

Public Trust Board – 29 September 2026

Declarations of Interest Report (2026/27)

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 – son's partner is a police officer in Northants police force	7002	21.08.26
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

Current Declarations:	Declaration Reference	Date Interest Arose
Outside Employment – NHFT – Joint CEO	4068	14.11.23
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: Josie Spencer, Non-Executive Director
Date of Annual Declaration: 11 May 2026

Current Declarations:	Declaration Reference:	Date Interest Arose:
Loyalty Interests – Stoke Golding Parish Council (Councillor)	6988	05.08.26
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



Current Declarations:	Declaration Reference:	Date Interest Arose:
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 – Northamptonshire Healthcare NHS Foundation Trust	3137	01.04.22

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 29 September 2026
Paper sponsored by:	Kate Dyer, Director of Governance and Risk
Paper authored by:	Sonja Whelan, Corporate Governance Coordinator
Date submitted:	17 September 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:	☐ Technology ☐ Healthy communities ☐ Responsive ☐ Including everyone ☐ Valuing our people ☒ Efficient 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

LPT Trust Board

Minutes of the Public Trust Board meeting held 28 July 2026 at 9.30am via Microsoft Teams

Present:

Faisal Hussain, Interim Group Chair
 Josie Spencer, Non-Executive Director/Deputy Chair (Chairing the meeting)
 Melanie Hall, Non-Executive Director/Interim Senior Independent Director
 Hetal Parmar, Non-Executive Director
 Liz Anderson, Non-Executive Director
 Angela Hillery, Group Chief Executive
 Jean Knight, Managing Director/Deputy Chief Executive
 Sharon Murphy, Chief Finance Officer
 Bhanu Chadalavada, Chief Medical Officer
 Linda Chibuzor, Group Chief Nurse
 Tim Harrison, Non-Executive Director

In Attendance:

Sam Leak, Executive Director of Community Health Services, Families, Young People and Children's Services, Learning Disabilities and Autism
 Sarah Willis, Group Chief People Officer
 David Williams, Group Executive Director of Strategy and Partnerships
 Paul Sheldon, Group Chief Commissioning Officer
 Anne Rackham, Group Chief Delivery and Integration Officer
 Kate Dyer, Director of Governance and Risk
 Chris Skelton, Associate Non-Executive Director
 Andres Patino (deputising on behalf of Tanya Hibbert)

TB/26-7/022	Apologies for Absence Apologies for absence were received from Tanya Hibbert. Andres Patino was welcomed to the meeting.
TB/26-7/023	Service Presentation: Early Language Support for Every Child (Directorate of Families, Young People and Children's Services, Learning Disabilities and Autism) Sam Leak introduced the service presentation which would focus on Early Language Support for Every Child (ELSEC). The team presenting included Janet Harrison (Head of Service), Clare Hazeldine (Speech and Language Therapy Clinical Lead), Anne Woodward (Speech and Language Therapist), Nicki Ryan (Therapy Support Worker - speech, language and communication), Alice Morley (Business Support Officer). Janet Harrison outlined the extensive partnership arrangements supporting ELSEC which included Leicestershire Partnership NHS Trust (LPT), the three local authorities; predominantly via their education and Special Educational

	Needs and Disabilities (SEND) teams, and the three local SEND Parent Carer Forums, whose contribution had been invaluable. Collaboration had also extended to early years settings and mainstream primary schools to develop a more innovative and responsive approach to emerging speech, language and communication needs. The work had been overseen by a system wide ELSEC Steering Group. The work began with the publication in March 2023 of the SEND and Alternative Provision Improvement Plan, which followed a national consultation on SEND reform. The plan identified ten priority ‘test and learn’ areas for reform, one of which focused on improving access to speech, language and communication support. Given that speech, language and communication needs represent one of the most prevalent SEND categories, the Department for Education (DfE) and NHS England (NHSE) had asked local areas to test preventative and early intervention approaches to language support. It was noted that speech and language difficulties were also commonly associated with early neurodevelopmental needs, an area of significant system priority. Nine SEND Change Programme Partnerships had been established nationally to test the reforms. Leicester, Leicestershire and Rutland (LLR) had been selected as the East Midlands SEND Change Programme Partnership and had received £1 million in transformation funding over approximately two and a half years and the ELSEC Pathfinder commenced in early 2024. The programme adopted a balanced system, population health approach, underpinned by a strong evidence base. Universal support focused on enabling children to develop communication skills through family, nursery and school environments. Targeted support provided evidence-based early intervention when needs first emerged, while specialist services were reserved for children with more complex communication needs, estimated to comprise around 10% of the child population. Local data from 2024 had indicated that up to 35% of children were being referred for speech and language support, highlighting the need for a preventative and graduated model of intervention. Looking ahead, it was advised that the programme had fulfilled the objectives set out within the original Memorandum of Understanding and was currently participating in the national evaluation across the nine Pathfinder sites, with findings expected to be published in the autumn. Attention had now turned to securing the programme's sustainability beyond the end of existing change programme funding in autumn 2026 and attention had shifted to the Government's Schools White Paper, <i>Every Child Achieving and Thriving</i> (published February 2025). The White Paper set out a 10-year programme of SEND reform and associated investment in inclusion. Working alongside the three local authorities, LLR SEND reform plans had been developed and approved by the DfE and NHSE. These plans included continuation of the ELSEC model to March 2029, supported by new SEND reform funding. Additional SEND reform funding had been secured through a newly introduced ‘Expert at Hand’ model. This funding would not only support the transfer of current staff and activity into the new arrangement but would also provide significant investment in additional posts to strengthen universal and targeted
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	work. In total, approximately £1.7m per annum had been secured for LPT over the current year and the following two years. A video was then shown of Emma Marfleet, Clinical Team Leader for ELSEC, presenting a case study illustrating the impact of the ELSEC pathway on a young child with delayed language development. The case demonstrated how early identification, family-centred support and coordinated intervention between health visitors, speech and language therapy staff, nursery staff and parents had enabled significant improvements in the child's communication skills within a short period. The child had benefited from timely access to support, avoiding a potentially lengthy wait for specialist intervention and reducing the risk of adverse impacts on school readiness and future educational outcomes. The Chair thanked the presenters for a comprehensive and insightful presentation and welcomed the significant improvement achieved in reducing waiting times for children's speech and language support through the ELSEC model. Questions/comments were then invited. During discussion, members commended the programme's whole system and population health approach, noting the strength of partnership working across health, education, local authority and family support services. The Board recognised the importance of the programme's contribution to the wider SEND and neurodevelopmental agenda, particularly through its emphasis on prevention, early intervention and reducing the need for more specialist support at a later stage. Members sought assurance regarding opportunities to share learning from the programme more widely, including through national work relating to neurodevelopmental need and prevalence studies. In response, it was noted that longer term evaluation opportunities were being explored with academic partners and that the training offer was being further integrated with local authority workforce development arrangements to provide a more streamlined approach for schools and education settings. Discussion also explored how successful outcomes were measured for children supported through the programme. The Board heard that improved communication skills were fundamental to school readiness, emotional wellbeing, social development, educational attainment and longer-term life opportunities. Members noted that timely support to develop speech, language and communication skills could have a significant positive impact on children's future outcomes and quality of life. The Board welcomed the positive impact demonstrated through the programme and expressed its appreciation to the ELSEC team for their work.
TB/26-7/024	Questions from the Public (verbal) There were no public questions.
TB/26-7/025	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/26-7/026	Minutes of the previous public meeting held 26 May 2026 (Paper B) The minutes were approved as an accurate record of proceedings. Resolved: The Board approved the minutes.
TB/26-7/027	Matters Arising (Paper C) There were no outstanding actions.
TB/26-7/028	Trust Board Workplan 2026/27 (Paper D) The Trust Board Workplan was presented for information. No questions or queries were received.
TB/26-7/029	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 June to July 2026. The following points were highlighted: • Attended NHS ConfedExpo - a number of informative presentations highlighted the role of digital innovation in improving patient and service user outcomes and experiences. It was particularly encouraging to note the widespread recognition of the need to ensure that individuals are not excluded as digital solutions continue to be developed and implemented. • Attended the Trust Long Service Awards event on 9 July 2026 - which celebrated the dedication and significant contributions of colleagues across the Trust. • Opened the joint LPT and NHFT South Asian Heritage Month event held virtually across both organisations - the event provided an opportunity to hear inspiring personal stories from colleagues, reflecting on their journeys, experiences and valuable contributions to the NHS. • Updated on the Fit and Proper Persons Test, noting that the process had been successfully completed and submitted within the required deadline. Thanks were expressed to colleagues for their support throughout the process. • All NED appraisals, with the exception of one, had been completed, with the final appraisal expected to be finalised shortly. Discussion followed and members highlighted the enthusiasm and creativity demonstrated by staff participating in the forthcoming Trust innovation event. Also, feedback from recent service visits reflected the diversity of the communities served by the Trust, the inclusive approach of frontline teams and a culture in which staff felt able to raise issues and suggestions for improvement openly and constructively. Resolved: The Board received this report for information.

TB/26-7/030	Chief Executive's Report (Paper F) Angela Hillery presented this report which provided an update on current national issues and policy developments that affect the Trust. Key matters highlighted included:- • Appreciation for the efforts of staff and volunteers in responding to periods of extreme heat, noting their flexibility, innovation and commitment in maintaining services during challenging conditions. • Progress made by Northamptonshire Healthcare NHS Foundation Trust in achieving Advanced Foundation Trust and Integrated Healthcare Organisation status, and the continued opportunities for shared learning across the Group. It was noted that LPT remained eligible for consideration within the national pipeline for Advanced Foundation Trust status. • Recent national changes in government leadership and the appointment of a new Secretary of State for Health and Social Care. The development of a cross government mental health strategy was welcomed, and the Trust's intention to contribute to the national call for evidence was noted. • Activities undertaken as part of South Asian Heritage Month, including an event hosted by the Reach Network, which provided an opportunity for colleagues to share experiences and celebrate the contribution of staff from South Asian communities. The co-chair of NHFT REACH staff network joined too and contributed to the session. Previously, the co-chair of LPT and colleagues had joined an evening REACH event in Northamptonshire. Tim Harrison sought an update regarding benchmarking data associated with access to crisis care through NHS 111 and asked whether analysis of the available data had been completed. Angela Hillery advised that the information was not immediately available but would be provided post meeting. The Chair highlighted the publication of the independent investigation into maternity and neonatal services and noted that, whilst LPT did not provide those services, there were broader lessons relating to quality, safety, culture, patient engagement and listening to service users and families. It was noted that the Quality and Safety Committee will review the relevant findings and feedback will be provided to the Board in due course.
TB/26-7/031	Managing Director's Report (Paper G) Jean Knight presented this report which provided an update on current local developments since the last Board meeting. Key points highlighted were: • The Trust's achievement as the second highest performing organisation nationally for the delivery of physical health checks for people with serious mental illness, with performance exceeding the national target at approximately 76%. This was a significant achievement and a demonstration of the Trust's commitment to improving the physical health outcomes of people with serious mental illness. • The Trust's success in being one of only five community and mental health trusts nationally to achieve full marks in the Patient Led Assessments of the Care Environment (PLACE) for cleanliness. The contribution of the Estates team and the positive outcome was welcomed.

	• A range of staff engagement, inclusion and recognition activities that had taken place since the previous report, including South Asian Heritage Month, Pride Month, Volunteers' Week, Learning Disabilities Week, and the presentation of further International Daisy Awards in recognition of outstanding staff contributions. • Additional information provided in relation to Mental Health Awareness Week, including community engagement activity undertaken in Hinckley and Bosworth. The Board noted the proactive approach taken by staff in reaching into local communities and promoting mental health awareness and support. • The recent announcement regarding local government reorganisation across Leicester, Leicestershire and Rutland, under which two new unitary authorities would be established from April 2028 was noted. This represented a significant system change and the Trust was actively engaging with partners to support the transition and assess any implications for service delivery. Resolved: The Board received this report for information.
TB/26-7/032	Environmental Analysis (verbal) Angela Hillery provided a verbal update on a number of partnership and system developments and advised that Dr Claire Fuller, who leads nationally on neighbourhood health and care policy, had recently visited the Leicester, Leicestershire and Rutland (LLR) Integrated Care Board cluster to gain a greater understanding of local neighbourhood working arrangements. The Trust had participated in the visit and contributed to discussions regarding system wide approaches to delivering integrated care. The Trust continued to be increasingly recognised and sought out nationally to contribute to policy development, working groups and sector learning. This was considered to reflect both the strength of the organisation and the expertise of its clinical and operational teams. It was noted that the Trust had recently been invited to share and promote its work on assertive outreach services at a regional forum, recognising that LPT was one of a relatively small number of organisations nationally providing a dedicated assertive outreach model. An update was then provided from the most recent Mental Health Collaborative meeting across LLR where the impact of neighbourhood mental health cafes across the LLR system was discussed. It was noted that:- • Forty neighbourhood café sessions were delivered each week by fifteen partner organisations. • Between April and June, the cafés recorded 2,810 contacts. • Analysis indicated that approximately 1,950 of those contacts may otherwise have sought support through more urgent services, including emergency departments, crisis services or primary care. • The data provided encouraging evidence of the value of early intervention, prevention and partnership working in supporting people closer to their communities and reducing demand on urgent care services. Appreciation was expressed for the commitment of partner organisations, the strong attendance and continued engagement, despite ongoing operational pressures.

	David Williams reflected on Dr Fuller's visit and noted that, having visited 22 of the 25 systems participating in the national programme, she had been able to provide valuable insight and challenge. Discussion had focused on reducing unwarranted variation, particularly within primary care, and the impact this could have across wider community and mental health services. The importance of continuing to strengthen partnership working was emphasised, with the ELSEC programme cited as a positive example of effective cross-system collaboration. The challenge of balancing increasing demand for urgent and emergency care with the delivery of preventative approaches was noted and members welcomed the observation that mental health had featured more prominently during the LLR neighbourhood health discussion than in any of Dr Fuller's previous system visits, which was considered a positive reflection of the system's commitment to mental health and neighbourhood-based working.
TB/26-7/033	Group Board Assurance Framework (Paper H) Kate Dyer presented this report and reminded members that the Board Assurance Framework (BAF) operated across the Group arrangement with Northamptonshire Healthcare NHS Foundation Trust and was aligned to the Group Strategy. Whilst ownership and oversight of the framework sat with the Group Trust Board, it remained important that the individual Trust Boards received regular updates, as the framework informed the Trust's risk profile and supported discussion of strategic risks and assurance. It was noted that actions within the framework predominantly related to Group-wide programmes of work or initiatives being delivered in a coordinated manner across both organisations. Detailed information regarding each strategic risk was included within the accompanying papers. The current risk profile comprised four risks rated as red, relating to access, safety, workforce and funding, together with five amber rated risks and three green rated risks. It was noted that risk ratings reflected not only the likelihood and impact of a risk materialising, but also the effectiveness of existing controls and the strength of available assurances. Sharon Murphy noted that, in relation to BAF 11 (delivery of the 2026/27 financial plan), the actions relating to run-rate reporting and CIP identification, which had been recorded as complete for NHFT, had also been completed for LPT but had not been reflected within the report due to paper submission deadlines. Liz Anderson sought assurance in relation to BAF06 (Emergency Preparedness), noting the increasing risks associated with climate change and environmental events, including flooding and extreme weather. She asked whether appropriate planning arrangements were in place to respond to such incidents. In response, Jean Knight assured the Board that comprehensive emergency preparedness arrangements were in place across Leicester, Leicestershire and Rutland through the Local Resilience Forum, including flood response plans and contingency arrangements for a wide range of environmental and other emergency events. Melanie Hall advised that all BAF risks received detailed scrutiny through the Level 1 Committee structure and that the Finance and Performance Committee

	had scheduled a deep dive review of BAF12, one of the newer risks added to the framework during the year, at its August meeting. Also, in recognition of the Committee's oversight responsibilities for BAF01 (digital), reporting on cyber security had been strengthened within the overall digital performance and assurance reporting arrangements. With regard to BAF07 (culture, staff experience and wellbeing), Sarah Willis advised that, whilst the Trust continued to demonstrate strong performance in areas including staff survey results, cultural leadership and inclusion, the external NHS environment remained subject to ongoing change and challenge; financial pressures, organisational transformation and continued service change had the potential to affect staff experience, wellbeing and organisational culture. Although many previously identified gaps had been addressed, it was recognised that the work required to maintain and further develop a positive staff experience was continuous. As a result, the risk remained appropriately rated to reflect the ongoing need for focus and mitigation.
TB/26-7/034	Audit and Risk Committee AAA Report: 12 June 2026 (Paper I) Hetal Parmar presented this report and drew attention to the following key points:- • An updated Risk Management Framework was received which had been amended to reflect Group working arrangements and the introduction of shared roles across the Group structure. • The Governance and Risk Report was also received, and it was noted that all Trust policies remained in date and continued to be effectively managed through the established review schedule. Ongoing work was being undertaken to align policy management processes with those of NHFT, supporting greater consistency across the Group and the development of common policies across both organisations would help to promote a consistent colleague experience and support the delivery of high-quality services. • A number of annual governance and financial matters had been considered including the Standing Financial Instructions (SFIs), the Scheme of Delegation, the Trust's Going Concern assessment and the Annual Accounts and associated governance documentation. • The significant effort undertaken by teams across the organisation to support these processes and the quality of the reports was acknowledged. • In relation to waivers and losses, the Committee had undertaken its annual detailed review and noted that the number of waivers had reduced. Whilst a small number of losses had been reported, the overall position remained positive and well controlled. • A number of positive assurance findings arising from both internal and external audit activity was welcomed. The assurances received reflected the continued commitment of colleagues across the organisation and contributed directly to both staff experience and the quality of patient care. Resolved: The Board received this report for information and assurance.
TB/26-7/035	Adoption of the Lord Mann Recommendations (Paper J)

	Sarah Willis presented this report on the Trust's response to the recommendations arising from the Lord Mann Review and explained that the outcome of the Review had been received in early June 2026 with the Trust being required to implement the actions set out within the accompanying letter. A Trust wide communication had been issued and a detailed mapping exercise had been undertaken to assess compliance against the recommendations, the results of which were included within the report. Significant progress had already been made against many of the required actions and much of the work aligned with existing programmes of activity, including the Trust's Together Against Racism strategy and the wider Equality, Diversity and Inclusion (EDI) agenda. Sarah Willis recommended that the Board formally adopt the recommendations set out within the report, including the seven principles of anti-racism, the definition of antisemitism and the definition of anti-Muslim hostility. Oversight and delivery of the actions would be led by Sarah Willis as Senior Responsible Officer through the Together Against Racism and EDI workstreams, with assurance provided through the Joint People and Culture Committee. It was noted that relevant matters relating to patient care and safety would be considered through the appropriate quality governance arrangements. The Trust was required to formally confirm to NHS England by 31 July 2026 that it had adopted the recommended principles and definitions. During discussion, it was noted that whilst significant progress had been made through the Trust's Together Against Racism programme and wider Equality, Diversity and Inclusion initiatives, experiences of racism and discrimination continued to occur within the NHS and society more broadly. The importance of maintaining a culture in which staff felt able to raise concerns through a range of mechanisms was emphasised, including Freedom to Speak Up, staff networks, staff surveys, line management arrangements and other engagement channels. The Trust continued to monitor intelligence from a variety of sources to understand staff experiences and inform improvement activity. Resolved: The Board approved the recommendations set out in the report and supported formal confirmation of their adoption to NHS England.
TB/26-7/036	Quality and Safety Committee AAA Report: 19 May 2026 and 16 June 2026 (Paper K) Josie Spencer presented this report and highlighted the following key points:- • No new alerts had been raised, although the existing alert relating to waiting times remained subject to ongoing oversight. • An update regarding increased referrals into Community Health Services, particularly within the City West locality was received - further work was being undertaken with Primary Care Networks to understand the drivers of demand. • Learning from Deaths remained under review, with a number of cases awaiting consideration through the established review process.

	- Assurance had been received through the Mental Health Act Annual Report, which had subsequently been approved by the Committee. - The Annual Safeguarding Declaration had been approved and published on the Trust website. - The Sexual Safety Annual Report had provided significant assurance regarding progress made against the Sexual Safety Charter during the previous year. - The Committee had recognised the Trust's strong performance in relation to physical health checks for people with serious mental illness. Resolved: The Board received this report for information and assurance.
TB/26-7/037	Safe Staffing Monthly Report (Paper L) Linda Chibuzor presented this report which provided a full overview of nursing safe staffing during the month of May 2026. The key points were highlighted as:- - An update was included on the inpatient nursing workforce matrix and associated safety indicators with accompanying scorecard information provided for assurance purposes. - Staffing arrangements continued to be monitored in line with National Quality Board standards and NHSE workforce safeguards guidance. Liz Anderson welcomed the assurance provided within the report and noted that staffing indicators remained broadly consistent with previous reporting periods. Referring to pressure ulcer incidents, she sought assurance regarding the management of patients who spent extended periods seated in chairs and whether this was considered within prevention arrangements. In response, Sam Leak advised that all patients had individualised care plans which specified requirements relating to mobility, time spent sitting out of bed and repositioning schedules, with care tailored to each patient's clinical needs. Linda Chibuzor further advised that, whilst staff actively supported and encouraged patients to follow agreed care plans, there were occasions where patients chose not to follow clinical recommendations, including declining to return to bed. In such circumstances, staff continued to support patients safely; however, this could increase the risk of pressure ulcers developing despite appropriate preventative measures being in place. Angela Hillery sought clarification regarding the continuing vacancy levels for Healthcare Support Workers, noting that recruitment campaigns often attracted strong levels of interest. Sarah Willis explained that, whilst recruitment pipelines remained positive, vacancy levels continued to be influenced by staff turnover and ongoing recruitment challenges in certain areas, particularly community and more remote settings. She advised that workforce supply continued to be closely monitored and targeted recruitment activity remained in place to address vacancies. Resolved: The Board received this report for information and assurance.
TB/26-7/038	Patient Safety and Learning Assurance Report (Paper M) Linda Chibuzor presented this report which provided assurance of the efficacy of the incident management and Duty of Candour compliance processes. Incident

	reporting supporting this paper had been reviewed and refreshed to assure that systems of control continued to be robust, effective, and reliable thus underlining the commitment to continuous improvement of incident and harm minimisation. Key points were highlighted as:- • The Trust continued to demonstrate a positive reporting culture, with near misses, no-harm incidents and low-harm incidents being actively reported, reviewed and categorised to support organisational learning. • Incident reviews were supported through the Incident Review and Learning Group, which brought together colleagues from across directorates to identify immediate learning and improvement opportunities ahead of formal investigations. • Reported restraint incidents had increased slightly during May 2026 compared with the previous reporting period; however, this was considered reflective of a strong reporting culture rather than a deterioration in performance. Members were reminded that restraint was used not only in response to violence and aggression but also, where clinically appropriate, to support the safe delivery of care and personal care activities. The Chair sought clarification regarding the number of staff trained in the Systems Engineering Initiative for Patient Safety (SEIPS) investigation methodology and whether the current level of training was sufficient to support high-quality incident investigations. Linda Chibuzor advised that the Trust intended to continue expanding the number of staff trained in the SEIPS methodology. Increased training capacity would enable a wider range of staff involved in incidents to participate in reviews and facilitate more timely learning. The training programme had been well received across both organisations within the Group, with LPT colleagues also supporting delivery of training to NHFT staff. Liz Anderson welcomed the development of the training programme and highlighted the contribution of Tracey Ward in supporting the delivery of SEIPS training, including work with medical students to strengthen understanding of patient safety and human factors among future healthcare professionals. Resolved: The Board received this report for information and assurance.
TB/26-7/039	Freedom to Speak Up Annual Report 2025-26 (Paper N) Pauline Lewitt was in attendance to present this report. She highlighted that the report had been aligned to the Group THRIVE Strategy and reflected the links between Freedom to Speak Up activity and the Trust's wider culture and engagement agenda. Key points were highlighted as:- • Overall Freedom to Speak Up compliance remained high at 98.4%, although a slight reduction had been identified amongst bank staff and medical trainees. Work was underway with the relevant teams to address this. • The number of Freedom to Speak Up contacts continued to increase gradually over time, reflecting continued engagement with services. • Worker wellbeing remained the most frequently reported theme. This reinforced the importance of ongoing investment in staff wellbeing, leadership development and the creation of supportive workplace cultures.

