	Variation	Understanding the Icons	Business Rule
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.	Metric is expected to consistently Fail the Target and is showing a Special Cause for Concern. An exception page is required on the Board Performance Report to support actions and delivery of a performance improvement.
		Common Cause - no significant change. Assurance indicates consistently (F)ailing the target.	Metric is expected to consistently Fail the Target and is showing Common Cause variation. An exception page is required on the Board Performance Report to support actions and delivery of a performance improvement.
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.	Metric is expected to consistently Fail the Target and is showing a special cause variation for improvement. An exception page is required on the Board Performance Report to support actions and delivery of a performance improvement.

Assurance: Achieving

Assurance	Variation	Understanding the Icons	Business Rule
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates consistently (P)assing the target.	Metric is expected to consistently Achieve the Target and is showing a Special Cause for Concern. Metric to be monitored at Directorate Performance Reviews.
		Common Cause - no significant change. Assurance indicates consistently (P)assing the target.	Metric is expected to consistently Achieve the Target and is showing Common Cause variation. Metric to be monitored at Directorate Performance Reviews.
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (P)assing the target.	Metric is expected to consistently Achieve the Target and is showing a special cause variation for improvement. Metric to be monitored at Directorate Performance Reviews.

Assurance: Hit and Miss

Assurance	Variation	Understanding the Icons	Business Rule
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates the metric may achieve or fail the target due to random variation.	There is no assurance that the metric will consistently achieve the target and is showing a Special Cause for Concern. Metric to be monitored at Directorate Performance Reviews.
		Common Cause - no significant change. Assurance indicates the metric may achieve or fail the target due to random variation.	There is no assurance that the metric will consistently achieve the target and is in Common Cause Variation. Metric to be monitored at Directorate Performance Reviews.
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates the metric may achieve or fail the target due to random variation.	There is no assurance that the metric will consistently achieve the target and is showing a Special Cause for Improvement. Metric to be monitored at Directorate Performance Reviews.

R

Leicestershire Partnership NHS Trust

Alert, Advise and Assure Highlight Report

Charitable Funds Committee, 23 June 2026

Meeting Chair and Report Author - Faisal Hussain

Quorate Y

Policies and expiry date:

ALERT: Alert to matters that need the Board's attention or action, eg areas of non-compliance, safety or threat to the Trust's strategy				
Agenda Item:	**Reference:**	**Lead:**	**Description:**	**BAF Ref**
None				

ADVISE: Advise the Board of areas subject to on-going monitoring or development or where there is negative assurance				
Agenda Item:	**Reference:**	**Lead:**	**Description:**	**BAF Ref**
Matters Arising/Action Log	CFC/26/018	Faisal Hussain	We have completed our reviews to understand what the Leicestershire and Rutland Mental Health Wellbeing fund (£500) was for and where it came from. As that process has concluded, we have no further information, but we believe all requirements around the funding & its use would have been adhered to at the time it was given.	
Matters Arising/Action Log	CFC/26/018	Faisal Hussain	The Committee approved the fundraising activity for the dementia friendly environments appeal in principle and is happy for the fundraising drive to commence. The Board will then need to approve the expenditure of the funds raised as the values will exceed committee delegated approval limits.	

ASSURE: Inform the Board where positive assurance has been received				
Agenda Item:	**Reference:**	**Lead:**	**Description:**	**BAF Ref**
Review of Charitable Funds Risk Register	CFC/26/019	Sharon Murphy	The Committee are aware of the one risk, related to cash balances which exceed the amount of cover available under the Financial Services Compensation Scheme (FSCS) limit. We have minimised this risk by moving some of the cash into the new Cazenove account. The committee approved the risk register.	
Review of Fundraising Strategy and Annual Priorities	CFC/26/020	Magdalena Korytkowska	The Committee reviewed and agreed with the Fundraising Strategy and Annual Priorities.	
Approval of Investment Strategy	CFC/26/021	Sharon Murphy	The Committee approved the investment strategy refresh and are happy to review the investment strategy ahead of any tendering exercise or as part of our consideration of our option to extend, rather than reviewing the strategy annually.	
Annual review of the effectiveness of the Committee, review of the Terms of Reference, approval of the annual work plan and review of Committee membership for submission to AAC	CFC/26/022	Faisal Hussain	The Committee noted the review of the effectiveness of the Committee and are happy to confirm a high level of assurance over the effectiveness of the Charitable Funds Committee during 2025/26.	
Quarterly Finance Report including Pipeline Report, investment	CFC/26/009	Jackie Moore	• The overall fund balance for Quarter 4 closed at £2.67m. This is an increase of £257k (11%) since the start of the financial year. • Expenditure totals £528k, with the majority of spend supporting patient wellbeing & amenities (£211k) and charity running costs (£184k).	

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
performance & legacies			• The balance sheet shows that the overall funds increased by £257k during the year. • Fixed asset investments have increased by £95k due to the improvement in the investment return. • The closing cash balance at the end of the year is £661k, which is an increase of £169k since the start of the year. This is due to a £250k legacy receipt.	

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding				
Agenda Item:	**Reference:**	**Lead:**	**Description:**	**BAF Ref**
Promoting Charitable Funds and Delivering the Strategy: Fundraising Managers' Report	CFC/26/023	Magdalena Korytkowska	We have released the spring newsletter and the group volunteering opportunities document. Upcoming publications include the summer newsletter in July 2026 and the impact report for the Annual General Meeting (AGM). The Raising Health annual report summary is included as part of LPT's annual report and will be presented at the AGM.	
Promoting Charitable Funds and Delivering the Strategy: Fundraising Managers' Report	CFC/26/023	Magdalena Korytkowska	We have been approached to support the North East London NHS Trust to share our best practice with their charitable funds team as the leadership has moved to a similar arrangement to LPT.	