	• Freedom to Speak Up Guardians continued to contribute to wider organisational culture initiatives, including the Our Future, Our Way programme, leadership development activity and cultural improvement work across the Trust. • Patient safety concerns raised through the Freedom to Speak Up process were escalated through established governance mechanisms and had informed improvements in areas including staffing arrangements, communication, training, documentation and multidisciplinary working. • Concerns relating to bullying, harassment and workplace behaviours continued to highlight the importance of maintaining respectful, inclusive and psychologically safe working environments, together with a continued focus on leadership behaviours and early intervention. • The Trust's Staff Survey results remained positive in relation to the People Promise theme 'We all have a voice that counts', with performance exceeding both the national average and benchmark comparator organisations. • Freedom to Speak Up activity continued to be closely aligned with other staff engagement initiatives, including Culture Cafés, Health and Wellbeing events and Equality, Diversity and Inclusion programmes, to support the development of an open and transparent organisational culture. • The Trust currently had 23 Freedom to Speak Up Champions in place, with further recruitment activity underway to increase coverage across the organisation. • The previous year's Speak Up Month had been successfully delivered across 29 sites, supported by Executive and Non-Executive Directors and colleagues from a range of teams. Increased visibility had resulted in greater staff engagement and confidence in speaking up. Plans were therefore in place to expand this year's programme, including extending activity to evening and weekend sessions. • The National Guardian's Office had closed in June 2026, with its functions transferring to NHSE. The implications of the change were being considered, however, the Freedom to Speak Up Guardian role would continue to form part of the NHS Standard Contract for 2026/27. • Actions arising from previous National Guardian's Office recommendations had largely been completed and the Trust's strategic and cultural improvement programmes continued to support the development of psychological safety and an environment in which staff felt confident to speak up. Jean Knight advised that the Executive Management Board had recently considered the number of Freedom to Speak Up Champions across the Trust and that directorates and enabling services were actively supporting efforts to expand the network and increase its reach across the organisation. She emphasised the importance of the staff voice to the Board and noted that Freedom to Speak Up represented a key mechanism through which staff feedback and concerns were heard, alongside other staff engagement channels. Jean Knight also expressed her appreciation to Pauline Lewitt and Chris Moyo, recognising the compassion, kindness and support they provided to colleagues across the Trust. Melanie Hall commended the clarity and quality of the report, noting that it provided both assurance regarding the effectiveness of Freedom to Speak Up
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	arrangements and valuable insight into staff experiences. She welcomed the successful implementation of the new Freedom to Speak Up system and praised the significant level of engagement undertaken across the organisation. Melanie Hall also noted the challenges of engaging with a geographically dispersed workforce and welcomed the team's continued visibility and reach. Sharon Murphy reflected positively on the previous year's Speak Up roadshows and the strong level of staff engagement observed during those events. Noting that the report demonstrated an increase in contacts following the roadshows, Sharon Murphy sought assurance regarding arrangements to maintain visibility and engagement throughout the year. In response, Pauline Lewitt advised that a programme of regular visits to services and teams was undertaken throughout the year, supplemented by attendance at team meetings, development events and other engagement opportunities. She noted that direct engagement with staff remained one of the most effective ways of raising awareness of Freedom to Speak Up arrangements and encouraging colleagues to seek support where required. Faisal Hussain thanked Pauline Lewitt and Chris Moyo for the quality of the report and their ongoing work as Freedom to Speak Up Guardians, noting the positive impact they had across the organisation and the strong relationships they have established with staff. He emphasised that promoting Freedom to Speak Up was a responsibility shared across the organisation, including by Executive and Non-Executive Directors, and highlighted the importance of continuing to encourage staff to raise concerns confidently and safely. Referring to worker wellbeing as the most frequently reported concern, Faisal Hussain queried whether further analysis could be undertaken to understand whether staff raising such concerns were aware of, and accessing, the range of health and wellbeing support available within the Trust, suggesting that this may help identify areas where support messages were not fully reaching staff. In response, Pauline Lewitt explained that worker wellbeing concerns were recorded within a broader categorisation framework, enabling underlying themes such as culture, leadership, policy and environment to be identified. She advised that staff raising wellbeing concerns were routinely signposted to appropriate support services and confirmed that more detailed information was collected than was presented within the summary report. Pauline acknowledged that further consideration could be given to identifying potential gaps in awareness and uptake of support services, including through comparison with insights from the National Staff Survey. Liz Anderson commended Pauline Lewitt for her leadership in promoting Freedom to Speak Up, including her work with medical students, and highlighted the importance of demonstrating the outcomes and learning arising from concerns raised. She also discussed the challenges of interpreting speaking up data and sought clarification on the extent to which anonymous reports could be analysed by professional group. Pauline advised that the anonymous reporting tool introduced in April enabled individuals to voluntarily record their work area and professional group whilst maintaining anonymity, providing greater insight than other anonymous reporting routes, which generally do not capture such information.
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	Bhanu Chadalavada supported the points raised by Liz Anderson and noted that, nationally, medical staff were less likely to raise concerns through Freedom to Speak Up mechanisms. He advised that a range of initiatives were in place to encourage speaking up within the medical workforce, including exception reporting, GMC surveys, induction programmes and targeted engagement with new cohorts of doctors. Bhanu explained that Pauline Lewitt and Chris continued to promote Freedom to Speak Up through induction activities and that arrangements were being developed to provide protected time within medical rotas to support early engagement. He emphasised the importance of embedding a speaking up culture from the earliest stages of professional development, including during medical student training, and noted that a number of actions were underway to strengthen this approach. The Board noted the update and assurance provided. Tim Harrison sought assurance that staff with limited access to line management arrangements, or reduced day-to-day contact with managers, were receiving equal exposure to Freedom to Speak Up information and support. In response, Pauline Lewitt advised that the continued development of the Freedom to Speak Up Champion network was intended to increase visibility and accessibility across the organisation, providing staff with a wider range of routes through which to seek advice or raise concerns. Hetal Parmar welcomed the work of the Freedom to Speak Up team and reflected positively on feedback received during recent service visits and staff engagement events. He noted both the breadth of issues raised through the Freedom to Speak Up process and the team's responsiveness in supporting colleagues. He also reported that staff appeared increasingly aware of the Freedom to Speak Up service and the routes available to them should they wish to raise concerns, which he regarded as a positive indication of the team's visibility and engagement across the Trust. The Chair thanked Pauline Lewitt, Chris Moyo and the wider team for their continued work and acknowledged the significant progress made in the development of the Freedom to Speak Up service and reporting arrangements. Resolved: The Board received this report, endorsed the recommendations, confirmed assurance regarding the effectiveness of the Trust's Freedom to Speak Up arrangements, and noted the assurances provided during the discussion.
TB/26-7/040	Finance and Performance Committee AAA Highlight Report: 18 June 2026 (Paper O) Melanie Hall presented this report and highlighted the following key points:- • The Committee reviewed the financial position, noting delivery challenges against efficiency targets and agreeing to undertake deeper reviews of directorate level performance to strengthen oversight and assurance. • The Committee noted a year-to-date capital underspend, primarily attributable to delays in the receipt of Public Dividend Capital funding. • The Committee reviewed the BAF, Group Value Programme and lead provider governance arrangements, agreeing enhanced oversight of the Adult Eating

	Disorder Service through annual reporting and continued scrutiny of programme delivery. - Assurance received regarding actions being taken to address waiting times and increasing service demand. - Assurance received from a range of annual reports covering financial management, cyber security, information governance, data protection and the Caldicott Guardian function. - The Committee reviewed the proposed Green Plan Delivery Dashboard and provided feedback to inform future reporting arrangements. - Notable achievements included national recognition of LPT's performance in relation to Section 136 arrangements, delivery of an additional 974 physical health checks by Mental Health Facilitators, and positive outcomes from the Data Security and Protection Toolkit audit. Resolved: The Board received this report for information and assurance.
TB/26-7/041	Finance Report – Month 3 (Paper P) Sharon Murphy presented this Month 3 Finance Report and highlighted the following key points:- - The Trust delivered a planned deficit of £1.4 million at Month 3. Whilst operational directorates continued to report overspends, with the most significant position reported within the Directorate of Mental Health, the rate of overspend had reduced and overall performance remained in line with plan following the release of reserves. - CIP delivery remained on track at Month 3 and continued to forecast achievement of its planned break-even position at year end. It was noted, however, that significant directorate level variances remained and that mitigating actions would be required to reduce associated risks. Further detailed scrutiny of CIP delivery was planned through the Finance and Performance Committee. - Pay costs highlighted ongoing pressures relating to pay run rates and the need for further action to support delivery of the financial plan. - Agency expenditure continued to perform positively and remained significantly below NHS expenditure limits, with only a minor variance reported against plan. - Better Payment Practice Code compliance and cash performance remained strong and were performing above plan. - Capital expenditure remained below plan due to delays in the receipt of national funding approvals. Whilst approval documentation had recently been received for a number of schemes, further work was required to develop and secure funding for additional schemes. As a result, some planned capital projects were unlikely to be delivered within the originally anticipated timescales. NHSE had been informed and was supportive of the position. - Work was underway to develop Years 2 and 3 of the Medium-Term Financial Plan, including the detailed development of the 2027/28 CIP. A further update would be provided to the Finance and Performance Committee. Chris Skelton sought assurance regarding delivery of the Trust's forecast financial position. Sharon Murphy advised that mitigating actions were being

	developed to support achievement of the planned break-even position and that the current variances were not unusual for this stage of the financial year. Melanie Hall suggested that the deconstruction of block contracts be considered at a future Board development session. Sharon Murphy supported this approach and advised that further discussion would be beneficial once the current exercise and its implications for LPT were better understood. Resolved: The Board received this report for information and assurance.
TB/26-7/042	Integrated Performance Report – Month 3 (Paper Q) Jean Knight presented this report which provided an overview of the Trust's performance against Key Performance Indicators (KPIs) for June 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:- • Work was underway to incorporate performance trajectories and newly issued national outcomes framework metrics into future reports. • Positive performance continued across a range of workforce indicators, including appraisals, staff turnover and mandatory training compliance. • Length of stay within mental health wards remained a concern, particularly in relation to patients who were clinically ready for discharge. Delays continued to be driven by factors including Court of Protection processes, Ministry of Justice requirements and the availability of appropriate accommodation. Work was ongoing with system partners to address these issues and strengthen oversight of delayed transfers of care. • Waiting times for adult and children's neurodevelopmental services remained a significant concern. Although work was underway with regional and system partners to identify potential solutions, no clear resolution had yet been identified. • Improvement was noted in a number of service areas, including Neighbourhood Mental Health Teams, Adult Speech and Language Therapy, and Paediatric Audiology. Resolved: The Board received and approved this report.
TB/26-7/043	Charitable Funds Committee AAA Highlight Report: 23 June 2026 (Paper R) Faisal Hussain presented this report and highlighted the following key points:- • The Committee had approved the Raising Health flagship appeals programme, including the Dementia Friendly Environments Appeal, with any future expenditure exceeding delegated limits to be referred to the Board for approval. • The Charity's financial position remained strong, with continued growth in fund balances and appropriate arrangements in place to manage financial risk. • Raising Health continued to receive growing national recognition, with members of the team invited to share the Trust's experience and good practice with other NHS organisations.

	Resolved: The Board received this report for information and assurance.
TB/26-7/044	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/26-7/045	Any Other Urgent Business Angela Hillery commented positively on the quality and clarity of the Board papers and noted the continued improvement in reporting. Faisal Hussain endorsed these comments and thanked Josie Spencer for chairing the meeting.
TB/26-7/046	Papers/updates not received in line with the work plan Emergency Preparedness, Resilience and Response (EPRR) Annual Report – <i>deferred to September 2026.</i>
	Close - date of next public meeting: Tuesday, 29 September 2026 at 9.30am

Public Trust Board 29 September 2026

Matters arising from the Public Trust Board meeting held 28 July 2026

Action sheet

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

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
Minutes of the previous Group Trust Board Meeting (from Sept26)	As required	-	-	-	-	X (29.09.26)	-	X (28.01.27)
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

		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
Environmental Analysis	Every meeting	X		X	X	X	X	X
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 (agenda item)	X (no agenda item – place as info item)	X (agenda item)	X (no agenda item – place as info item)	X (agenda item)
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 and ToR (<i>to be appended to AAA Highlight Report</i>)	Annual Chair, ARC				X			
Trust Board Annual Effectiveness Review and Terms of Reference	Annual Dir Gov & Risk				X			
Flash reports since the last meeting	Every meeting Dir Gov & Risk				X	X	X	X
Quality, Safety and Compliance:								
Quality and Safety Committee AAA Highlight Report (<i>Annual Reports to be appended following the June QSC</i>)	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)

		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
Safe Staffing Monthly Report	Every meeting Group Chief Nurse	X		X	X	X	X	X
Patient Safety and Learning Assurance Report	Every meeting Group Chief Nurse	X		X	X	X	X	X
Freedom to Speak Up Annual Report (FTSU Guardian to attend to present)	Annual Managing Dir			X				
Emergency Preparedness, Resilience and Response (EPRR) Annual Report	Annual Managing Dir			✗ 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) Deferred to Nov	X (29.10.26) And (20.08.26)	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

		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
Risk Based Items When Required:								
Outline/Full Business Cases	As required							
CQC Inspection Reports	As required							
National/Local Reports	As Required							
Externally Commissioned Reports	As required							
System-wide Winter Planning	As required							
Award of legal contracts	As required							
Appointment of Senior Independent Director, Deputy Chair, Chairs of Committees	As required							
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					

Public Trust Board 29th September 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 August 26 – September 26. Activities relating to formal Committees of the Board are reported through custom reports.

Analysis of the Issue

NED Update

I am happy to share that my tenure as Interim Joint Chair has been extended to 30th September 2028 and I would also like to take this opportunity to thank Elizabeth Anderson, whose Non-Executive Director tenure – as University of Leicester appointed representative – ended at the end of August. Thank you to Liz for her positive contribution and support throughout her time with us.

Chair/NED Appraisals, Recruitment and Succession Planning

NED appraisals have been completed and are scheduled to be shared with NHSE by end of September 2026 in line with regulatory reporting requirements.

Joint Board Development Workshop

On 6 August 2026, Board colleagues came together for a Joint Board Development Workshop which provided dedicated time for strategic discussion and reflection. The workshop considered leadership and governance arrangements as part of the annual well-led self-assessment process, reviewed the opportunities and risks associated with population health management and Integrated Health Organisation contracts, explored the outcomes of the Board skills survey to inform future development and succession planning, and considered winter planning requirements and associated assurance responsibilities for 2026/27.

System Chairs

I continue to meet regularly with Chairs from across the LNR healthcare, both on a 1:1 basis and in group format.

Mental Health Chairs Network

At the August Mental Health Chairs Network, I had the opportunity to contribute to a practical and insightful discussion alongside David Clayton, Joint Trust Chair of Dorset Healthcare University NHS Foundation Trust and Dorset County Hospital, and Frances West, Chair of Berkshire Healthcare NHS Foundation Trust. The session focused on the journey of Trusts' Advance Foundation Trust status, as well as the experience of Northamptonshire Healthcare NHS Foundation Trust as one of the first organisations to receive Integrated Health Organisation designation. It provided a valuable opportunity to share learning, reflect on the opportunities and challenges associated with these developments, and consider how national policy and emerging organisational models may shape the future of mental health, community and integrated care providers.

At September's Mental Health Chairs Network meeting, we heard from Emma Paveley, Senior Policy Manager of the Mental Health Network, who provided an update on supported housing, and Dr Mary Docherty, NHS England's National Clinical Director for Adult Mental Health, who shared the developing Mental Health Personalised Care Framework. The session provided a helpful opportunity to consider the importance of joined-up approaches between health, housing and wider system partners, alongside the continued focus on personalised, recovery-focused care for people accessing adult mental health services. It also supported further reflection on how these national priorities may inform local strategic planning, partnership working and the delivery of more responsive, person-centred mental health services.

NHS College of Leadership & Management

I was pleased to be invited to join a small focus group of senior NHS leaders contributing to the development of the new NHS College of Leadership and Management offer. The discussion focused on the College's emerging vision, priorities and offer, with participants providing early feedback to help shape its future direction and ensure it reflects the needs of leaders, managers and organisations across the NHS. The outputs from this engagement will inform the College's ongoing development and future business planning

NHSE National Discussion Amos & Ockenden Review

I attended this national Chairs event hosted by NHSE Chair, Penny Dash, on 10th August 2026. The session considered the findings and implications of the recent national reviews into maternity and neonatal services and the NHS response to improving safety, quality and outcomes. A national improvement plan and assurance framework has been established, placing a strong emphasis on Board oversight, accountability and delivery of measurable improvements for women, babies, families and staff.

Discussion focused on the underlying causes of poor outcomes, including organisational culture, leadership, workforce pressures, inequalities and the need to ensure that women and staff are listened to. There was a particular emphasis on the role of Boards in maintaining collective ownership of safety, quality improvement and public accountability.

In light of the lessons emerging from these reviews, the Trust will be arranging a Board Development Workshop in the near future to consider the key findings and learning from national



and regional inquiries, including those undertaken in Nottingham and elsewhere, and to reflect on their implications for Board leadership, assurance and organisational culture.

Working with Partners and Stakeholders

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

- NHS Confederation Mental Health Chairs Call
- System Chair Meetings
- Joint NED Catch Up meetings
- Group Hospital Status Meeting
- Chair focus group on NHS College of Leadership & Management

Public, Patient and Staff Engagement

Myself and some fellow NEDs had the pleasure of attending the Director of Nursing and Allied Health Professionals Fellowship celebration day. It was a great opportunity to celebrate with this latest cohort and mark the completion of their fellowship journey. It was an honour to present the fellowship certificates and Dr Anne Scott Awards during the event.

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

- Director of Nursing and Allied Health Professionals Fellowship celebration day
- DAISY Award Celebrations
- Service Visit: Occupation Therapy – Bradgate Mental Health Unit
- Service Visit: CAMHS Crisis
- Consultant Interviews

LPT's Annual General Meeting took place on 8th September at which we presented our 2025/26 annual report and shared our progress against our vision – building compassionate care and wellbeing for all – and our journey to Thrive together. This year we heard from Angela Hillery, Chief Executive, Sharon Murphy, Chief Finance Officer and Linda Chibuzor, Group Chief Nurse.

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 September 2026
Paper sponsored by:	Faisal Hussain, Interim Group Chair
Paper authored by:	Sinead Ellis-Austin, Head of Chair/CEO Office
Date submitted:	September 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:	☒ Technology ☒ Healthy communities ☒ Responsive ☒ Including everyone ☒ Valuing our people ☒ Efficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	N/A
Is the decision required consistent with LPT's risk appetite:	N/A
False or Misleading Information (FOMI) considerations:	None
Positive confirmation that the content does not risk	Yes

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

Appendix 1

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Hetal Parmar	24/07/2026	Seacole Members Meeting	E
Hetal Parmar	30/07/2026	ARC Discussion with NHFT	I
Faisal Hussain	01/08/2026	CEO 1:1	I
Faisal Hussain	04/08/2026	Mentor Lena Samuels	E
Hetal Parmar	05/08/2026	NED catch-up re FPC	I
Melanie Hall	5/8/26	Service visit to Ashby Ward	I
Chris Skelton	05/08/2026	Service Visit - Occupational Therapy Gym Bradgate Mental Health Unit	I
Faisal Hussain	05/08/2026	Mental Health Network Chairs Conference Call	E
Faisal Hussain	06/08/2026	Joint Corporate Governance Catch Up	I
Faisal Hussain	07/08/2026	Deloitte re NHSE Board Development Programme	I
Faisal Hussain	07/08/2026	CEO	I
Hetal Parmar	10/08/2026	ARC Agenda review	I
Faisal Hussain	10/08/2026	NHSE National Discussion Amos & Ockenden Review	E

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Melanie Hall	11/8/26	Freedom To Speak Up Guardian meeting	I
Faisal Hussain	11/08/2026	UHN Chair Catch Up	E
Hetal Parmar	12/08/2026	ELSEC Meeting	I
Faisal Hussain	12/08/2026	Chair/Deputy Chair Meeting	I
Liz Anderson	13/08/2026	Service Visit Diana Service Team	I
Melanie Hall	13/8/26	ARC Agenda setting meeting	I
Faisal Hussain	13/08/2026	Group Chief People Officer	I
Faisal Hussain	13/08/2026	Chair focus group on NHS College of Leadership & Management	E
Faisal Hussain	17/08/2026	Group CEO	I
Chair/NEDs	17/08/2026	Joint NED Catch Up	I
Josie Spencer	18/08/2026	Virtual Big Pitch	I
Liz Anderson	19/08/2026	Group Hospital Status Meeting	I
Melanie Hall	19/08/2026	Pre FPC meeting with Chief Finance Officer	I
Josie Spencer	20/08/2026	Meeting with NHFT Quality & Safety Committee Chair	I

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Josie Spencer	25/08/2026	Service Visit Beacon Unit	I
Josie Spencer	26/08/2026	Monthly Update Call NHSE Regional Chair	E
Faisal Hussain/Josie Spencer/Liz Anderson	01/09/2026	Director of Nursing and Allied Health Professionals Fellowship celebration day	I
Chris Skelton	02/09/2026	Service Visit - CAMHS Crisis Service	I
Faisal Hussain	02/09/2026	Mental Health Network Chairs Conference Call	E
Faisal Hussain	02/09/2026	Deputy Chair LPT	I
Faisal Hussain	02/09/2026	Joint Corporate Governance Meeting	I
Faisal Hussain	02/09/2026	EMAS Chair	E
Faisal Hussain/Tim Harrison/Josie Spencer	02/09/2026	Joint Nomination & Remuneration Committee	I
Faisal Hussain	03/09/2026	UHN Chair	E
Faisal Hussain	08/09/2026	Group Executive Director of Strategy & Partnership	I
Faisal Hussain	08/09/2026	LNR System Chairs Meeting	E
Melanie Hall	10/09/2026	LPT Consultant Interviews	I

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Chairs/NEDs	14/09/2026	Joint NED Meeting	I
Faisal Hussain	16/09/2026	Mental Health Network Chairs Conference Call	E
Faisal Hussain	16/09/2026	Joint Corporate Governance meeting	I
Faisal Hussain	17/09/2026	Chair/Deputy Chair meeting	I
*Melanie Hall	21/09/2026	NED Catch up	I
*Josie Spencer	22/09/2026	Service Visit Arts in Mental Health	I
*Melanie Hall	22/09/2026	Daisy Award Ceremony	I
*Faisal Hussain	30/09/2026	Mental Health Network Chairs Conference Call	E

*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

ELSEC= Early Learning Support for Every Child

FTSU = Freedom To Speak Up

FPC = Finance & Performance Committee

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

ICB = Integrated Care Board

ICS = Integrated Care System

LLR = Leicester, Leicestershire & Rutland

LNR = Leicester, Leicestershire, Rutland and Northamptonshire

LPT = Leicestershire Partnership NHS Trust

LNAHP = Leicestershire & Northamptonshire Academic Health Partners

NED = Non-Executive Director

NRC = Nomination and Remuneration Committee

JPCC = Joint People and Culture Committee

NHFT = Northamptonshire Healthcare NHS Foundation Trust

NHSE = NHS England

QSC = Quality and Safety Committee

REACH = Race, Ethnicity and Cultural Heritage

SIDs = Senior Independent Directors

UHL = University Hospitals of Leicester

UHN = University Hospitals of Northamptonshire



UoL = University of Leicester



Trust Board 29 September 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

Annual General Meeting

Over 100 people attended our Annual General Meeting on 8 September. The event was run online and was open to all our staff, partners, service users, members of the public and stakeholders. It showcased Trust's highlights and achievements from over the last year, as outlined in our [2025/26 annual report](#) and [quality account](#).

Our Chair, Faisal Hussain presented an introduction to our organisation, our vision, values and mission. He also shared the outstanding [impact report from our charity Raising Health](#). Chief executive Angela Hillery outlined our progress against our vision – together we thrive, building compassionate care and wellbeing for all – and our journey to making a difference, together. This included a [film summarising the last year](#). There was also an update on our finances from our chief finance officer and a summary of our quality account from our chief nurse.

It ended with a Question and Answer session, taking questions submitted prior to and during the event. You can watch a recording of the AGM here:
https://youtu.be/tbpE8nJ50jw?si=b5Vlev06m_7sJKX

The CQC rated our Agnes Unit mental health inpatient wards for learning disabilities and autism as 'Good'

LPT received its fourth 'Good' rated inspection report in a row from the CQC in August, following an unannounced inspection of its inpatient wards for learning disabilities and autism at the Agnes Unit in May 2026.

The unit was rated 'Good' overall, with Good across all five domains: Safe, Effective, Caring, Responsive and Well-led. This is an improvement from the previous inspection in 2021, which had rated the service as 'Requires Improvement'.

Inspectors praised staff for providing compassionate, respectful and high-quality care, found strong safeguarding, risk management and medicines' management practices and saw a positive learning culture, using patients' feedback and experience to continuously improve care.

Latest National Oversight Framework (NOF) rating

We are pleased to share that LPT has been ranked in segment 2 (out of 4 possible segments) and moved up from 23rd to 12th out of 58 community and mental health trusts in the latest publication of the Government's new NHS leagues tables, which rate the performance of NHS Trusts in England. We will continue to build on this performance and use it to continually improve.

All acute and non-acute NHS and ambulance trusts in England have received a segment rating of between 1 (highest ranking) and 4 - for the lowest performing and most challenged. Segment 2 is described as: "The organisation has good performance across most domains. Specific issues exist."

New parking arrangements at LPT sites launched

A new car parking system was introduced at some of our sites on Tuesday 1 September. The system has been put in place to protect free parking for staff, patients and visitors who have a legitimate reason to be on site and deter vehicles who have no right to park in LPT car parks. The new parking arrangements are now in place at Loughborough Hospital, LPT car parks at the Glenfield Hospital site, and LPT car parks the Leicester General site. See details on our website: [New parking arrangements at LPT sites - Leicestershire Partnership NHS Trust](#).

New Hinckley community tongue-tie clinic launched during breastfeeding awareness month

LPT's Healthy Together Infant Feeding Team has launched a second community frenotomy clinic as part of a pilot to support families whose babies are having feeding difficulties due to tongue-tie. The new clinic is based at Hynca Lodge in Hinckley. Before the pilot, many families had to wait a long time to have the procedure done in hospital, have it done at a clinic outside of LLR, or pay to have it done privately.

Since it launched, the pilot has seen over 330 babies treated in a clinic. All families seen by the service were done so within two weeks of their referral, with over 94% of families asked saying the procedure has resulted in improvement in their baby's feeding.

DECODE research health tool could help prevent avoidable deaths in people with learning disabilities

A new digital health tool has been developed to identify future health risks in people with learning disabilities by DECODE researchers. The research project, led by Loughborough University and Leicestershire Partnership NHS Trust, has used artificial intelligence and health data to develop the tool, which could help save lives by enabling healthcare professionals to spot potential health problems earlier. This will allow them to work with people with learning disabilities to take preventative action. Researchers think the tool could be ready to trial in real healthcare settings within four years.

Local volunteers and businesses support hospital garden improvements in Rutland

LPT's Rutland Memorial Hospital's end-of-life garden was given a makeover by volunteers from the Rutland Lions Club. Members of the Rutland Lions cleared years of overgrowth from the courtyard garden, while local business MS Exterior Cleaning and volunteers restored benches and refreshed communal areas. The volunteering opportunity was supported by the Trust's charity,



Raising Health, and volunteering teams. The site is now being enjoyed by patients, visitors and staff members.

Celebrating Excellence shortlist announced

We have announced our shortlist of Celebrating Excellence Awards finalists to staff. This year we had over 270 nominations. Every person nominated received a personalised letter to thank them for their hard work, dedication and compassion, with finalists also invited to attend a special awards ceremony on Thursday 1 October. Thank you to our sponsors for helping to make this event happen.

LPT teams recognised at university awards

We had several of our teams presented with gongs at De Montfort University's Celebration of Practice Learning (COPLe) Awards, which recognises the excellence shown by healthcare teams in creating exceptional learning experiences for students. These included our Gillivers Short Breaks Service, for Nursing Placement of the Year 2026; the Integrated Community Specialist Palliative Care Team (ICSPCT), which received a Highly Commended Runner-Up award in the Nursing Placement of the Year 2026; and the Northwest Leicestershire District Nursing Team received Post Registration Placement Team of the Year.

We celebrated the first graduates of the Introduction to Psychoanalytic Approaches Programme

LPT's Laura Ison, Dr Rashid Khan, Dr Julianah Mosanaya and Dr Sonia Thomas successfully completed the Introduction to Psychoanalytic Approaches (IPA) training programme. They were among the first cohort to graduate from the programme, delivered in partnership with psychodynamic psychotherapy services across Leicestershire, Derbyshire and Nottinghamshire.

The programme was developed to introduce psychoanalytic thinking to busy clinicians working with patients who present with complex needs and challenging situations.

South Asian Heritage Month celebrations

Colleagues from LPT and NHFT came together on Wednesday 22 July to celebrate South Asian Heritage Month, embracing this year's theme of "Unity and Diversity". The event welcomed colleagues from across both organisations for an afternoon of cultural celebration, networking, and inspiring stories.

Unannounced CQC inspection at the Beacon Unit

At the beginning of August we had an unannounced inspection of our child and adolescent mental health wards from our regulators, the Care Quality Commission (CQC).

Four CQC inspectors visited the Beacon Unit on Tuesday 4 August 2026 and we have subsequently submitted a range of supporting evidence. We are awaiting their report.

Four innovative projects secured funding at The Big Pitch

On Friday 31 July, we held our Big Pitch event, where shortlisted project leads presented their innovative ideas to a judging panel. The initiative enables our workforce to submit innovative ideas for seed funding, to test out improvements in our services.



Those who received funding to progress their ideas were Rebecca Wallen, occupational therapist advanced practitioner for her project to introduce a nationally validated digital outcome measure within Children's Occupational Therapy team; Louisa Ward, COMHAD practitioner, for her idea to co-produce a Leicester-themed interactive board game designed to support substance use education in mental health and forensic inpatient settings; Annie Francis, occupational therapist, to trial an innovative digital service model aimed at improving access to falls prevention assessments, interventions and support for people with learning disabilities; and, finally, Gemma Kott, physiotherapist, for her idea to run a new integrated clinic designed to provide earlier specialist assessment, improve access to mobility equipment and support greater independence for adults with learning disabilities.

Trust Board adopted Lord Mann review recommendations in full

The Trust Board has adopted the recommendations of the Lord Mann Review in full as part of our continued commitment to creating an inclusive, anti-racist organisation where everyone feels valued, respected and able to thrive.

The Lord Mann Review sets out a number of recommendations aimed at strengthening action against racism, improving accountability, supporting staff who experience discrimination, and embedding anti-racist practices across NHS organisations.

Two projects nominated for HSJ Awards

The Developing Diverse Leadership (DDL) Programme, led by the Leicester, Leicestershire and Rutland Academy and significantly shaped through the contribution of LPT's Equality, Diversity and Inclusion (EDI) Lead, has been shortlisted for Workforce Initiative of the Year at the 2026 Health Service Journal (HSJ) Awards.

LPT's neuromodulation pathway for patients in crisis, which utilises Flow stimulation headsets and is supported by our Raising Health charity, has been shortlisted for Mental Health Innovation of the Year.

We will find out if we have been successful in winning, following the event in November.

Raising Health charity shortlisted for national Health Tech Awards - Most Promising Pilot award

We are pleased to share that our charity Raising Health is a finalist in the national Health Tech Newspaper Awards in the Most Promising Pilot category - for the work we've done to fund the neuro flow headsets for mental health crisis services. Winners will be announced at an online live event on 7 October.

Raising Health supported the delivery of an innovative pilot programme enabling patients to access Flow Neuroscience's transcranial direct current stimulation (tDCS) headsets. Flow therapy works by delivering a gentle electrical current to areas of the brain associated with mood regulation, sleep and motivation. In 2024, LPT's crisis resolution and home treatment team piloted the use of Flow headsets, achieving results including 80 percent of patients reporting a reduction, with some patients experiencing a drop in suicidal ideation by up to 75 percent. Through a fundraising campaign, Raising Health raised £40,000 within 12 months. This enabled us to purchase 150 headsets and extend the programme into adult eating disorder and community



mental health teams. Clinical outcomes show that 71 percent of patients experienced a reliable reduction in depressive symptoms within six weeks, with sustained reductions in suicidal ideation of 33 percent by week three and 66 percent by week ten. Over a quarter of patients reached full clinical remission by ten weeks. Patients also reported meaningful improvements in daily functioning, with an average 11.66-point improvement on the Work and Social Adjustment Scale.

Our Future Our Way deliverables launched

The latest set of initiatives developed through the Our Future Our Way culture improvement programme were launched in August, showing how we turn staff feedback into practical action. Change leaders analysed feedback from the NHS Staff Survey and engagement opportunities before co-designing solutions focused on two key priorities identified by staff: equitable career development and addressing experiences of racism and discrimination. New resources to support career development included a job application support guide, interview skills training session and interview skills workbook, all designed to help colleagues build confidence and progress their careers. New tools and guidance to support staff experiencing and witnessing racism and discrimination, included a dedicated 'Supporting staff experiencing racism and discrimination' toolkit.

The Our Future Our Way programme was recently presented at the Healthcare Financial Management Authority (HFMA) national conference and at the LLR Quality Improvement Symposium – sharing the 7-year journey the programme has been on to make significant culture improvement changes that have led to LPT's staff survey results move up to one of the best performing amongst its peer Trusts.

Clinical Lead has article published in Wounds UK

Anita Kilroy-Findley, Clinical Lead in Tissue Viability, who has contributed to national publications on several occasions, has her latest article 'Building specialist capability: Developing a proficiency-based induction for tissue viability service' has been published in Wounds UK. In the article Anita talks about how a structured induction has been developed for the tissue viability service at LPT to strengthen practitioner confidence, clinical governance, and safe decision making. Read the full article on the Wounds UK [website](#).

Update on Equality and Human Rights Commission Codes of Practice for services: definition of biological sex

The Equality and Human Rights Commission (EHRC) statutory Codes of Practice, which reflect the Supreme Court's definition of biological sex under the Equality Act 2010 came into force on Wednesday 5 August. NHS organisations including LPT, are beginning preparations for the implementation of the new requirements whilst we await more detailed guidance from NHS England. Some of the work we will do will include audits of our facilities, engaging with patients, service users and staff and carrying out equality impact assessments. Our policies and standard operating procedures will be updated accordingly following engagement and consultation.

Together Against Racism – our ongoing commitment to belonging, equity and inclusion for all

Our Together Against Racism programme remains one of our most important Group-wide priorities. It is a core expression of our THRIVE strategy, and especially of what Valuing our people means. Tackling racism is vital, and so is our commitment to supporting and protecting



colleagues across all protected characteristics. It's about fairness, dignity and belonging for everyone.

Our latest Together Against Racism 2026 update shares details about the progress made across our Group in tackling racism and inequality.

Green goals – leading sustainability and our corporate approach

Since the launch of our Group Sustainability Report in July, we're encouraging colleagues to learn more about what it means and how Leicestershire Partnership NHS Trust (LPT) and NHFT are joining together to deliver our net-zero ambitions safely, considerately and diligently.

Solar schemes in place for summer of sun

We have made the most of this sizzling summer with new solar panels. In June/July a series of photovoltaic arrays were completed on top of several of our hospitals and units in Coalville and Leicester which are already generating electricity and reducing the trust's carbon footprint. They are an important part of our ambition to make the NHS carbon neutral by 2040.

Shaping the future of health services in Lutterworth

Plans are progressing to shape the future of health services in Lutterworth, with partners exploring how care can be delivered closer to home through a neighbourhood health approach. The work is aligned to the ambitions of the NHS 10-Year Plan, including prevention, supporting people to stay well, and improving access to local services. Further updates will be shared as work continues and decisions on the NHS England capital submission are received.

WorkWell Showcase

WorkWell is a support service that addresses the rising flow of people out of work. It is backed by the Department for Work and Pensions and the Department of Health and Social Care and aims nationally to support around 60,000 long-term sick or disabled people to start, stay, and succeed in work through integrated work and health support. On 8 July, Dame Patricia Hewitt and Dame Carol Black visited the Maidstone Centre to meet the LLR Work Well programme team, of which LPT is an official partner, and listen to plans to expand employment support in mental health services. They praised the team's innovative approach and commitment to delivering the national WorkWell rollout. Find out more here.

<https://leicesterleicestershireandrutlandhwp.uk/people-and-health/workwell-in-leicester-leicestershire-and-rutland/>.

Community Engagement Strengthening Support for Diverse Communities

Part of our Mental Health directorate, the City North team continues to build strong community connections through regular outreach events. At the monthly Age UK community drop-in session in Leicester city centre, partners from Better Mental Health for All, Age UK and Leicester City Council's Enablement Team engaged with around 30 residents, primarily from Asian communities aged 40 to 65. The team also attended the Stocking Farm Community Shop Community Day alongside CAMHS and Leicester City Council Adult Education colleagues, creating opportunities to raise awareness of local mental health support and strengthen links between community and statutory services.

Healthy Together Helpline team visited



Healthy Together runs a helpline for parents and carers of children and young people aged 0-11 in primary schools in Leicestershire and Rutland and 0-19 in Leicester. Offering advice and support on a range of topics affecting families, the Healthy Together Helpline is the easiest way to speak directly to a health visitor or school nurse over the phone.

Dr Shaun McGill, Acting Assistant Director – Public Health Commissioning Partnership – Leicestershire County Council visited our Healthy Together Helpline team for learning and observation of practice and processes. Following the visit, in his feedback, Dr McGill stated he was “... particularly impressed with the breadth of things that the HTH team are able to support families with, and it emphasised for me just how important it is to have different ways for families to seek advice. The use of the telephone line as well as the ChatHealth service are both important for helping to improve accessibility to Healthy Together. Speaking with the team also helped me to identify ways that I can continue to advocate for, and support, the service as a commissioner.”

Japanese Student Visit

In August, LPT was joined at the Evington Centre by 19 Japanese students from Juntendo University. The 19 nursing students (a mixture of second- and fourth-year students) were visiting Leicester through an educational trip, organised by DeMontfort University. Community health Services was delighted to be organising and hosting a workshop, for the third year running.

Local Government changes in LLR

The Government has announced how local councils in Leicester, Leicestershire and Rutland will be reorganised. After considering three different proposals, it has confirmed that, from April 2028, all local council services will be provided by two new unitary councils, which is a type of local government that combines the responsibilities of both county and district councils into a single tier, instead of the current arrangements.

A proposed boundary map with an overview of the new council areas has been published by [Leicester City Council](#).

Health and Wellbeing Boards

Rutland County Council Health and Wellbeing Board - 7 July - LPT not required to present, agenda included patient care locally, LLR ICS update, JSNA update, joint health & wellbeing strategy and better care fund. Papers available via Leicester County Council website [link](#). The next meeting is due to be held on 29 September; agenda at time of generating this report has not yet been released. Papers will be available via Leicester County Council's website [link](#).

Leicester County Council Health & Wellbeing Board Development/workshop session part 2 – 19 August – building on the outcomes of the first workshop held in June, this session focused on identifying the structure and governance model required to enable the Health and Wellbeing Board to deliver its agreed purpose effectively.

Leicester City Public Health and Health Integration (PHHI) – 1 September - LPT not required to present, agenda included winter pressures, Leicester neighbourhood approach, health protection and Healthwatch's annual report. Papers available via Leicester City Council's [link](#).



Leicester County Health and Communities Overview Scrutiny Committee – 9 September - LPT not required to present on this occasion; agenda included winter pressures, Healthwatch annual report and health, public health and communities' performance update. Papers available via Leicester County Council's website [link](#).

Leicester City Council Health and Wellbeing Board – no meeting has been held since reported in July's paper for the meeting held on 4 June. Papers for the meeting to be held on 1 October will become available via Leicester City Council's website [link](#).

Leicester County Council Health & Wellbeing Board – no meeting has been held since reported in July's paper for the meeting held on 15 June. The next meeting will be held on 17 September, after the deadline for submission of papers to LPT's Trust Board. Papers will be available via Leicester County Council's website [link](#).

Staff Voice

Service visits

The Board undertook 24 service visits in July and August across a wide range of operational and enabling services and sites, including several community-based mental health services for adults of working age locations, mental health long stay/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.

Speak Up month – October

The safety of our staff and patients within our services is a significant priority for LPT. Key to providing that safe environment lies in giving strong focus to our Speaking Up culture. Although we strive every day to make speaking up business as usual, the UK national Speak Up Month campaign in October will see the return of our annual 'roadshows', during which 35 LPT sites will be visited to promote and encourage LPT colleagues to speak up if they see something they are not comfortable with or barriers they are experiencing in implementing improvement to a service they feel would benefit patients and staff alike.

Co-streaming in Mental Health Liaison service pilot

Commenced on 15th June 2026. As of the end of July 2026, a total of 86 patients have been seen as part of the Co-streaming process.

Patient Voice

The Trust is advancing its culture of co-production and lived experience leadership across care planning, service improvement, communications, and strategy.

Key achievements and recognition

- National & Group Impact: Launched a joint Group Co-production Charter with Northamptonshire Healthcare NHS Foundation Trust and presented LPT's Lived Experience Leadership Framework at NHS England's national spotlight event.



- **Youth & Panel Influence:** The Youth Advisory Board drove digital, survey, and peer support developments, while the Reader Panel improved the quality of clinical and patient-facing materials.
- **Staff & Service Excellence:** Lived experience was embedded into DIALOG+ care planning, peer support services earned highly positive feedback, and Involvement Network members received Celebrating Excellence nominations.

Future Focus

To maintain momentum, the Trust will focus on sustaining participation, embedding the new Group Co-production Charter across all services, and consistently measuring the impact of co-production on patient care.

Service visits

Patients spoken to on a visit to The Willows in August, reported feeling supported and relaxed. One patient on the Clarendon Ward at the Evington Centre had submitted at 'Pride of Britain' nomination for the ward following the care they received. In the Beacon Unit patients feedback regarding the food they received led to co-production of reviewing their meals. Patients in this Unit also commented on feeling supported and receiving the help they felt they needed and enjoyed the activities provided.

After listening to patients advising one of their main issues was loneliness, our integrated mental health team now include a holistic review of each patient and conduct visits to home environments.

Introduction to Co-Production

LPT already knows how essential patient and staff co-production is and the mutual benefits it brings. LPT has planned more training sessions for staff to join to build on our already strong patient/staff co-production ethos and discover how co-production can help create better outcomes, stronger relationships and more meaningful involvement in service design and delivery.

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. The DAISY Awards are an international recognition programme that celebrates nurses and midwives who go above and beyond to provide outstanding care.

Two members of our nursing staff have recently been recognised for the award.

ADHD nurse specialist, Cheryl Gillott, was nominated by the mother of a young person she has supported for approximately eight years in recognition of the profound and lasting impact Cheryl has had on both the young person and their family, particularly during some of their most challenging times. The mother also noted Cheryl's expertise in ADHD, autism and mental health, and praised her for the empathy, understanding and reassurance she consistently brings to her role.

Mental health nurse, Zang Irene Jem, known to colleagues and patients as Irene, has been recognised by a patient for the positive impact her compassionate and person-centred care had on



themselves and their family. The patient, who was an inpatient on Heather Ward at the Bradgate Unit, highlighted how Irene took the time to listen without judgement, treated them as a person rather than just a patient, and provided encouragement and hope during a difficult admission. The patient described Irene as a professional, consistent and deeply compassionate nurse whose support helped them feel heard, respected and more positive about the future. The nomination concluded that Irene represents the very best of nursing care.

Friends and Family Test (FFT) – July and August

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 July and August 2026, our Trust received a total of 3,391 Friends and Family Test (FFT) feedback responses from our patients; average response rate of 14.75%, with an overall positive score of 90%.

July 2026 Friends and Family Test



Total feedback figure: 1739	Response rate: 13%	Positive score: 90.57%	Negative score: 5.12%
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Continence Nursing Service

"It was nice to talk through my problems with someone professional, sympathetic & encouraging. I was given self help tools but reassured that there are further options available if these don't improve my issues, such a relief after such a long time. Its given me hope."

Perinatal

"Professionals always show compassion, listen well and make you feel at ease and normalise how you are feeling which is extremely helpful. The session was well run and organised, thought and care had gone into the session."

LD community teams

"It was really very valuable. The Physiotherapist was very flexible, came and took extra time, put a plan in place for the service user, supported him with mobilising, was very patient, and improved his quality of life. The Physiotherapist talked to the staff who know the service user very well and took guidance from staff. Physiotherapist was very adaptable in communicating with the service user."

Respiratory Specialist Service

"Our respiratory nurse was excellent. Very polite, knowledgeable, wanted to help in anyway he could. Did various checks and arranged for further attention through the department. Nothing was too much trouble and a credit to the NHS. We thank him."

MHSOP integrated care

"I had a lovely and inspiring learning experience when working within the integrated care mental health team. They created an environment that was welcoming and fostered a collaborative approach where I was encouraged to discuss my opinions and ask questions."

Mental health in schools

"I loved how we always did something fun. I feel like these sessions have helped a lot. It helped me a lot. I learnt that some worries we can't deal with and they aren't in our control."

**What our
patients said
in
July**

Our July 2026 Friends and Family Test (FFT) results demonstrate the positive impact colleagues are making every day, with 1,739 responses received, a 90.57% positive score, and a response rate of 13%.



August 2026 Friends and Family Test

Total feedback figure: 1652	Response rate: 16.5%	Positive score: 89.5%	Negative score: 4.6%
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Palliative Care Service

"Very friendly, really helpful, can't do enough to help, very gentle and caring. Very polite and well mannered. Answered any questions I had. It helps having someone come in that is nice and friendly when going through chemo."

MHSOP integrated care

"My mental health nurse understood where I was coming from. He was calm and approachable. Our conversations were serious and relaxed at times. He helped me become more confident and get out more. More importantly he listened to me he gave me ideas to try help me."

Health Visiting

"I cannot thank her enough for making me feel so listened to and comfortable throughout the visit. She also left me with sources to get more info and support if needed especially breastfeeding support groups who I've got in touch with and they have made me feel so comfortable and confident in asking for help."

The Falls service

"The ladies running the course were all very caring and their knowledge was very apparent. they were always polite and respectful. the ladies always made sure we were safe and they provided alternative moves based on our ability."

LLR Enhanced High Intensity Psychological Therapies

"This has been the single most incredible experience with the NHS I have ever had - I am floored by how integrative, personalised and meaningful the impact of this service has been to my life! Thank you so much to everyone in the team!"

Children's SALT

"It was nice to actually see a speech therapist and have a face-to-face meeting. Even better that it was actually the same therapist that I had already spoken to previously."

**What our
patients said
in
August**

Our August 2026 Friends and Family Test (FFT) results demonstrate the positive impact colleagues are making every day, with 1,652 responses received, a 89.5% positive score, and an increased response rate on the previous month of 16.5%.

Over July and August, the general themes identified demonstrated that kindness, expertise and communication skills of our staff continue to have the biggest impact on patient experience and highlights the professionalism, expertise and kindness shown by teams across our Trust.

FFT services transferred to new provider from 1 September

To ensure that you have the best possible experience when engaging with LPT services, your feedback continues to be extremely valuable, as it tells us how we are doing and helps us to improve our services. From 1 September 2026 we transferred FFT reporting arrangements to a new provider with enhanced survey management, improved reporting functionality, and greater flexibility for services to collect and analyse patient feedback. Demographic questions have been included in the survey to ensure we are asking the correct demographic questions and using the correct language. We encourage all patients to have their say and engage in our FFT feedback service. Full information on how to leave feedback can be found here:

[Friends and family test \(FFT\) - Leicestershire Partnership NHS Trust.](#)

Relevant External Meetings attended since last Trust Board meeting

August 2026	September 2026
LLR Local Health Resilience Partnership	Creative Health Network introduction
Executive Sponsorship of F2SU Community of Practice	Local Resilience Forum Executive Board
LLR Sync	LPT Annual General Meeting
LNR Health Partners' Executive	LPT and Healthwatch Meeting
Health and Wellbeing Board JSNA Steering Group	Monthly Midlands COO/MD/DoN with NHSE
	*Leicester City Integrated Health and Care Group (was ISOC and JICB)
	*CQC/LPT -Quarterly Engagement
	*UHL–UHN Developing Diverse Leadership Programmes Launch
	LNR Health Partners' Executive
	*LLR ICB and NICB Board development session
	* Mental Health Collaborative

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

Proposal

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

Decision Required

Briefing – no decision required

The Board is asked to consider this report and to decide whether it requires any clarification or further information on the content.

Governance Table

For Board and Board Committees:	Trust Board of Directors
Paper sponsored by:	Jean Knight, Managing Director
Paper authored by:	Sam Beaty, Business Manager
Date submitted:	xx.09.26
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:	November 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

Level 1, 2 and 3 Alert, Advise and Assure (AAA) Highlight Report

LPT Committee / Group : Audit and Risk Committee

Date of Meeting: 11 September 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)
Internal Audit Progress Report	ARC/26/058	360 Assurance Client Manager	A moderate assurance opinion had been given to the Absence Management: Long Term Sickness Absence Review as (i) there was no reporting against policy compliance, and (ii) whilst the stages of the procedure were generally being applied by line managers, they were not done consistently in a timely manner and/or in line with policy. Combined, these heightened risk to the organisation around the support being provided to staff. In-depth discussion took place and ARC noted that the recommendations were being actioned by the HR Team, whilst 360 Internal Audit would review where benchmarks could be enhanced in future. ARC also noted the assurance received from this scrutiny by Internal Audit on this important aspect of staff wellbeing.	N/A		

ASSURE: Inform the Board where positive assurance has been received

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Counter Fraud, Bribery and Corruption Report	ARC/26/059	360 Assurance Counter Fraud Specialist	Discussion focussed on LPT's approach to counter fraud awareness as the Trust currently rated itself amber for component 11 (<i>access to and completion of training</i>) of the Counter Fraud Functional Standard Return. ARC noted that, whilst counter fraud training was not mandatory in the Trust, an uptake of bespoke planned training / awareness could provide evidence to improve the rating.	N/A		
Code of Conduct Policy	ARC/26/061	Director of Governance & Risk	A review of the policy had been undertaken following receipt of guidance around external employment specifically in relation to political roles. No other major changes had been made and ARC approved the updated policy.	N/A		
ARC Annual Review 2025/26	ARC/26/062	Director of Governance & Risk	ARC reflected on the effectiveness of the committee during the year in terms of its obligations, fulfilling its terms of reference and the ongoing development and improvement work. The ToR for 2026/27 were approved. The full report is appended to this triple A report.	N/A		
Governance and Risk Report	ARC/26/063	Director of Governance & 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 approved at EMB. • LPT's Governance Team worked closely with NHFT's team and an integrated approach would be progressed during the year. Work on the group BAF continued. • Preparations continued in readiness for a corporate well led inspection. • Work was underway to carry out a self-assessment under the provider capability framework • All policies were in date.	All		

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Emergency Preparedness, Resilience & Response	ARC/26/064&5	Head of EPRR	ARC received assurance from the Annual Report on EPRR activities carried out by LPT during 2025/26. ARC also received assurance that LPT had undertaken a self-assessment review against the NHS Core Standards for EPRR and deemed itself fully compliant. A confirm and challenge exercise would be carried out with NHS England.	N/A		
Treasury Management Policy	ARC/26/066	Chief Finance Officer	ARC approved the updated policy which had last been updated in December 2023. Changes mainly related to governance, job titles and terminology as well as revised capital investment financial controls to mitigate risks associated with contractor insolvency.	BAF10 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)
Internal Audit Progress Report	ARC/26/058	360 Assurance Client Manager	Progress against internal audit actions was reported at 100% for first follow up of high and medium risks as well as the overall implementation rate. A benchmarking exercise on the implementation of actions in 2025/26 had been carried out which had established that LPT was the highest performing Trust and equal top across all of 360 Assurance's client base.	N/A		
External Audit Progress Report	ARC/26/060	Director KPMG	The audit of the 2025/26 annual accounts had been finalised and KPMG had issued a clean Auditor's Report as expected.	N/A		

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			

Appendix

Audit and Risk Committee – 11 September 2026

Audit and Risk Committee Annual Effectiveness Review 2025-26

Purpose

To provide an annual review of the effectiveness of the Audit and Risk Committee for 2025-26

Analysis of the issue

The role of the Audit and Risk Committee is to seek and provide assurance to the Trust Board in relation to the effectiveness of their internal system of governance, risk management, and control. It is a level one statutory committee of the Board and is chaired by a non-executive director.

A full review of the effectiveness of the Committee has been provided in Appendix A which has concluded that the Committee has been effective during the year and has fulfilled the current Terms of Reference (ToR).

The Terms of Reference were last reviewed March 25 and are included at appendix B for approval. We are not recommending any alterations to the ToR for 2026/27.

Proposal

To demonstrate that the ARC has been effective during the year and has been subject to ongoing development and improvement.

Decision required

- To confirm a level of assurance over the effectiveness of the ARC during 2025/26.
- To approve the ToR for 26/27

Appendix A ARC Annual Effectiveness Review 2025/26

1. Fulfilling the Terms of Reference

1.1 Governance Arrangements

All meetings continue to be held virtually on Microsoft Teams and this is both efficient and effective. The ARC does not have any feeder level 2 committees within the corporate governance structure.

1.2 Terms of Reference and Work Plan

The duties of the ToR were covered through the work plan and agendas during the year.

1.3 Membership

Membership attendance has been satisfactory, and each meeting was quorate. The Committee is comprised of three independent non-executive Directors; quoracy is two non-executive directors. A number of officers including the Finance Director and the Director of Governance and Risk attend meetings of the Committee.

The ToR states that the Committee shall meet no less than four times a year. Four meetings were held during the year plus an extraordinary meeting in April 2025 for the year end accounts.

Attendance at ARC meetings 1 April 2025 to 31 March 2026:

Member	Role	Attendance
Hetal Parmar	NED & Chair	5 of 5
Faisal Hussain (until Dec 2025)	NED	4 of 4
Manjit Darby (until November 2025)	NED	3 of 3
Josie Spencer (from Jan 2026)	NED	1 of 1
Tim Harrison (December 2025 only)	NED	1 of 1
Sharon Murphy	Director of Finance	5 of 5
Kate Dyer	Director of Governance & Risk	4 of 5

2. Committee Effectiveness

- 2.1 The meetings have been considered as well-run throughout the year. Papers are issued five working days ahead of the meeting and are of good quality. The minutes of the meetings continue to reflect thorough and informed debate for items with a rigour for matters not proceeding as expected and support for positive progress as assured. After every meeting the Committee provides a 3A Highlight Report for assurance levels received for agenda topics to the Trust Board. The alerts are also provided in detail to the Executive Management Board.

3. Members and Attendees Feedback 2025/26

We have collated feedback from members and attendees of the Committee relating to areas of achievement and success, and any challenges and barriers during 2025/26.

3.1 Achievements and successes in 2025/26

- Supporting development of the updated BAF (LPT and Group).
- Approval of the internal audit plan and follow-up / closure rate of internal audit actions, with priority given to high and medium risk.
- Scrutiny of the final accounts, especially given a challenging year leading to an unqualified external audit opinion on annual accounts.
- Counter Fraud return.
- Oversight (via auditor panel) of external audit procurement process & appointment of external auditors.
- Continued oversight & assurance of a wide ranging work plan.
- Constructive and appropriately challenging discussions in a very supportive environment.
- Agreed appropriate internal audit plan for 2026/27.
- 100 % follow up rate for agreed audit actions.

3.2 Challenges and barriers during 2025/26

- Supporting greater innovation, within risk appetite, to support the THRIVE strategy.
- Evolution to more aligned working at Group level (LPT and NHFT), accepting varying contexts.
- Greater focus on linking reports and insights back to patient outcomes.
- The Committee is limited by the information presented to it and must always challenge to ensure it is discussing the right issues.

4. Future Plans

The future plans and recommendations identified for 2026/27 will support the Committee to continue to focus on the right agenda during the year and are detailed below:

- Core workplan items will remain the same for 2026/27.
- The Internal Audit planning process will continue; the plan for 25/26 included NEDs in the discussion and sign off and this will be the same for 26/27. The audit programme keeps the committee focussed during the year. Have some flexibility with the internal audit programme to ensure that emerging issues are appropriately examined.
- Monitoring the production of the annual report and accounts to ensure statutory requirements are achieved
- Including Well-led considerations, including greater focus on impacts for patient care and patient outcomes as part of ARC reporting.

Appendix B ARC Terms of Reference Review 2026/27

Leicestershire Partnership NHS Trust Audit and Risk Committee Terms of Reference 2026/27

Version	2026/27 v1
Executive Lead	Chief Finance Officer
Approved	Audit and Risk Committee September 2026
Ratified	Trust Board September 2026
Review Date	Annual Review September 2027

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Audit and Risk Committee ('the Committee'). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

2. Membership

The Committee shall be appointed by the Board from amongst its independent, non-executive directors and shall consist of not less than three members. A quorum shall be two of the three independent members. One of the members will be appointed chair of the Committee by the Board. The Chair of the Trust itself shall not be a member of the Committee.

The membership will include:

- Three independent Non-executive Directors.

In attendance there will be the following officers from the Trust:

- Director of Finance and Performance will hold executive responsibility for the meeting
- Director of Corporate Governance

Others in attendance will include:

- Director 360 Assurance (Internal Audit)
- Client Manager 360 Assurance (Internal Audit)
- Principal Anti-crime specialist 360 Assurance (Counter Fraud)
- Partner KPMG (External Audit)
- The Trust's accountable officer (annual)

3. Attendance at meetings

- The Director of Finance and appropriate internal and external audit representatives shall normally attend meetings.
- The counter fraud specialist (LCFS) will attend a minimum of two committee meetings a year.
- The accountable officer should be invited to attend meetings and should discuss at least annually with the audit committee the process for assurance that supports the governance statement. They

should also attend when the committee considers the draft annual governance statement and the annual report and accounts.

- Other executive directors/ managers should be invited to attend, particularly when the committee is discussing areas of risk or operation that are the responsibility of that director/ manager.
- Representatives from other organisations (for example, the NHS Counter Fraud Authority (NHSCFA)) and other individuals may be invited to attend on occasion, by invitation.
- The PA to the Director of Finance shall be secretary to the committee and shall attend to take minutes of the meeting and provide appropriate support to the chair and committee members.
- At least once a year the Committee Chair should meet privately with the internal auditors, external auditors and LCFS either separately or together. Additional meetings may be scheduled to discuss specific issues if required.

4. Access

The head of internal audit and representative of external audit have a right of direct access to the chair of the committee. This also extends to the local counter fraud specialist, as well as the security management specialist.

5. Frequency of meetings

The committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. A benchmark of four to five meetings per annum (with a possible additional meeting to specifically review the annual report and accounts) at appropriate times in the reporting and audit cycle is suggested. The chair of the committee, board, accountable/ accounting officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary.

To assist in the management of business over the year an annual workplan will be maintained, capturing the main items of business at each scheduled meeting.

6. Authority

The committee is authorised by the board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise, if it considers this necessary.

7. Responsibilities

The committee's duties/ responsibilities can be categorised as follows:

Governance, risk management and internal control

The Committee shall review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the committee will review the adequacy and effectiveness of:



- all risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board
- the underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including the NHS Code of Governance and NHS Provider licence
- the policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHSCFA.

In carrying out this work the committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the committee will have effective relationships with other key committees (for example, the quality committee, or equivalent) so that it understands processes and linkages. However, these other committees must not usurp the committee's role.

Internal audit

The committee shall ensure that there is an effective internal audit function that meets the Global Internal Audit Standards 2024 and provides appropriate independent assurance to the committee, accountable/ accounting officer and board. This will be achieved by:

- considering the provision of the internal audit service and the costs involved
- reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
- considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- monitoring the effectiveness of internal audit and carrying out an annual review.

External audit

The committee shall review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:



- considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the board when appropriate)
- discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- reviewing all external audit reports, including the report to those charged with governance (before its submission to the board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

Other assurance functions

The committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation. These may include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/ inspectors (for example, the Care Quality Commission, NHS Resolution) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies).

In addition, the committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the audit committee's own areas of responsibility. In particular, this will include any committees covering safety/ quality, for which assurance from clinical audit can be assessed, and risk management.

Following guidance from NHSEI in December 2021, the Board has approved an allocation of Non-Executive Director Champion roles and has appointed a Senior Independent Director. The champion role for security management (counter fraud) has been aligned to the Chair of the ARC, with the ARC being the responsible Committee.

In addition, the guidance recommended that a further 11 key themes should be overseen through committee structures. The one which applies to the Audit and Risk Committee is Emergency Preparedness.

Counter fraud

The committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.

With regards to the local counter fraud specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

Management

The committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control. The committee may

also request specific reports from individual functions within the organisation (for example, compliance reviews or accreditation reports).

Financial reporting

The committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The committee should ensure that the systems for financial reporting to the board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The committee shall review the annual report and financial statements before submission to the board, or on behalf of the board where appropriate delegated authority is place, focusing particularly on:

- the wording in the annual governance statement and other disclosures relevant to the terms of reference of the committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted misstatements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- letters of representation
- explanations for significant variances.

System for raising concerns

The committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently, and in line with the relevant policies. This will be done annually. Regular oversight of themes from our Freedom to Speak Up activity is taken through our People and Culture Committee.

Governance regulatory compliance

The committee shall review the organisation's reporting on compliance with the *NHS Provider Licence* and the *NHS code of governance*. The committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

Auditor Panel

Panel membership comprises two non-Executive members and the Director of Finance. A nominated non-Executive is to act as Chair of the Audit Panel.

The Deputy Director of Finance shall normally attend the meetings.

One Non-Executive Director and the Director of Finance need to attend for quoracy.

The Panel is to conduct an appropriate LPT procurement process, as outlined in section 9 of the Trust's Standing Financial Instructions (SFIs) for the appointment of external auditors.

The Panel is to recommend to the Trust Board the appointment of external auditors.



The Panel is to ensure:

- Contract arrangements (i.e., procurement and the selection of external auditors) are appropriate.
- The relationship and communications with the external auditors are professional
- Conflicts of interest are effectively dealt with.
- It is also important that the Auditor Panel is alert to the possibility of conflicts of interest – for example, if non-audit services work is awarded to the external audit provider, how will the Auditor Panel ensure that the auditors' independence is maintained?

If the Trust Board asks the Panel, it must advise on any proposal to enter into a liability limitation agreement with audit firms (this would be considered as part of the procurement process).

The Trust Board can determine to remove any member of the Auditor Panel including the Chair. The Chair of the Trust Board would need to re-consider the membership of the Committee in the case of a Non-executive Panel member being removed.

The Panel shall provide update reports to the Committee and to the Trust Board.

8. Behaviours and conduct

Trust values

Members will be expected to conduct business in line with the trust values and objectives. Members of, and those attending, the committee shall behave in accordance with the trust's constitution, standing orders, and standards of business conduct policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

9. Accountability and reporting

The committee shall report to the board on how it discharges its responsibilities.

The minutes of the committee's meetings shall be formally recorded by the secretary and the AAA assurance report will be made available for the board. The chair of the committee shall draw to the attention of the board any issues that require disclosure to the full board, or require executive action.

The committee will report to the board at least annually on its work in support of the annual governance statement, specifically commenting on the:

- fitness for purpose of the assurance framework
- completeness and 'embeddedness' of risk management in the organisation
- effectiveness of governance arrangements
- appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

This annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed.

An annual committee effectiveness evaluation will be undertaken and reported to the committee and the board.

The audit committee will review these terms of reference, at least annually as part of the annual committee effectiveness review and recommend any changes to the board.

10. Secretariat and administration

The committee shall be supported administratively by its secretary. Their duties in this respect will include:

- agreement of agendas with the chair and attendees
- preparation, collation and circulation of papers in good time
- ensuring that those invited to each meeting attend
- taking the minutes and helping the chair to prepare reports to the board
- Support the Chair in draft the AAA escalation and assurance report for the board
- keeping a record of matters arising and issues to be carried forward
- arranging meetings for the chair: for example, with the internal/ external auditors or local counter fraud specialists
- maintaining records of members' appointments and renewal dates and so on
- advising the committee on pertinent issues/ areas of interest/ policy developments
- ensuring that action points are taken forward between meetings
- ensuring that committee members receive the development and training they need.

11. Review

The committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the board for approval.

Governance table

For Board and Board Committees: Paper sponsored by:	Audit and Risk Committee 11 September 2026 Kate Dyer, Director of Governance and Risk												
Paper authored by:	Kate Dyer Director of Governance and Risk												
Date submitted:	1 September 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):	None												
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	NA												
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Annual												
LPT strategic alignment:	<table> <tr><td>T - Technology</td><td></td></tr> <tr><td>H – Healthy Communities</td><td></td></tr> <tr><td>R - Responsive</td><td></td></tr> <tr><td>I – Including Everyone</td><td></td></tr> <tr><td>V – Valuing our People</td><td></td></tr> <tr><td>E – Efficient & Effective</td><td>Yes</td></tr> </table>	T - Technology		H – Healthy Communities		R - Responsive		I – Including Everyone		V – Valuing our People		E – Efficient & Effective	Yes
T - Technology													
H – Healthy Communities													
R - Responsive													
I – Including Everyone													
V – Valuing our People													
E – Efficient & Effective	Yes												
CRR/BAF considerations (<i>list risk number and title of risk</i>):	NA												
Is the decision required consistent with LPT's risk appetite:	Yes												
False and misleading information (FOMI) considerations:	None												
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed												
Equality considerations:	None												

Trust Board 29 September 2026

Trust Board Annual Effectiveness Review 2025/26

Purpose

To provide an annual review of the effectiveness of the Trust Board for 2025/26.

Analysis

NHS Trust Boards play a key role in shaping the strategy, vision, and purpose of an organisation. They are responsible for holding the organisation to account for the delivery of the strategy and to ensure value for money. They are also responsible for assuring that risks to the organisation and the public are managed and mitigated effectively. Led by an independent chair and composed of a mixture of both executive and independent non-executive members, the Trust Board has a collective responsibility for the performance of the organisation, and for delivery against our Group strategy.

Leicestershire Partnership NHS Trust (LPT) and Northamptonshire Healthcare NHS Foundation Trust (NHFT) have worked in a group arrangement since 2021. Each organisation has embraced the opportunity to collaborate on projects to the benefit of our staff and those we care for and work with. Since May 2025, our two Trusts have held regular Group joint boards in public and include confidential meetings and board development sessions focusing on our Group priorities. These Group board meetings combine both sets of board members. They do not replace our LPT Board; they co-exist and do not duplicate material.

As part of the Group model, we have a number of board member positions which are Group roles across both organisations; these individuals sit on both boards.

The LPT Trust Board meets virtually to hold Public & Confidential meetings on a bi-monthly basis. A Group Public Trust Board is in place to review group related activity and is held 4-monthly. Bi-monthly development meetings also take place face to face.

Our Board Development Programme for the year comprised of 7 workshops, 4 of which were held with our partners at NHFT on common topics. In addition to the core topics, this year's programme provided the Board with the opportunity to focus on several areas of development for the Trust.

The Trust Board Terms of Reference (ToR) have been reviewed for 2026 and are attached at appendix A for approval.

Effectiveness of the Trust Board Meetings

Trust Board meetings have been evaluated and deemed to be effective during 2025/26. Items on the Trust Board work plan were received during the 2025/26 year and to date either in line with expectations or deferred and noted on our Board agenda.

Membership attendance has been good; each meeting was quorate, and each meeting has included clinical representation across 2025/26.

Attendance at Public & Confidential Trust Board meetings 1 April 2025 to 31 March 2026:

Member	Role	Attendance
Crishni Waring	Chair (last meeting Oct 25)	4 of 4
Faisal Hussain	NED & Deputy Chair. Interim Group Chair from Nov25	7 of 7
Hetal Parmar	NED	7 of 7
Alexander Carpenter	NED (last meeting May 25)	1 of 1
Melanie Hall	NED	7 of 7
Manjit Darby	NED	2 of 5
Josie Spencer	NED	7 of 7
Elizabeth Anderson	NED	7 of 7
Angela Hillery	CEO	7 of 7
Jean Knight	Managing Director	7 of 7
Sharon Murphy	Director of Finance	7 of 7
Bhanu Chadalavada	Medical Director	7 of 7
James Mullins	Acting Director of Nursing (last meeting Oct 25)	4 of 4
Linda Chibuzor	Group Chief Nurse (from Nov 25)	3 of 3
Kate Dyer	Director of Governance & Risk	7 of 7
Samantha Leak	Director of Community Health Services (and FYPCLDA)	7 of 7
Tanya Hibbert	Director of Mental Health	7 of 7
Paul Williams	Acting Director of FYPCLDA (last meeting Aug 25)	2 of 3
Sarah Willis	Director of HR & OD/Group Chief People Officer	7 of 7
Paul Sheldon	Chief Finance Officer	6 of 7
David Williams	Director of Strategy & Partnerships	6 of 7
Tim Harrison	NED (first meeting Jan 26)	1 of 2
Chris Skelton	NED (first meeting Jan 26)	2 of 2

Trust Board meetings have been considered as well-run throughout 2025/26. Papers are issued five working days ahead of the meeting. The size of the agenda and length of the papers remains an ongoing challenge, and the ongoing transformation of the governance structure continues to support the clarity of work planning for the Trust Board. The Group Trust Board has served to ease the burden further and supports the prevention duplication of work across the Trusts.

The minutes of the meetings continue to reflect thorough and informed debate for items with a rigour for matters not proceeding as expected and evidence support for positive progress as assurance. Actions are managed with a dynamic action log which demonstrates good responsiveness across the year.

Each of the level 1 Committees (the Board sub committees) have undertaken a review of effectiveness for 2025/26 and these have been approved by each of the committees. The level 1 annual effectiveness reviews have concluded that the Committees have been effective during the year and have fulfilled their Terms of Reference. The reviews have identified several improvement actions for the Committees for 2026/27 onwards. Assurance over the effectiveness of the reviews was confirmed at the September 2026 Audit and Risk Committee and this is reported to Board in the ARC AAA report.

Trust Board Compliance with the Code of Governance

- The Code of governance Section C: Composition, succession and evaluation 1.3 states *Annual evaluation of the board of directors should consider its composition, diversity and how effectively members work together to achieve objectives. Individual evaluation should demonstrate whether each director continues to contribute effectively.*

Our annual evaluation of the Board includes this annual review of board effectiveness, a self-assessment of provider capability and our annual well led self-assessment. This year we have also completed a review of progress against the recommendations from an external review of leadership and governance undertaken in 2024/25. We have also recently undertaken a review of board skills which is contributing to the format of the NHS England Board development programmes taking place and being delivered this year by Deloitte.

As part of the annual appraisal process, individual evaluations are conducted to determine whether each director continues to contribute effectively, both in terms of their engagement and the value they bring to the Board's collective performance.

- The Code of governance Section C: Composition, succession and evaluation 4.5 states *There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors...NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.*

We conduct a formal annual evaluation of the performance of the Board of Directors and its committees; each level one committee will receive an annual review of effectiveness. The Chair and individual directors all undertake annual appraisals and regular one to ones. These processes are designed to ensure accountability, enhance effectiveness, and support continuous improvement in governance practices.

Board member feedback

We have collated feedback from members and attendees of the Board relating to areas of achievement and success, and any challenges and barriers during 2025/26; the key areas have been collated and summarised below.

Achievements and successes in 2025/26:

Board engagement and discussion

- Focussed board discussions facilitated by reports which continue to improve, seeing more clarity, brevity and focus.
- Focussed board engagement in development sessions.
- Greater focus on strategic items, discussion and clear alignment to THRIVE strategy.

Patient voice

- Enhanced patient story, service presentation and staff voice – with clear follow up on any learning. Effective at showcasing the work of the Trust.
- Patient experience and quality of services is a priority in the Trust, evidenced by informative presentations at Board.

Governance and Risk

- Successful and seamless transition of new interim chair arrangements into Board.
- Move to group Board structure and more group roles.
- BAF development/risk development.

Culture

- Living our values and balancing different objectives in challenging financial circumstances.
- The culture of the Board continues to develop, and the inclusion of further group roles hasn't impacted on the feeling of trust, psychological safety and constructive challenge.

Delivery

- Continued oversight and assurance of a wide-ranging work plan, including delivery of the financial plan and flu campaign and regulatory matters.
- Agreement of the success measures of the corporate plan at a recent awayday.

Challenges and barriers during 2025/26:

Clarity of data and information

- Continue to improve clarity of integrated performance report.
- Papers could be more strategic and outcome focused.

Remit

- Continue to define the remit of the LPT Board and that of the Group Board.
- Ensure service, staff and patient stores are balanced and show not only positive but negative situations and what we have learnt from them.

Pressures

- National issues and external factors which include cost of living crisis, changes at NHSE, ICBs, waiting lists etc impact on delivery and are difficult to solve in a local context.
- Financial pressures mean that solutions to challenges are not always easily solved.

Future Plans;

- Continue to put patients first, with more focus on patient engagement and feedback
- Ongoing oversight of THRIVE strategic goals, and ongoing regard to the roles of LPT and Group Board. Potential to reduce LPT Board time given the Group Board remit.
- Continuing to ensure we remain strategic, with a focus on outcomes and sustainability and emphasis on triangulation and receiving evidence for assurance.
- Continue to have oversight of key items such as
 - Financial delivery and balance with quality/safety
 - Governance and Risk
 - Transformation and delivery of the NHS Long Term Plan
 - Health inequalities, Patient, and Carer Race Equality Framework (PCREF)
 - Regulatory Compliance (CQC)
- Continue to improve the quality of written papers.

Proposal

To receive assurance over the effectiveness of the Trust Board during 2025/26.

Decision required

- To confirm a level of assurance over the effectiveness of the Trust Board
- To approve the ToR for 2026/27

Appendix A – LPT Trust Board Terms of Reference 2026/27

Leicestershire Partnership NHS Trust

Trust Board Terms of Reference

Version	2026/27 v1
Executive Lead	Director of Governance and Risk
Date Approved	Trust Board September 2026
Review Date	Annual Review September 2027

1.0 Constitution

The Trust Board of Directors ('the Board') is accountable to the Secretary of State for the effective direction of the affairs of Leicestershire Partnership NHS Trust ('the Trust'), setting the strategic direction and appetite for risk of the Trust, establishing arrangements for effective governance and management, and holding management to account for delivery with particular emphasis on the safety and quality of the Trust's services and achievement of the required financial performance.

Leicestershire Partnership NHS Trust (LPT) and Northamptonshire Healthcare NHS Foundation Trust (NHFT) have worked in a group arrangement since 2021. Each organisation has embraced the opportunity to collaborate on projects to the benefit of our staff and those we care for and work with. Since May 2025, our two Trusts have held regular Group joint boards in public and include confidential meetings and board development sessions focusing on our Group priorities. These Group board meetings combine both sets of board members. They do not replace our LPT Board; they co-exist and do not duplicate material.

As part of the Group model, we have a number of board member positions which are Group roles across both organisations; these individuals sit on both boards.

The Board has established the following Board Committees, referred to as the Level 1 Committees, in two instances these are jointly held level 1 committees in common with NHFT;

- Audit and Risk Committee
- Charitable Funds Committee
- Finance and Performance Committee
- Joint People and Culture Committee
- Quality and Safety Committee
- Joint Remuneration Committee
- ~~Joint Working Group~~

2.0 Purpose

- The purpose of the Board is to govern the organisation effectively and ensure that the Trust is providing safe, high quality, patient centred care.

- the Board is responsible for ensuring that the Trust is a value-based organisation which provides great care, is a great place to work and provides great value for money, where everyone counts and contributes.
- the Board leads the Trust by undertaking the following key roles:
 - oversight of the management of staff wellbeing and patient safety.
 - formulating strategy, defining the organisation's purpose, and identifying strategic priorities and objectives.
 - ensuring accountability by holding the organisation to account for the delivery of the strategy and scrutinising performance.
 - seeking assurance that systems of governance and internal control are robust and reliable and to set the appetite for risk.
 - shaping a positive culture for the Board and the organisation.

3.0 Responsibilities

The general responsibilities of the Board are:

- To maintain and improve quality of care.
- to ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity.
- to foster positive and productive external relationships with partners and stakeholders in the local health economy, in particular with patient/user groups and forums, Local Authorities, Health and Wellbeing Boards, Leicester, Leicestershire, and Rutland Integrated Care System partners, HealthWatch and Primary Care Networks.
- to exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost-effective manner.
- to ensure compliance with all applicable law, regulation, and statutory guidance.
- in fulfilling its duties, the Board will work in a way that makes the best use of the skills of non-executive and executive directors.
- a Memorandum of Understanding has been made between the Trust and Northamptonshire Healthcare NHS Foundation Trust (NHFT) for the formulation of a 'Group' model between the Trusts. ~~'committees in common' arrangement, operating as a joint working group to establish their group model structure without delegating board decision making authority to it; the Group focuses on agreed strategic areas in common and reports into both boards.~~

Leadership

The Board provides active leadership to the organisation by:

- Ensuring there is a clear vision and strategy for the Trust that is well known and understood by stakeholders and is being implemented within a framework of prudent and effective controls which enable risk to be assessed and managed.
- ensuring the Trust is a good employer by the development of a workforce strategy and its appropriate implementation and operation.
- promotes the health and wellbeing of staff.
- implements effective board and committee structures and clear lines of reporting and accountability throughout the organisation.

Quality

The Board:

- Ensures that the Trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experiences are achieved.
- fosters a culture that puts patients first.
- ensures that it engages with all its stakeholders, including patient and staff, on quality issues.
- ensures that issues are escalated appropriately and dealt with in a timely manner.

Strategy

The Board:

- oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required.
- develops and maintains an annual business plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders.
- ensures that national policies and strategies are effectively addressed and implemented within the Trust.
- **Works with NHFT under the Group model arrangements to set and maintain a Group** ~~the Trust's~~ strategic vision, aims and objectives, being cognisant of the Leicester, Leicestershire, **Northampton** and Rutland integrated care system, for ensuring the necessary financial, workforce and physical resources are in place to meet its objectives.
- ~~Considers the opportunities for aligning a strategic framework within the Group arrangements~~
- **Working with NHFT it;**
 - o determines the nature and extent of the risk it is willing to take in achieving its strategic objectives.
 - o monitors and reviews management performance to ensure the Trust's objectives are met.

Culture, ethics and integrity

The Board:

- Is responsible for setting values, ensuring they are communicated and adhered to, and that the behaviour of the Board is entirely consistent with those values.
- promotes a patient-centred culture of openness, transparency, and candour.
- ensures that high standards of corporate governance and personal integrity are maintained in the conduct of Trust business.
- ensures the application of appropriate ethical standards in sensitive areas such as research and development.
- ensures fairness and continuity to improve people practices.
- embeds the Learning Organisation and Quality Improvement ethos into all activities.
- Promotes learning from best practice and maximises opportunities for learning across the Group.
- ensures that directors and staff adhere to any codes of conduct adopted or introduced from time to time.
- promotes diversity and inclusion.
- is responsible for maintaining a Freedom to Speak Up Culture.

Governance and Compliance

The Board:

- Ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance and appropriate codes of conduct, accountability, and openness applicable to NHS Provider organisations.
- ensures that all licence conditions relating to the Trust's governance arrangements are complied with.
- ensures that the Trust has comprehensive governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements.
- ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective and safe services taking account of patient and carer experiences and maintaining the dignity of those cared for.
- Promotes the provision of assurance from all three lines of assurance, including
 - o 1st line staff, student, patient, carer and volunteer voice
 - o 2nd line specialists and heads of service
 - o 3rd line independent reports
- ensures that all the required returns and disclosures are made to the regulators.
- formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of Trust business.
- agrees the schedule of matters reserved for decision by the Board.
- ensures the proper management of and compliance with the Mental Health Act and other statutory requirements of the Trust.
- approves the Annual Report, Quality Account and Annual Accounts.
- considers directives, comments and recommendations from its committees and takes the appropriate action.
- ensures there are appropriately constituted appointment and evaluation arrangements for senior positions.
- ensures that the statutory duties of the Trust are effectively discharged.
- acts as corporate Trustee for the Trust's charitable funds.
- will conduct an annual appraisal of the Board's effectiveness.

Risk

The Board:

- Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities.
- ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement in the development of care plans, the review of quality of services provided and the development of new services.

Finance

The Board:

- Ensures that the Trust operates effectively, efficiently and economically.
- oversees the achievement of the Trust's control total.

- ensures the continuing financial viability of the organisation.
- ensures the proper management of resources and that financial responsibilities are fulfilled.
- ensures that the Trust achieves the targets and requirements of stakeholders within the available resources.
- reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

4.0 Membership

The Board is comprised of a Chair, six non-executive Directors, a Chief Executive Officer and four other voting directors. In addition to this, the Trust has seven directors in attendance as detailed below:

Voting Members

- Chair
- Non-Executive Directors
- Chief Executive Officer
- Managing Director/Deputy Chief Executive
- ~~Director of Finance and Performance~~ Chief Finance Officer
- Medical Director
- Chief Nurse/Director of Nursing, Quality and Allied Health Professionals

Non-Voting Members

- Associate Non-Executive Director
- Group Chief People Officer
- Executive Director of Community Health Services and Families, Young People and Children's & Learning Disabilities Services
- Executive Director of Mental Health
- Director of Governance and Risk
- Group Executive Director of Strategy and Partnerships
- Group Chief Commissioning Officer
- Group Chief Delivery and Integration Officer
- ~~The Trust's Operational Directors (one for each of the three clinical directorates)~~
- ~~Director of Human Resources and Organisational Development~~
- ~~Director of Corporate Governance (Trust Secretary)~~
- ~~Group Director of Strategy and Partnerships~~
- ~~Group Chief Finance Officer~~

In the case of the number of votes for and against a motion being equal, the Chair of the Board will have a second, casting vote.

Members will be expected to attend at least 75% of meetings.

Non-Executive Director responsibilities

Non-executive directors fulfil the following roles and responsibilities on behalf of the Board.

- Senior Independent Director
- Deputy Chair
- Committee Chairs
- Relevant lead roles in line with national guidance

5.0 Quorum

No business shall be transacted at meetings of the Board unless the following are present:

- A minimum of two voting directors.
- at least two non-executive directors including the Chair or designated deputy chair.

6.0 Frequency

- Bi-monthly Public and Confidential Meetings.
- bi-monthly Development meetings will be held in private to support board development and strategic planning; **these are primary undertaken with NHFT under our Group model arrangements however LPT specific board development sessions are held where required**.
- ~~joint development sessions with NHFT to support board development for areas of key joint strategic interest and learning.~~

7.0 Administration

- The Board shall be supported administratively by the Corporate Governance Department.
- the agenda shall be agreed with the Chair or designated Deputy Chair in consultation with the Director of Governance and Risk.
- the Corporate Governance Department will support the production of the paper pack and ensure the pack is circulated within five working days prior to the meeting, attend the meetings to take the minutes, keep a record of matters arising and generally provide support to the Chair and designated Deputy Chair, and members of the Board.

8.0 Authority

The Board may:

- Seek any information it requires from any employee of the Trust in order to perform its duties.
- obtain external legal or other professional advice on any matter within its terms of reference, and
- call any employee to attend a meeting of the Board as and when required.

9.0 Workplan and Reporting

- The Board will approve an annual workplan. This will contain standard items which the Board agenda will contain at each meeting; it will also outline those reports which are not delegated to the level 1 Committees, these will be scheduled for board oversight throughout the year. These include items that the Board receives based on its constitutional, statutory and mandatory requirements, including items according to the scheme of delegation and best practice items recommended for board oversight. Items delegated to the level 1 Committees will not be considered at Board unless by exception.
- the Board will receive updates from the Level 1 Committees via use of highlight reports to an agreed format. The Chairs of Committees will also be responsible

for ensuring relevant information and decisions are reported and cascaded back through the appropriate communication channels.

- where the Board has a shared oversight of matters with the Level 1 Committees, the relevant Level 1 Committee shall provide the report in full, appended to the highlight report.
- the Level 1 Committees shall append the full report for items escalated as a concern on the highlight report, and for anything requiring Board approval.
- member's attendance at meetings will be disclosed in the Board's annual effectiveness review and the Trust's Annual Report.
- Trust Board and the Audit and Risk Committee annual reviews of effectiveness will be received at the Public Board. The Remuneration Committee annual review of effectiveness will be received at the Confidential Board. All other annual reviews of effectiveness for the level 1 Committees will be received by the Audit and Risk Committee and assurance will be provided in the AAA report to Board.

Governance table

For Board and Board Committees:	Confidential Trust Board 29 September 2026
Paper sponsored by:	Kate Dyer Director of Governance and Risk
Paper authored by:	Kate Dyer Director of Governance and Risk
Date submitted:	18 September 2026
Name and date of other committee / forum at which this report / issue was considered:	None
Assurance level gained if considered elsewhere	NA
Date of next report:	September 2027
THRIVE strategic alignment:	☐ Technology ☐ Healthy communities ☐ Responsive ☐ Including everyone ☐ Valuing our people ☒ Efficient and effective
Board Assurance Framework considerations:	NA
Is the decision required consistent with LPT's risk appetite:	NA
False or Misleading Information considerations:	None
Positive confirmation that the content does not risk the safety of patients or the public:	Yes
Equality considerations:	None



Trust Board 29 September 2026

Joint Nominations and Remuneration Committee

Purpose of the Report

The Nominations and Remuneration Committee is one of only two Committees the Board is required to have by law. The Board has previously agreed for its Nominations and Remuneration Committee to meet in common with the equivalent body from Northamptonshire Healthcare NHS Foundation Trust (NHFT).

The terms of reference for the Joint Nominations and Remuneration Committee are appended to this report for the Board's consideration and approval.

Analysis of the Issue

The Trust is required under Schedule 7 of the NHS Act 2006 to establish a committee of Non-Executive Directors of the Board to appoint or remove, and to decide the remuneration and allowances, and the other terms and conditions of office of, the executive directors.

Considering the opportunities for, and the practicalities of, appointment to joint or group executive director positions, both LPT and NHFT Boards wished for their Nominations and Remuneration Committees to meet in common as a Joint Committee.

Proposal

The Nominations and Remuneration Committees from both Trusts have developed terms of reference for the meeting in common, operating as the Joint Committee. These are appended to this report for the Board's consideration.

Decision Required

The Board is asked to receive and approve the terms of reference for the Joint Nominations and Remuneration Committee appended to this report.

Governance Table

For Board and Board Committees:	Public Trust Board 29 September 2026
Paper sponsored by:	Kate Dyer Director of Governance and Risk
Paper authored by:	Kate Dyer Director of Governance and Risk
Date submitted:	18 September 2026
Name and date of other committee / forum at which this report / issue was considered:	Nominations and Remuneration Committee
Assurance level gained if considered elsewhere	☒ Assured
Date of next report:	As required
THRIVE strategic alignment:	☐ Technology ☐ Healthy communities ☐ Responsive ☐ Including everyone ☒ Valuing our people ☐ Efficient and effective
Board Assurance Framework considerations:	GBAF 07 / GBAF 08
Is the decision required consistent with LPT's risk appetite:	N/A
False or Misleading Information considerations:	None
Positive confirmation that the content does not risk the safety of patients or the public:	Yes
Equality considerations:	None

Appendix – Terms of Reference for the Joint Nominations and Remuneration Committee

Provided as a separate, accompanying paper

Joint Nominations and Remuneration Committee Terms of Reference

Leicestershire Partnership NHS Trust (LPT) and Northamptonshire Healthcare NHS Foundation Trust (NHFT)

Version	Date	Author
1.0	December 2025	Joint NRC

AUTHORITY

The Joint Nominations and Remuneration Committee (Joint NRC) is a formal Committee of the Boards of Directors of Leicestershire Partnership NHS Trust (LPT) and Northamptonshire Healthcare NHS Foundation Trust (NHFT) and will act within these Terms of Reference on behalf of both Boards.

The Committee will operate in accordance with the Standing Orders of both Trusts, the Fit and Proper Persons Requirement, and the NHS Provider Code of Governance.

KEY OBJECTIVES, DUTIES, RESPONSIBILITIES AND SCOPE

Nominations Functions

Ensure a formal, rigorous, and transparent procedure for the appointment of Executive Directors across LPT and NHFT, confirming they meet Fit and Proper Person requirements.

Lead the process for identification and nomination of the Chief Executive for approval by the Council of Governors.

Oversee the process for appointments of Executive Directors across both Trusts.

Oversee board skills, knowledge, and experience.

Consider succession planning considering future challenges and opportunities.

Appoint executive search consultants as required.

Ensure robust procedures for appointing nominated representatives (not employed by either Trust) to partnership/joint venture boards.

Oversee appointments to joint roles within the group structure and any other joint arrangements between LPT and NHFT.

Remuneration Functions

Ensure a formal and transparent policy on Executive Director remuneration.

Determine and review contractual arrangements for Executive Directors, including severance packages.

Set structure and levels of remuneration for Executive Directors.

Ensure transparent appraisal processes for Executive Director performance.

Monitor Executive Director performance.

Agree remuneration and contractual terms for nominated representatives (not employed by either Trust) on partnership/joint venture boards.

Oversee the application of the Very Senior Manager pay framework for Executive Directors and Directors below Board level on very senior management contracts, administered by the CEO with HR advice; CEO to report annually.

Oversee and apply where appropriate performance related bonus payments in line with the VSM pay framework provisions.

Receive annual assurance from the Chair on Fit and Proper Person compliance.

MEMBERSHIP

Committee chaired by the Trust Chair (or Joint Chair if applicable).

Two Non-Executive Directors from both Trusts; including the chair of the Joint People and Culture Committee.

Chief Executive is a voting member for all nominations functions except those relating to their own appointment.

Group Chief People Officer and other Directors/advisors may attend as appropriate.

Sub-groups may be established for specific tasks with agreed remit and reporting.

QUORUM

Minimum of four members, excluding the Chief Executive for discussions on their own appointment.

FREQUENCY OF MEETINGS

At least bi-annually.

REPORTING

Report annually to both Boards of Directors.

MINUTES

Supported by HR & OD; minutes available to all members.

EFFECTIVENESS REVIEW

Periodic review by both Boards.

Equality and Inclusion

Committee must ensure compliance with Public Sector Equality Duty for all relevant decisions, using a checklist approach (as per Equality Act 2010).

Appendix 1 - Public Sector Equality Duty Checklist

- Who will be affected by this decision? What information is there about its likely effects on them?
- Have you consulted with people who might be affected?
- Could this decision affect some groups of people more than others? Is it likely to have a disproportionately bad effect on some groups?
- Could the proposal be amended to avoid or reduce this disproportionate effect?
- Does this decision offer an opportunity to promote equality or good relations between different groups?
- Accessible environments: Physical access and access to information (e.g., Large Print, Digital, BSL, Non-English translations).
- Decisions should be reviewed to see what effects they have actually had. Do you need to make arrangements now so that information will be available for this review?

Level 1, 2 and 3 Alert, Advise and Assure (AAA) Highlight Report

LPT Committee/Group: Quality and Safety Committee

Date of Meeting: 18th August 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/26/078	Jean Knight	The Committee discussed the cessation of non-recurrent ADHD funding and noted concerns that waiting lists were likely to increase further in the absence of additional commissioner support. New system model in development but 5 years from implementation. Further conversations taking place with commissioners	04 05		
Quality and Safety Dashboard	QSC/26/081	Dr Bhanu Chadalavada	The Committee was advised of the work underway in response to the Equality and Human Rights Commission's revised definition relating to biological sex. A dedicated task and finish group had been established to assess the impact of the changes on both patients and staff. The work is being led by Dr Bhanu Chadalavada with support from the	05		

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
			Trust's Equality and Diversity Lead and nursing and directorates colleagues. As part of this programme, a Privacy, Dignity and Same-Sex Accommodation Audit has been issued to clinical areas, incorporating additional elements arising from the recent ruling, to establish a baseline position across the organisation.			

ASSURE: Inform the Board where positive assurance has been received

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Action Log	QSC/26/075	Linda Chibuzor	The Committee received an update report on assurance arrangements for Equality and Quality Impact Assessments associated with Cost Improvement activity and impact on patient safety and quality of care. Members noted that the purpose of the process is not to demonstrate absence of impact, but rather to ensure that impact has been properly identified, assessed, and mitigated before implementation. Assurance was provided regarding the review, challenge and sign-off arrangements currently in place and the links between executive oversight and quality governance. The Committee received and noted the report, accepted the proposed next steps and recommendations, and agreed to receive a further detailed update, including example EQIAs together with a proposed timeline for reporting at the October 2026 Quality and Safety Committee.	05		
Quality Improvement Report	QSC/26/083	Linda Chibuzor	The Committee received the Quality Improvement Report summarising a range of improvement initiatives currently underway and articulating examples of good practice and excellence across services. The inclusion of audit activity and	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)
			examples of improvement work occurring across the Trust was welcomed. The progress against priorities for 2026/27 and reviewed examples of excellence arising from quality improvement initiatives was noted. Thee report provided considerable assurance regarding the strength of the Trust’s quality improvement culture.			
Patient Experience Q1 2026-27	QSC/26/085	Linda Chibuzor	The Committee received the quarterly Patient Experience report. Improvements were noted in complaints performance, 92% of complaints had been closed within target timescales and 99% acknowledged within three working days in June 2026. Evidence of high levels of patient satisfaction were included, over 91% of reported experiences being positive and a 52% increase in compliments received during the quarter. Other elements highlighted in the report were around the strong processes for co-production arrangements, approval of the Trust’s co-production charter and successful achievement of the Carer’s Trust Triangle of Care accreditation. The Committee peer support worker patient story was welcomed as a powerful illustration of recovery-focused practice.	05		
Emergency Preparedness, Resilience and Response (EPRR) Annual report 2025-26	QSC/26/090	Jean Knight	The Committee received the EPRR annual report which highlighted the positive work undertaken throughout the year, particularly in site-based business continuity planning. Members welcomed national recognition of some of the Trust’s approaches and heard that full compliance against national standards was anticipated to be maintained.	06		



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)
LPT Medical Director update	QSC/26/076	Dr Bhanu Chadalavada	The Committee also received an update regarding the “Big Pitch” innovation event. Thirty-six projects had been submitted, with six eventually presented. Members commended the enthusiasm, innovation and quality of preparation demonstrated by staff, together with the strong support provided through mentoring and development arrangements.	03		
Accountability Framework Meeting Triple A report	QSC/26/078	Jean Knight	The Committee were advised of a number of outstanding areas of practice were highlighted, including work undertaken during Dying Matters Awareness Week and the implementation of mental health co-streaming within the Emergency Department at UHL. Members welcomed the early positive impact being reported and requested continued monitoring so that outcomes and benefits could be demonstrated over time.	05		
Quality Improvement Report	QSC/26/083	Linda Chibuzor	The Committee were informed of the One Stop Memory Service re-designed model enables patients to attend a single appointment where they receive assessment, consultant review and diagnosis on the same day. 383 appointments were offered and 88% of patients received a same day diagnosis. This has had a significant positive impact on reducing waiting times and improving patient experience.	04 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.

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			

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)
16 th 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		



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.

Trust Board 29 September 2026

Safe Staffing July 2026

Purpose of the Report

This report provides a full overview of nursing safe staffing during the month of July 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 is 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.

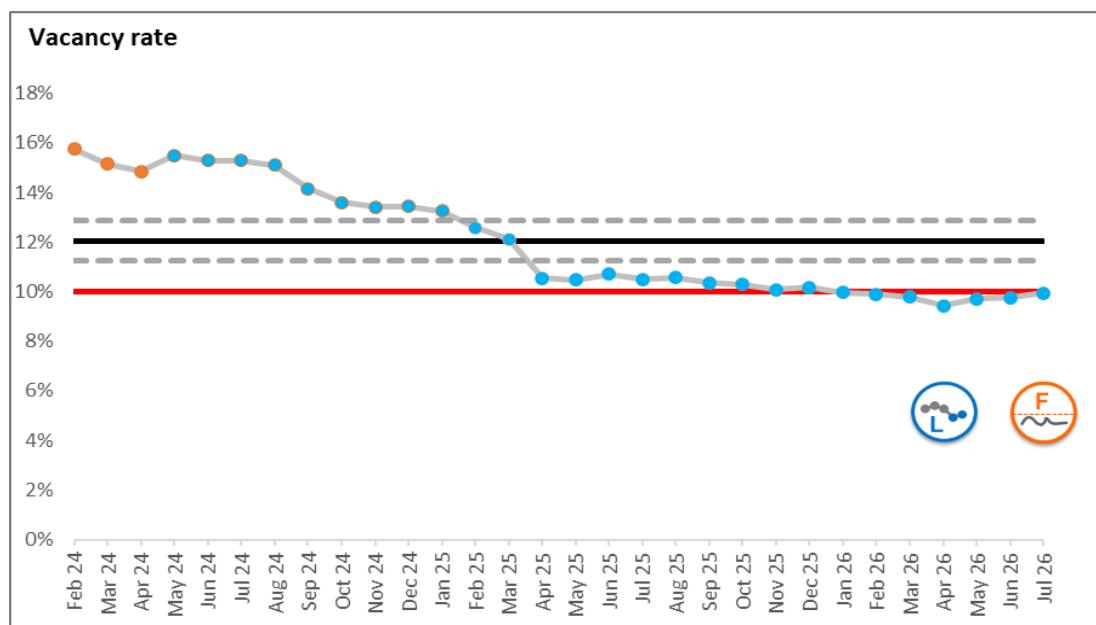
The Trust demonstrates its position regarding mandatory submission of fill rates required by the Department of Health via UNIFY and paying attention to any variance below 80% and above 110%. The upload of these figures to UNIFY occurs on the 15th of each month following review and sign off by the Group 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 July 2026, the overall Trust vacancy rate was 9.9% which is slightly below the Trust target of 10%.



Registered Nurses

- Vacancy position is at 242.3 Whole Time Equivalent (WTE) with a 12.0% vacancy rate, an increase of 0.3% since June 2026.
- Turnover for nurses is at 5.6% which is below the Trust target of 10%.
- Sickness reported at 6.5% a decrease of 0.2% since June 2026.
- 6.0 WTE nursing staff (bands 5 to 8a) were appointed in July 2026.

Health Care Support Worker (HCSW)

- Vacancy position is at 175.9 WTE with a 16.25% vacancy rate, an increase of 0.45% since July 2026.
- Turnover rate is at 8.22%. which is below our internal target of no more than 10%.
- Sickness reported at 6.9% which is a decrease of 1.4% since July 2026.
- A total of 14.1 WTE HCSW were appointed in July 2026.

Allied Health Professionals (AHPs)

- Vacancy position is at 57.1WTE with a 6.2% vacancy rate, an increase of 0.2% since July 2026.
- Turnover rate remains at 8.44%, which is below our internal target of no more than 10% turnover.
- Sickness reported at 4.4%, which is a decrease of 0.5% since July 2026.
- 4.0 WTE AHP was appointed in July 2026

Medical

- Vacancy position is at 15.5 WTE with a 9.7% vacancy rate with an increase of 2.6% since June 2026.
- Turnover rate is at 11.3%, which is above our internal target of no more than 10% turnover.
- Sickness reported at 1.1% which is a decrease of 0.8% since July 2026.
- No medical staff appointed in July 2026.

Temporary workforce

- Temporary worker utilisation rate increased this month by 0.33% reported at 20.61% overall, of this, Trust wide agency usage decreased this month by 0.12% to 0.40% 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 82.8%.
- Across the Trust, on average appraisal rates and clinical supervision remain consistently compliant (green).

Right Place

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

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

Table 1 below identifies key areas to note for July 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	Staffing Temporary workforce utilisation higher for: Rutland and Ward 1 St Lukes, above 20% 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. Ten wards are utilising less than 20% temporary workforce, of which six utilising less than 15% and two wards using less than 10%. Allied Health Professional (AHP) Staffing - Moderate Risk Rating Amber Sickness and maternity leave across all community hospital in-patient wards, recruitment in progress and band 7s working closely together to cover each ward daily. Impacting provision of consistent therapy. There is no direct correlation on patient safety incidents. AHP leads strengthening incident reporting and introduction of job planning.	Green
CHS In-patients	Fill rate HCSWs fill rates above 110% on days and night shifts have improved in July 2026. One ward (Rutland) had a fill rate above 110% for HCSWs on night shifts, 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. Enhanced Therapeutic Observations of Care (ETOC) improvement work with a daily task and finish group continues, linked to the trust wide NHS England ETOC programme. Education has been increased and improvements to embed ETOC practice.	Green
CHS In-patients	Nurse Sensitive Indicators (NSIs) Falls 25 falls incidents reported, which is consistent with June 2026. All falls' incidents reported as low/no harm. Staffing was not identified in initial review as a contributory factor.	Green

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
	<u>Medication incidents</u> Medication incidents increased from 10 in June to 12 in July 2026. All reported as low/no harm. <u>Pressure Ulcers</u> The number of category 2 pressure ulcers developed or deteriorated in our care has decreased from 9 in June to 4 in July 2026. Pressure ulcer improvement work continues with weekly and additional monthly meetings to monitor the refined validation process for all pressure ulcers developed in our care. Ward mattress usage is also monitored on a weekly basis by the CHS Matron team. <u>Staffing Related Incidents</u> The number of safe staffing related incidents remained at 7 in July 2026 across 6 sites. Incidents reported were relating to staffing shortages due to sickness, one incident relating to ETOC and another due to a shortage of therapy staff. All staffing related incidents reported as low/no harm.	
DMH In-patients	Staffing High percentage of temporary workforce to meet planned staffing on Watermead 47.9%, Ashby, Belvoir, and Heather all above 40%. Additional 5 wards all above 25% 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, a patient on long term one to one therapeutic observations, backfilling with additional HCSW's, 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.	Green
DMH In-patients	Fill rate Fill rate below 80% for HCSWs on the day shift at Mill Lodge due to a low bed occupancy and staffing adjusted accordingly.	Green

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
	Fill rate above 110% for HCSWs on day shifts on all other wards apart from Griffin, Coleman, Gwendolen, Kirby, Phoenix, and the Willows. Fill rate above 110% for HCSWs on night shifts on all wards apart from Bosworth, Griffin, Phoenix, Kirby and the Willows HCSW fill rate above 110% was due to high patient acuity and dependency requiring increased therapeutic observations, patients requiring additional staff for personal care, management of falls and deterioration in mental and physical health needs.	
DMH In-patients	Nurse Sensitive Indicators: <u>Falls</u> An increase in the number of falls incidents from 45 in June to 80 in July 2026. Increase in falls incidents due to patient group in Mental Health Services Older People (MHSOP). One moderate fall reported where a patient fell from their mobility scooter and sustained a leg injury. 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. <u>Medication Incidents</u> The number of medication incidents decreased from 31 in June to 20 in July 2026. All incidents were reported as no, or low harm and staffing was not a contributory factor.	Green
FYPC.LDA in- patient	Staffing 42.8% 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. Safe staffing is reviewed daily due to increased patient acuity and complexity with staffing levels adjusted accordingly.	Green

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
	Beacon Unit continue utilise a high number of temporary workforce with advance booking of staff. Mitigation remains in place; potential risks being closely monitored.	
FYPC.LDA in- patient	Fill Rate Below 80% for RNs on day shifts and night shifts at the Agnes unit and night shifts only and The Grange. Below 80% for HCSWs on days shifts and night shifts at the Agnes unit and day 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. Both units worked within the agreed safe staffing model however the fill rate is showing as 'Red' due to the number of shifts available on heath roster and the unit may either cover those with an RN or HCSW. On going review to support staff having an interrupted break during their shift. Mitigation was provided with cross cover for significant reduced RN fill rate on the nights shifts at the Grange during July 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 July 2026. Staffing levels reviewed and adjusted accordingly at the Agnes unit. Reduced RN and HCSW fill rate due to operating on 1 pod (below equivalent commissioned beds). Due to level of acuity and patient numbers, staffing was adjusted accordingly with a minimum of 2 RN per shift. Planned staffing at the Agnes unit is 4 RN per shift. Business Support updated with current planned staffing. Below 80% for HCSWs on nights at the Beacon unit. The unit was staffed with minimum of 2 RNs rather than 3 RNs per shifts as per e-roster allocation on occasions however this was within the safe staffing model and had adjusted staffing for the night shift based on acuity and 1:1 observation. Above 110% for HCSWs on day and night shifts on Welford ED. 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.	Green

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
FYPC.LDA in- patient	Nurse Sensitive Indicators: Falls 7 falls incidents were reported as in July 2026, five of which were on Beacon and staffing was not a contributory factor. Medication Incidents The number of medication related incidents decreased from 6 in June to 4 in July 2026 and staffing was not a contributory factor. Staffing related Incidents There was 1 staffing related incident reported in July 2026 on Welford ED relating to RN and HCSW staffing levels. 2 RNs were maintained, and incident reported as low/no harm.	Green
CHS Community	Overall community nursing Service OPEL has been level 2/3, 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 vacancies, bank, agency usage and reduction. Planned introduction of new Dynamic Risk Assessment (DRA) process from the 1/7/26 to support safe staffing provision. Continuing quality improvement work focusing on pressure ulcer and insulin continues and although the community nursing transformation programme has concluded, 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. All Community Nursing Hubs have now implemented the Community Nursing Safer Staffing Tool (CNSST) and completed 1 data set collection. Plans to complete the second data collection continue to be worked through. AHP Community Therapy - Moderate Risk Rating Amber Significant staffing challenges within East Central due to vacancy, sickness and within clinical leadership team impacting waiting lists. Mitigation includes clinical leads and staff providing cross cover, relocated clinics creating clinical capacity, falls service support and induction of new starters supported by other hubs. Community Integrated Neurological and Stroke service (CINNS) due to sickness and maternity leave significant support being provided to mitigate risks and improve waiting times. Delays in responding to urgent care response (UCR) appointments due to reduced capacity. Triage system in place to reduce the risk.	Green

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
DMH Community	Key areas to note – Mental Health Urgent Care Hub (MHUCH) continues to experience challenges with safer staffing due to vacancies in the team. Bank/overtime utilised to ensure safer staffing and cross cover from Mental Health Liaison Service (MHLS) when pressured. Sickness/planned annual leave and vacancies impacting the Crisis Team. Working to OPEL level3/4 with team leaders stepping into planned staffing supporting service delivery. Further leavers expected and agency staff being considered to support service delivery. Challenges continue in Place of Safety Assessment unit (PSAU) and mental Health Response Vehicle service with Mental Health Practitioner (MHP) vacancies being filled with additional temporary workforce and additional hours/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. Call handling challenges in Mental Health Central Access Point (MHCAP) due to reduced staffing, being backfilled with temporary workforce. Ongoing recruitment continues. No Change - 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 are now separating into two teams, however staffing reduced due to significant sickness and annual leave. City East continue to review patient tracker list, case management and waiting times for Community Psychiatric Nurse (CPN) input. Psychosis Intervention Early Recovery (PIER) caseloads remain high, overall reducing and some delays continue in transferring patients to Neighbourhood Mental Health Teams (NMHT). Melton and Rutland CMHT staffing challenges due to reduced band 7 senior nursing leadership, sickness, and staff leavers. The Community Mental Health Team (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. AHP Community Therapy - Occupational therapy (OT) posts in Adult Mental services in City West, City East, Charnwood, East Leicestershire, Recruitment is progressing and staff returning from maternity leave and long-term sickness in July 2026. Mental Health Services for Older People in South Leicestershire, Melton, Rutland, Harborough and Charnwood affected by vacancies, sickness and maternity leave. Service transformation in	Green

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
	progress focusing on Referral to Treatment, time limited packages of care, meaningful contact and new referral and discharge criteria.	
FYPC.LDA Community	No change to 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 3 city teams remain grouped together to mitigate and maintain service stability. Diana Respiratory Physiotherapy reached maximum caseload capacity; mitigation includes prioritising end of life patients and recruitment in progress to cover maternity leave. LDA Speech and Language Therapy staffing reduced due to extended jury service. Staff returning to work from sick leave. Childrens Occupational Therapy staffing reduced, new starters recruited are starting later in the year and band 6 post recruited to. 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 listed as fragile services. No change to 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.	Green

Summary

- Considering the triangulated review of workforce metrics, nurse sensitive indicators, patient feedback, and outcomes in July 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 – July 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

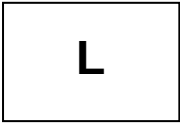
For Board and Board Committees:	Trust Board
Paper sponsored by:	Linda Chibuzor Group Chief Nurse/Executive Director of Nursing, AHPs and Quality
Paper authored by:	Elaine Curtin Workforce and Safe Staffing Matron, Jane Martin Assistant Director of Nursing and Quality, Emma Wallis Deputy Director of Nursing and Quality
Date submitted:	2 September 2026
Name and date of other committee / forum at which this report / issue was considered:	Executive Management Board 1.9.2026
Level of assurance gained if considered elsewhere	☒ Assured ☐ Partially assured. ☐ Not assured
Date of next report:	Bi-Monthly
THRIVE strategic alignment:	☐ Technology ☐ Healthy communities ☐ Responsive ☐ Including everyone ☐ Valuing our people ☒ Efficient 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

Nursing Scorecard - July 2026

There are 2 tables, the first contains the main report data and the 2nd contains further descriptions 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	23	22	100.4% Green	97.3% Green	100.0% Green	100.0% Green	100.0%	100.0%	16.4% Green	16.2% Green	0.2% Green	9	0 Up	0 Down	1 No Change	0 No Change	0 No Change	
Clarendon Ward - CW01	21	20	93.4% Green	109.7% Green	100.0% Green	99.9% Green	100.0%	100.0%	9.0% Green	8.8% Green	0.2% Green	10	0 Down	3 No Change	0 No Change	0 No Change	0 No Change	
Dalglish Ward - MMDW	17	16	99.6% Green	104.9% Green	100.0% Green	108.3% Green	100.0%	100.0%	16.3% Green	15.1% Green	1.1% Green	10	1 Down	1 Down	0 No Change	1 Up	0 No Change	
Rutland Ward - RURW	18	16	98.5% Green	102.3% Green	100.3% Green	153.1% Blue	100.0%	100.0%	27.2% Amber	26.4% Amber	0.8% Green	9	0 Down	2 Down	0 No Change	2 No Change	0 No Change	
Ward 1 - SL1	20	18	92.2% Green	100.2% Green	100.0% Green	99.2% Green	100.0%	100.0%	21.9% Amber	21.9% Amber	0.0% Green	11	0 No Change	1 Down	0 Up	0 No Change	0 No Change	
Ward 3 - SL3	14	13	105.8% Green	102.7% Green	98.4% Green	100.1% Green	100.0%	100.0%	17.4% Green	16.9% Green	0.4% Green	9	2 Down	1 Down	0 Up	0 Down	0 No Change	
Charnwood Ward - LBCW	19	17	97.4% Green	98.9% Green	100.0% Green	98.8% Green	100.0%	100.0%	13.8% Green	13.8% Green	0.0% Green	10	0 Down	0 Down	0 No Change	0 No Change	0 No Change	
East Ward - HSEW	27	26	86.3% Green	104.4% Green	95.5% Green	101.3% Green	100.0%	100.0%	6.8% Green	6.8% Green	0.0% Green	9	2 Down	7 Up	1 No Change	1 Down	0 No Change	
Ellistown Ward - CVEL	20	18	95.2% Green	100.7% Green	100.0% Green	99.2% Green	100.0%	100.0%	13.9% Green	13.9% Green	0.0% Green	10	4 Up	2 Up	0 No Change	0 No Change	0 No Change	
Snibston Ward - CVSN	20	18	101.8% Green	100.3% Green	100.1% Green	100.0% Green	100.0%	100.0%	17.2% Green	17.2% Green	0.0% Green	9	1 Up	1 No Change	0 No Change	0 No Change	0 No Change	
Swithland Ward - LBSW	21	19	82.4% Green	99.9% Green	100.0% Green	101.1% Green	100.0%	100.0%	13.7% Green	13.7% Green	0.0% Green	8	0 Down	5 Down	0 No Change	0 Up	0 No Change	
Ward 4 - CVW4	15	14	100.6% Green	98.5% Green	100.1% Green	100.0% Green	100.0%	100.0%	12.5% Green	12.4% Green	0.2% Green	11	2 Up	2 Down	0 No Change	0 Down	0 No Change	
Ashby	14	14	86.5% Green	158.7% Blue	97.0% Green	149.7% Blue		100.0%	41.9% Amber	40.0% Amber	2.0% Green	10	0 Down	6 Up	0 No Change	0 No Change	0 No Change	
Aston	17	16	106.6% Green	119.3% Blue	98.9% Green	134.3% Blue		100.0%	27.2% Amber	26.6% Amber	0.5% Green	8	0 No Change	0 Down	0 No Change	0 No Change	0 No Change	
Beaumont	22	22	84.0% Green	113.2% Blue	98.2% Green	111.5% Blue		100.0%	27.6% Amber	27.4% Amber	0.2% Green	7	4 Up	4 Up	0 No Change	0 No Change	0 No Change	
Belvoir Unit	10	9	95.7% Green	122.0% Blue	98.4% Green	127.6% Blue		100.0%	40.3% Amber	38.6% Amber	1.7% Green	20	2 Up	0 Up	0 Up	0 No Change	0 No Change	
Bosworth	14	13	87.5% Green	127.4% Blue	102.8% Green	109.9% Green	100.0%	100.0%	29.9% Amber	29.9% Amber	0.0% Green	9	1 Down	2 Down	0 No Change	0 No Change	0 No Change	
Griffin - Herschel Prins	6	6	102.2% Green	100.0% Green	100.7% Green	105.3% Green		100.0%	26.5% Amber	26.5% Amber	0.0% Green	23	0 Down	1 Up	0 No Change	0 No Change	0 No Change	
Heather	18	18	90.2% Green	120.1% Blue	104.5% Green	117.6% Blue		100.0%	42.8% Amber	40.4% Amber	2.4% Green	8	1 Down	5 Down	0 No Change	0 No Change	0 No Change	
Watermead	20	20	98.8% Green	163.5% Blue	97.3% Green	174.1% Blue		100.0%	47.9% Amber	45.8% Amber	2.2% Green	9	1 No Change	2 No Change	2 No Change	0 No Change	0 No Change	
Coleman	19	17	95.7% Green	101.1% Green	99.9% Green	111.4% Blue	100.0%	100.0%	23.2% Amber	23.1% Amber	0.2% Green	14	1 Up	11 Down	0 No Change	0 No Change	0 No Change	
Gwendolen	19	17	80.2% Green	99.2% Green	96.7% Green	125.1% Blue		100.0%	27.5% Amber	26.5% Amber	1.0% Green	13	1 Up	14 Down	1 No Change	0 Up	0 No Change	
Kirby	23	21	98.4% Green	106.9% Green	97.1% Green	105.2% Green	100.0%	100.0%	20.0% Amber	20.0% Amber	0.0% Green	8	3 Up	13 Down	0 No Change	0 No Change	0 No Change	
Langley (MHSOP)	19	17	96.6% Green	124.4% Blue	100.0% Green	113.9% Blue			15.5% Green	15.5% Green	0.0% Green	8	2 Up	6 Down	0 Up	0 No Change	0 No Change	
Mill Lodge	14	5	104.9% Green	77.8% Red	103.1% Green	140.1% Blue		100.0%	16.7% Green	16.7% Green	0.0% Green	31	0 Up	9 Down	0 No Change	0 No Change	0 No Change	
Phoenix - Herschel Prins	12	12	83.3% Green	87.4% Green	100.2% Green	99.3% Green		100.0%	13.4% Green	13.4% Green	0.0% Green	10	0 Down	1 Up	0 No Change	0 No Change	0 No Change	
Skye Wing - Stewart House	30	29	87.1% Green	114.4% Blue	100.0% Green	115.3% Blue		100.0%	24.2% Amber	24.2% Amber	0.0% Green	6	4 Up	5 Down	0 No Change	0 No Change	0 No Change	
Willows	9	8	103.8% Green	96.6% Green	100.0% Green	99.7% Green		100.0%	12.8% Green	12.8% Green	0.0% Green	12	0 Up	1 Up	1 No Change	0 No Change	0 No Change	
CAMHS Beacon Ward - Inpatient Adolescent	17	4	104.1% Green	107.2% Green	96.8% Green	65.2% Red	100.0%	100.0%	42.8% Amber	42.2% Amber	0.6% Green	42	3 Up	5 Down	0 Up	0 No Change	0 No Change	
Welford (ED)	15	13	95.8% Green	133.9% Blue	98.4% Green	117.3% Blue	100.0%	100.0%	17.2% Green	17.0% Green	0.2% Green	13	0 Down	1 No Change	0 No Change	0 No Change	0 No Change	
1 The Grange	1	1	81.2% Green	84.6% Green	29.0% Red	80.3% Green			0.8% Green	0.8% Green	0.0% Green	42	0 No Change	0 Down	0 No Change	0 No Change	0 No Change	
Agnes Unit	1	1	49.7% Red	50.9% Red	55.6% Red	38.1% Red			0.7% Green	0.7% Green	0.0% Green	152	1 Up	0 Down	0 No Change	0 No Change	0 No Change	
Gillivers	2	2	106.0% Green	48.0% Red	106.6% Green	97.2% Green			5.8% Green	5.8% Green	0.0% Green	35	0 Up	1 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.					



Public Trust Board – 29th September 2026

Patient Safety & Learning Assurance Report for July/August 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 July and August 2026, there were 3638 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 61.82% of all patient incidents reported during this period and are explored in order and in more detail below. This equates to an average of 1819 incidents per month during July and August 2026.

Top 5 reported patient safety incidents for July and August 2026

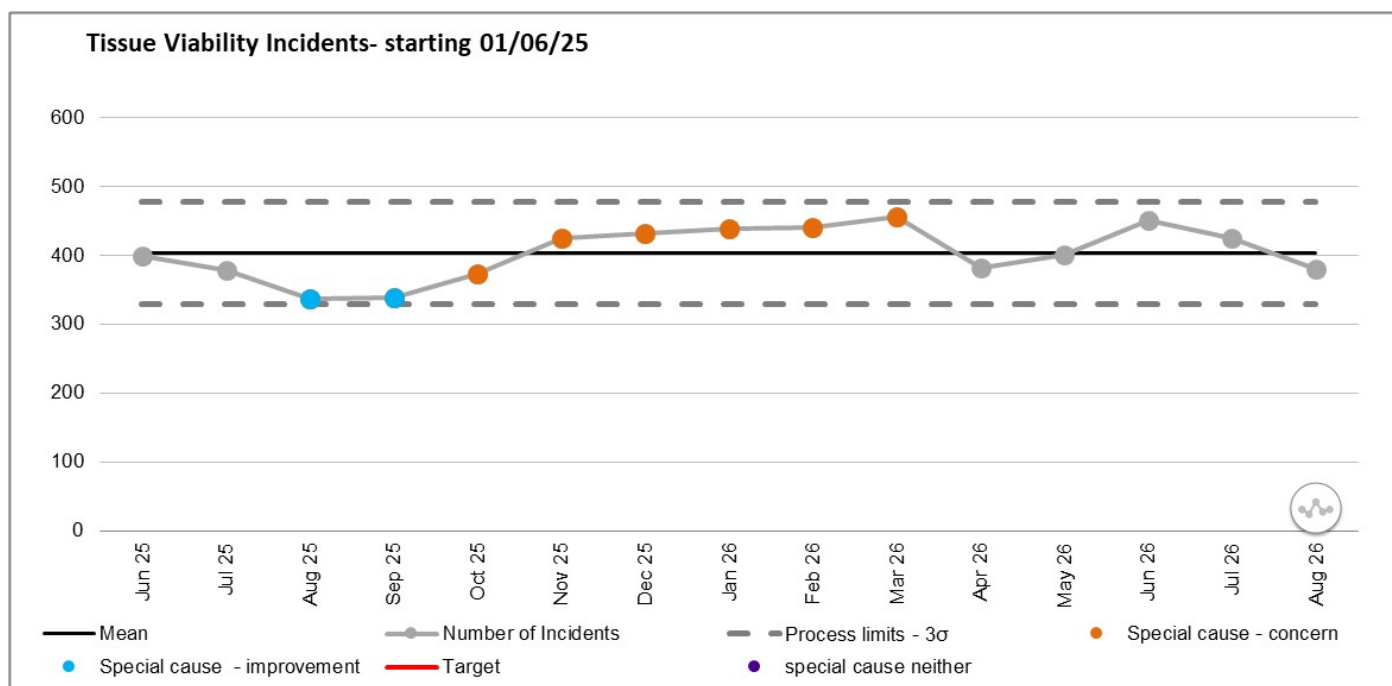
Category	Number of incidents	Directorate with highest % of the total reported
1. Tissue Viability	803	CHS (99.13%)
2. Self-Harm	580	DMH (87.41%)
3. Care/Treatment Using Restraint or Holds	315	DMH (79.37%)
4. Violence/Assault	307	DMH (93.49%)
5. Falls	244	DMH (59.02%)

Degree of harm recorded for all patient safety incidents for July and August 2026

Reported degree of harm	Number	% of total incidents reported
No Harm	2054	56.46%
Minor/Low Harm	1527	41.97%
Moderate Harm	38	1.04%
Severe Harm	2	0.05%
Death	17	0.47%

NB: these incidents were reported in July and August 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



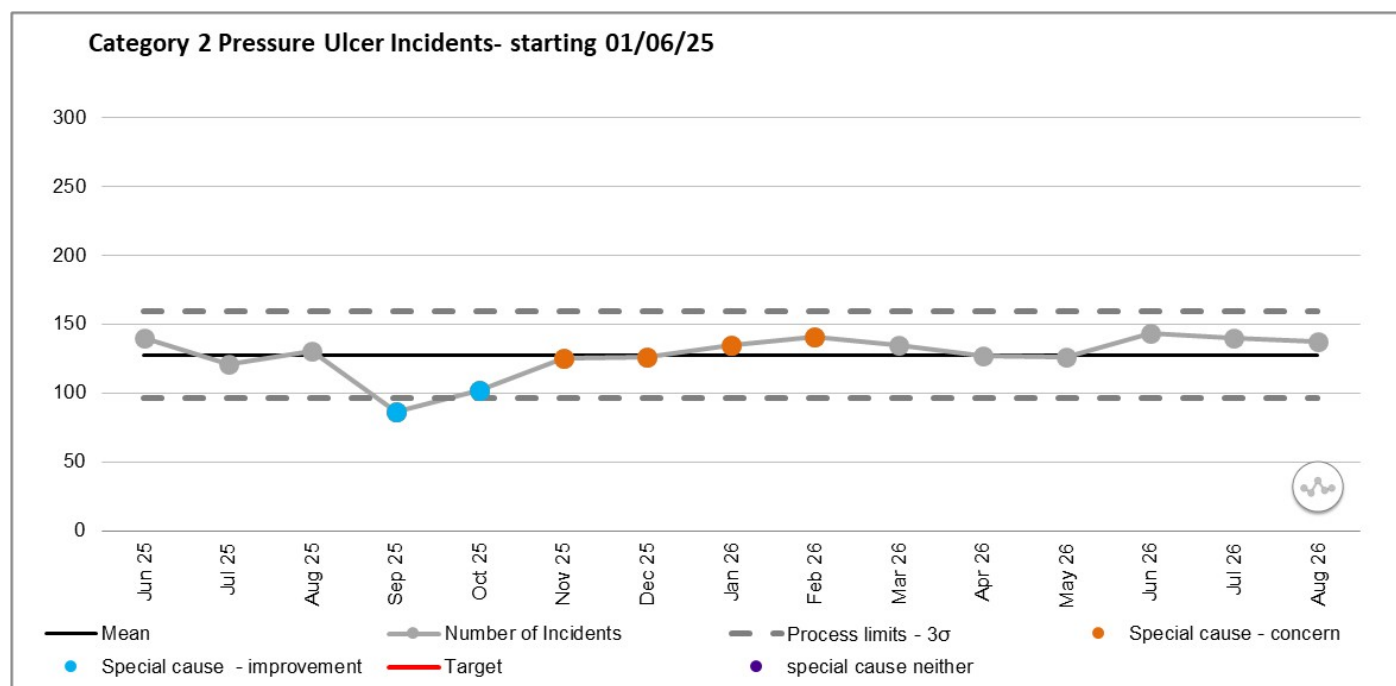
22.07% of all patient safety incidents reported relate to 'Tissue Viability' during July and August 2026; this equates to 803 incidents. This category includes pressure ulcers on admission, developed or deteriorated in our care, skin tears, scalds, wounds, and moisture associated skin damage. As Pressure ulcers (category 2,3,4 and unstageable) represent 69.36% of these, the report will focus on this aspect of patient harm.

In July and August 2026, there were 557 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 3.34% increase in pressure ulcers reported in comparison to the previous 2 months reporting.

During this period, 535 (96.05%) were reported in Community Health Services (CHS) Community Nursing Services and 20 (3.59%) were reported in Community Hospitals (Inpatients).

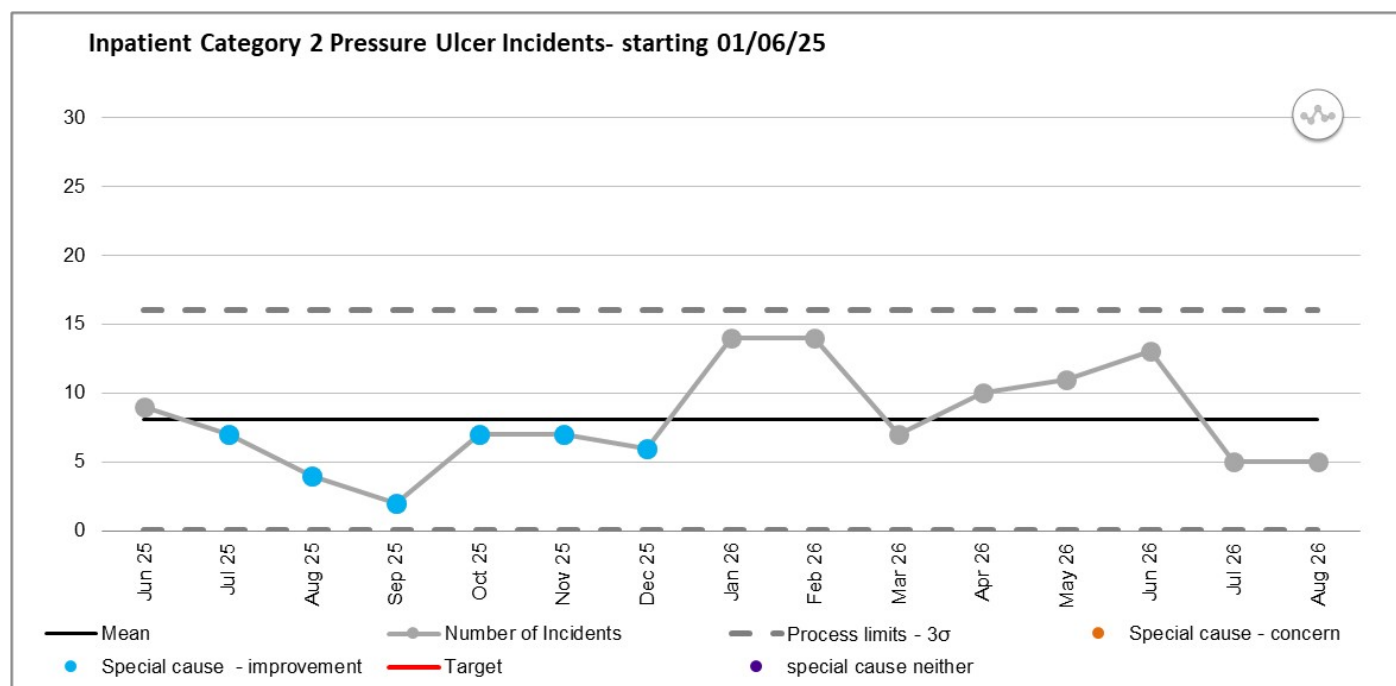
The remaining 2 incidents (0.36%) were reported in Families, Young People, Children's, Learning Disability & Autism directorate (FYPCLD), 2 Category 2 Pressure Ulcers reported by the Diana Service.

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



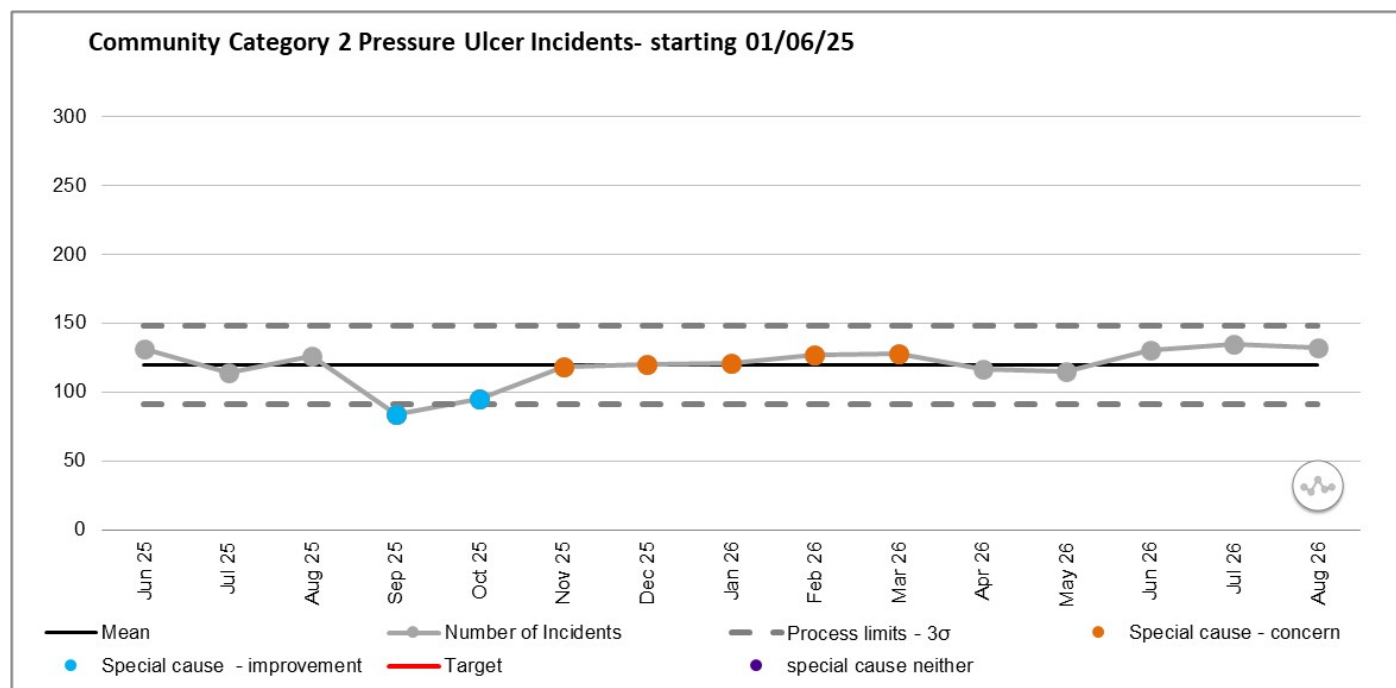
Analysis at the CHS Pressure Ulcer group has noted that there has been an increase in Moisture Associated Skin Damage (MASD) incidents leading to Category 2 pressure ulcers. Learning from the Community Hospital Quality Account priority for MASD is to be shared across community nursing hubs.

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



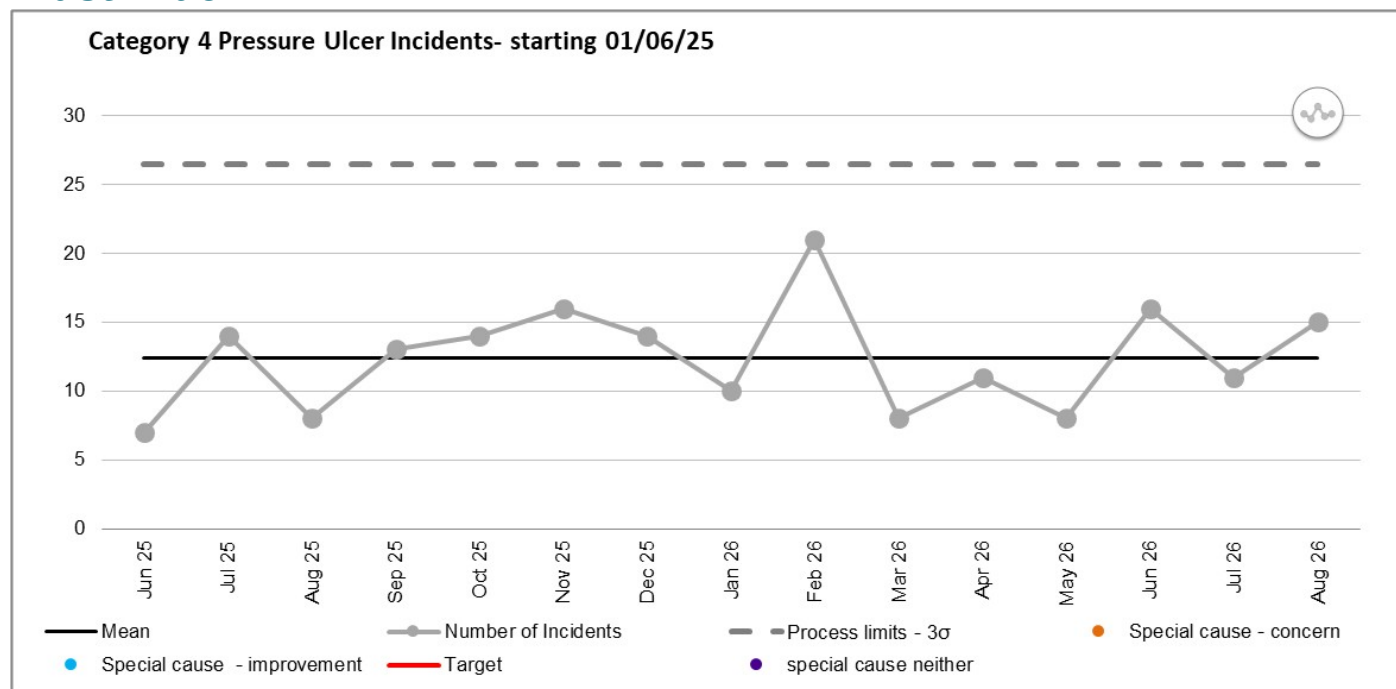
We have seen a decrease in category 2 pressure ulcers developed in our care in the last 2 months; Community Hospital Deputy Head of Nursing and Matrons continue with pressure ulcer huddles, learning and sharing from incidents and review of prevention work and focussed actions.

Community Category 2 pressure ulcers developed in our care.



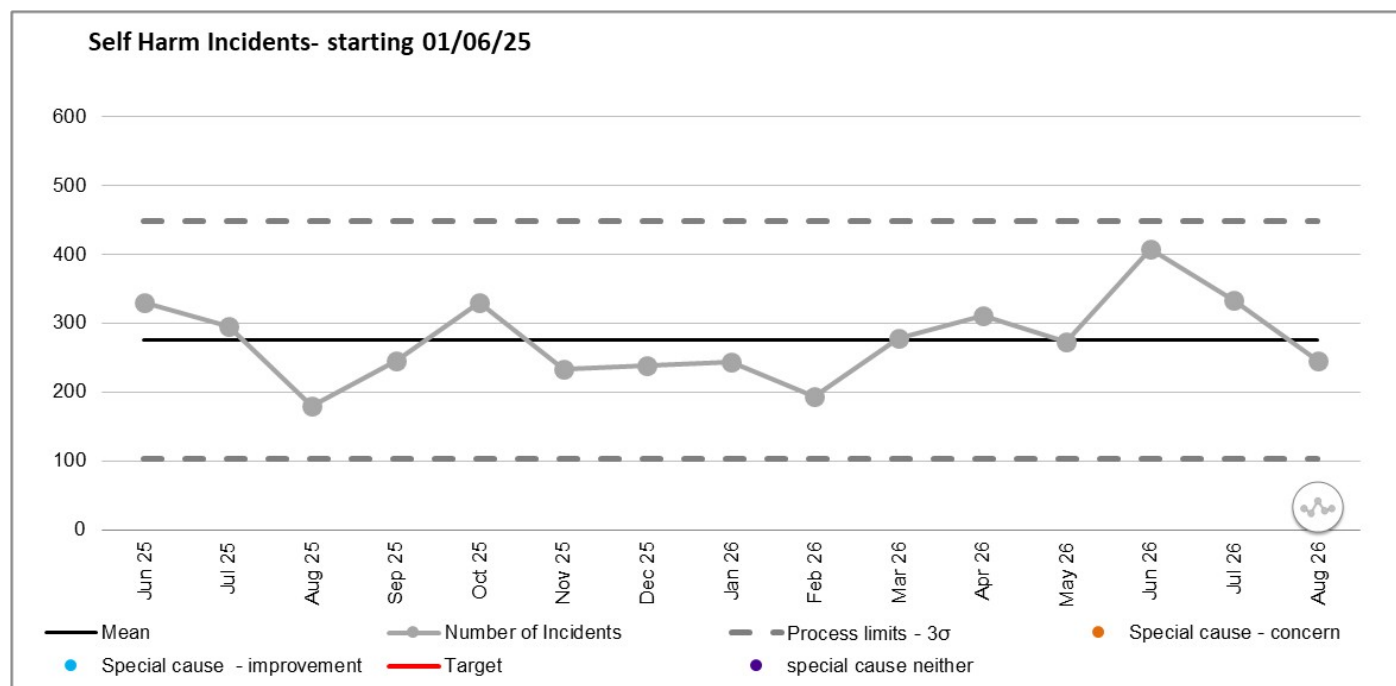
In community nursing there has been no change to the position and the SPC is currently showing normal variation this is close to the mean number of incidents. For context there are 6683 patients on the community nursing caseload, the percentage of patients with a pressure ulcer developed or deteriorated in our care remains low at 2.29%. Several pressure ulcer improvement projects are in place across community nursing.

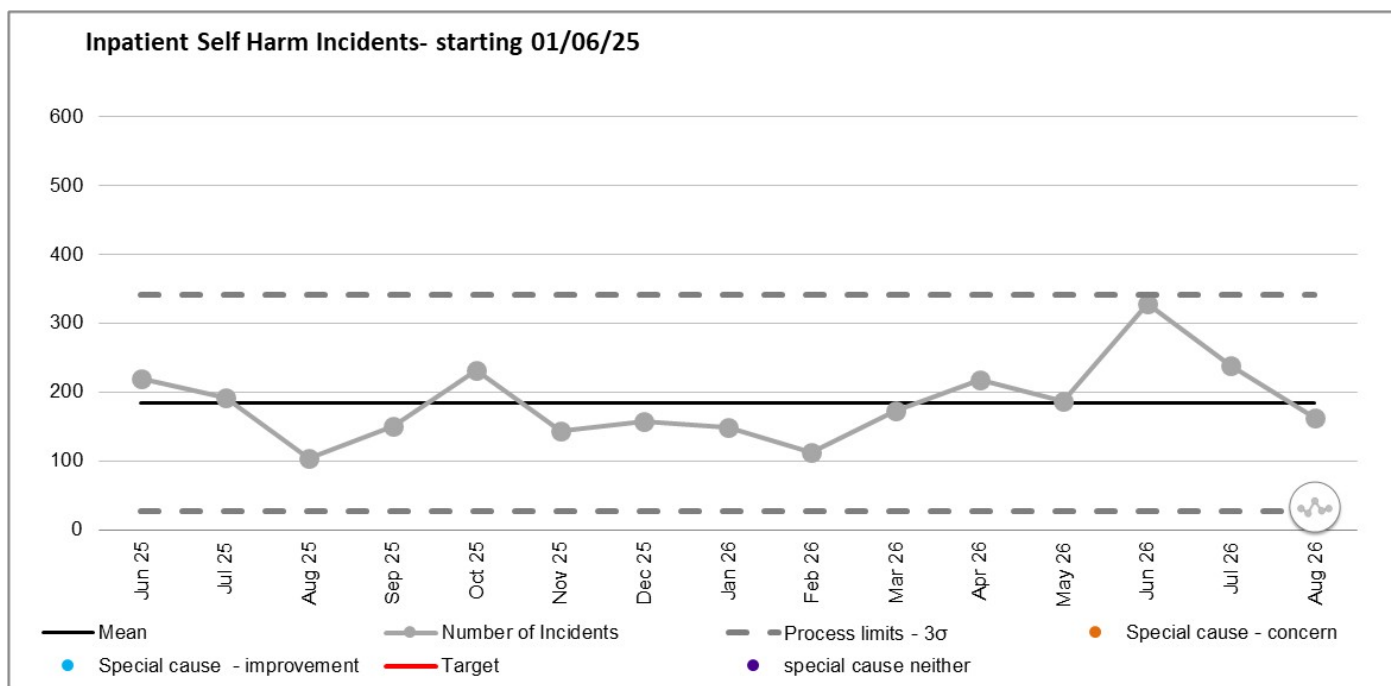
Category 4 Pressure Ulcers developed or deteriorated in our care – Trust wide.



The SPC chart shows common cause variation for category 4 pressure ulcers developed or deteriorated in our care. The CHS Pressure ulcer delivery group continues to learn from findings of reviews, implement improvement work around repositioning and strengthening the pressure ulcer audit process and equipment processes. Work is ongoing with care homes to establish arrangements for sharing repositioning (turning) records, as some care homes use electronic systems that LPT staff do not currently have access to. This can limit visibility of pressure ulcer prevention activity completed by care home staff.

Self-Harm – inpatient and community





There were 580 patient self-harm incidents reported during July and August 2026, this equates to 15.94% of all reported patient safety incidents during this period. Of the 580 incidents reported as patient self-harm, 402 were inpatient incidents and 178 were community incidents.

During the previous reporting period, there were 677 self-harm incidents reported across both inpatient and community settings, this shows a decrease of 14.33% during the current reporting period. The community incidents are being reviewed to identify any themes and trends.

The number of incidents has been analysed and over the reporting period there are 2 areas with the largest number of self-harm incidents reported relative to the total number (580) of such incidents reported. These incidents occurred on **Watermead Ward** and **Beaumont Ward**, both acute inpatient admission wards based at the **Bradgate Unit**.

- Watermead Ward – 132 incidents (22.76%) This figure involves 12 patients; this is a similar figure to the previous reporting period which was 134)
- Beaumont Ward – 110 incidents (18.97%) This figure involves 16 patients; this is an increase from 82 total incidents reported in the previous reporting period.

As a result, the Self-Harm and Suicide Prevention Lead met with the Head of Inpatient Services to discuss options for a more detailed review of incidents occurring on inpatient wards. A meeting is planned for the end of September 2026 with data support colleagues to undertake a deeper analysis and produce a report outlining findings and recommendations.

In the interim, the current ward managers were contacted to gain a general understanding of any contributory factors and challenges. Feedback identified the high acuity of the wards and complexity of the current inpatient cohort. A significant proportion of incidents were associated with two patients who presented with elevated self-harm risks and complex risk profiles.

A quality improvement project is due to be presented to the Quality and Safety Group in relation to Ashby Ward on 24 September 2026. This approach reflects the previous self-harm reduction work

undertaken on Heather Ward, which had historically reported the highest levels of self-harm incidents.

Self-harm prevention training is currently being developed for publication on **ULearn**. A completion date has not yet been confirmed. Once available, further work will be required to determine the target audience and implementation plan.

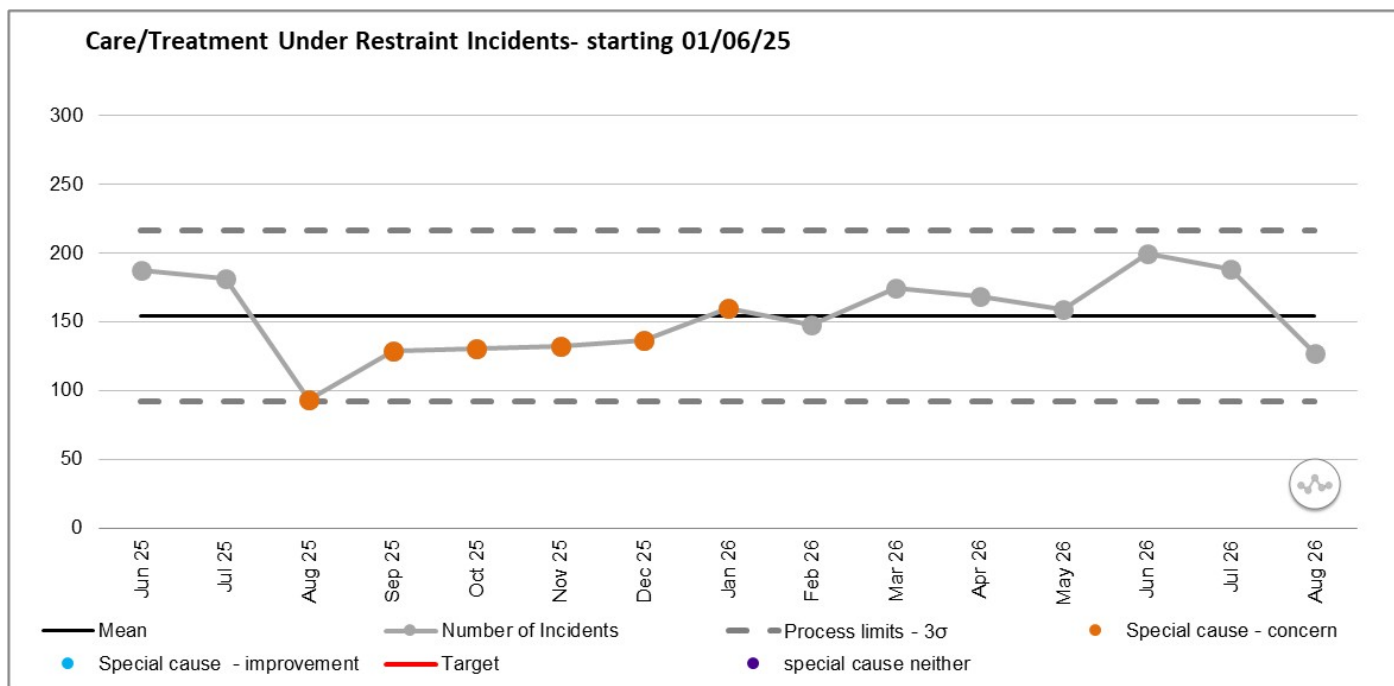
Harm Levels

Within the 2 areas of Watermead Ward and Beaumont Ward there were no incidents reported as moderate harm or above. Of the 132 incidents reported by Watermead Ward 65 (49.24%) were recorded as minor/low harm, with the remaining 67 (50.76%) being reported as no harm. Of the 110 incidents reported by Beaumont Ward 62 (56.36%) were recorded as minor/low harm, with the remaining 48 (43.64%) being recorded as no harm.

Overall, of the 580 total reported self-harm incidents, 1 (0.17%) was recorded as major harm, 2 (0.34%) have been recorded as moderate harm, 277 (47.76%) have been recorded as minor/low harm, and 300 (51.72%) have been recorded as no harm.

Of the three reported as moderate and major two have been reviewed through the Incident Review and learning (IRLM) process and have not resulted in a requirement for further investigation the third incident is being reviewed in directorate.

2. Care & Treatment Using Restraint or Holds



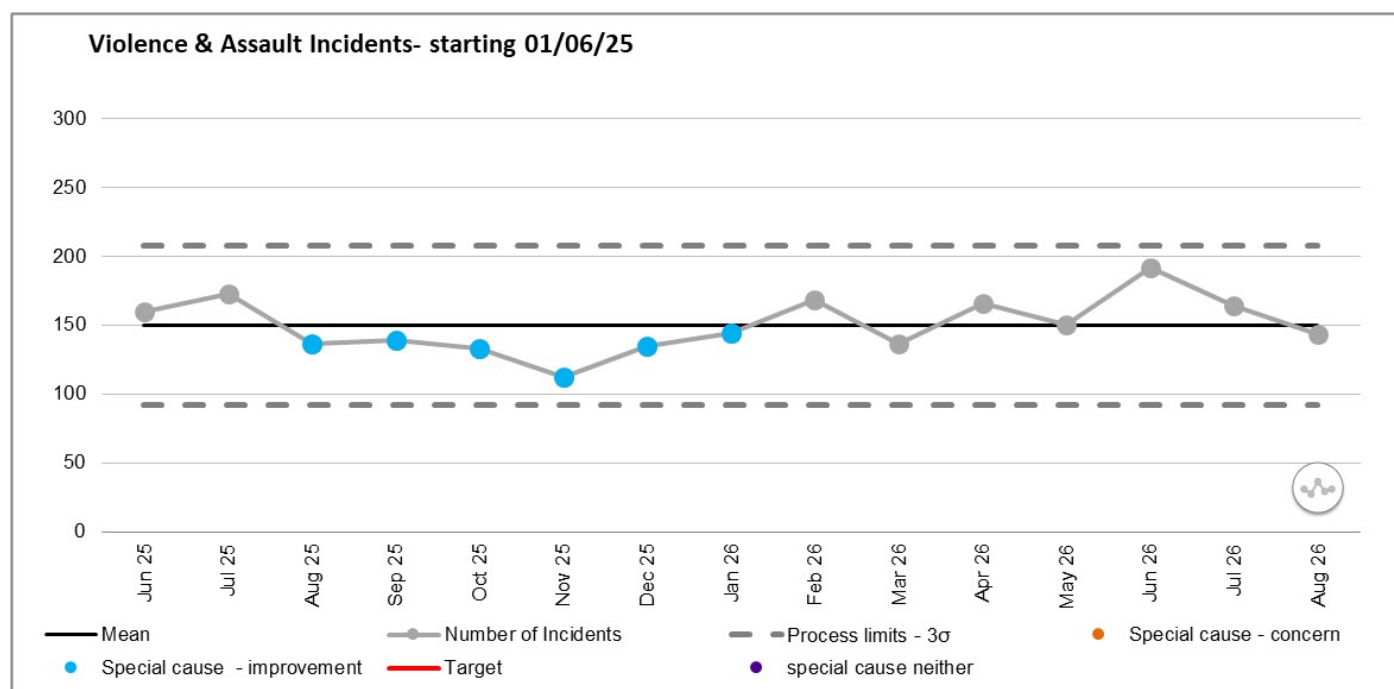
There were 315 incidents where holds were used to support care delivery during July and August 2026, representing 8.66% of all reported patient safety incidents during this period. During the previous reporting period, there were 355 incidents reported where holds were utilised, therefore this shows a decrease of 11.27% during the current reporting period.

The reporting of incidents using holds currently fall into 2 categories; those related to the use of restraint holds for management of violence, aggression, and acute self-harm and those where 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 the clinical trainers are to receive clinical holding training to train others by the Trust current in October 2026.

The analysis of incidents where holds have been used to deliver care shows that over the reporting period, there have been 2 areas with a significant number of incidents reported relative to the total number (315) incidents. The holds used in Mill lodge is relating to the safe care and management 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 198 (62.86%) incidents, compared to 136 during the last reporting period, due to a patient requiring holding during personal care. The restraint and holding 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 58 (18.41%) incidents, a decrease on the 118 reported during the last reporting period.

Overall, of the 315 incidents reported where restraint or holds were utilised, 57 (18.10%) were reported as minor/low harm, and 258 (81.90%) were reported as no harm.

3. Violence & Assault

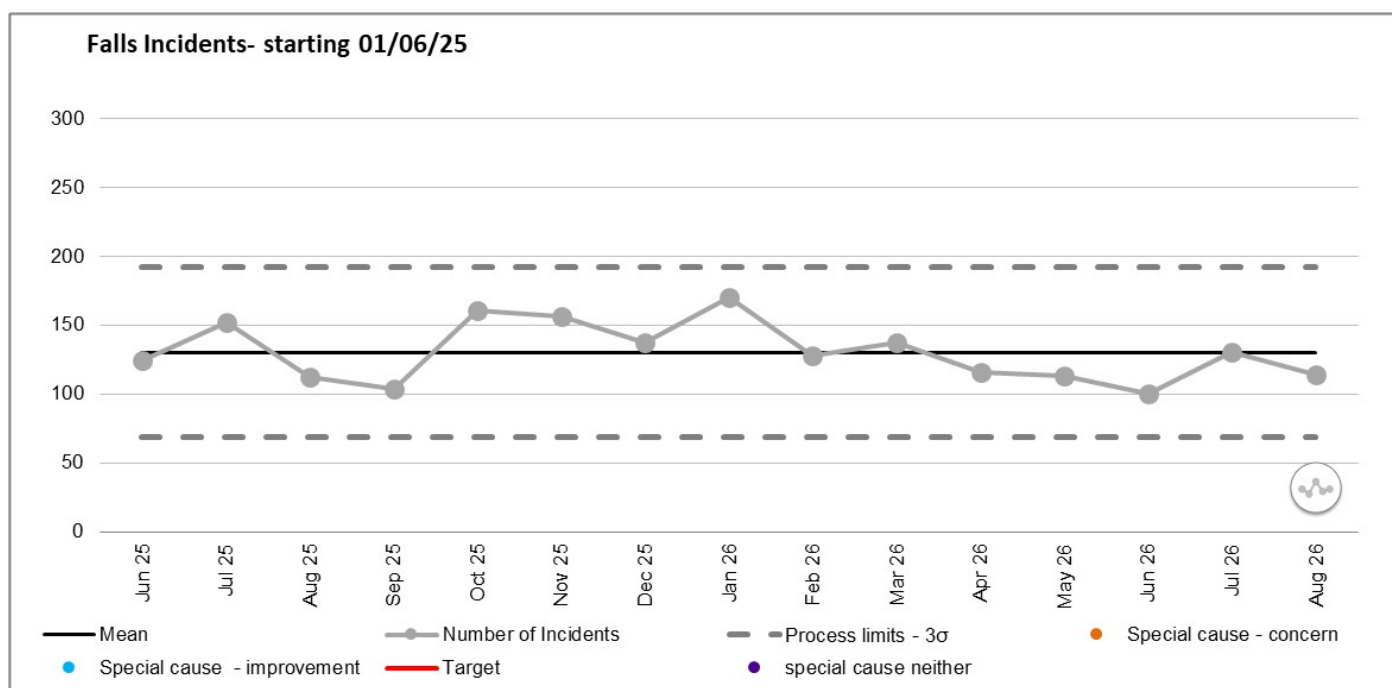


There were 307 incidents of violence and assault reported during July and August 2026. These incidents are reported under the category's patient violence towards other patients, people not employed by the trust and incidents of disruptive behaviour towards others. This represents 8.44% of all reported patient safety incidents. During the previous reporting period, there were 340 violence and assault incidents reported, this shows a decrease of 9.71% during the current reporting period.

The number of violence and assault incidents has been analysed and over the reporting period, there are 2 areas with the highest number of incidents reported relative to the total number (307) of violence and assault incidents, Belvoir Ward (male psychiatric intensive care unit – PICU) with 55 (17.92%) incidents, and Griffin Ward (female psychiatric intensive care unit – PICU) with 51 (16.61%) incidents. Of these 307 incidents, 179 (58.31%) were reported as physical disruptive behaviour. The incidents on both wards relate to patients requiring commencement of medication treatment to stabilise mental health and related behaviours.

Of the 307 incidents reported as Violence and Assault, 2 (0.65%) was recorded as moderate harm, 88 (28.66%) were recorded as minor/low harm, and 217 (70.68%) were recorded as no harm. The two moderate harm incidents were a duplicate of the same incident. This was reviewed through the IRLM process with no onward review required.

4. Falls



There were 244 falls incidents during July and August 2026 representing 6.71% of all reported patient safety incidents. During the previous reporting period there were 210 falls incidents reported, this shows an increase of 16.19% during the current reporting period.

The number of falls incidents have been analysed and over the reporting period, out of the 244 reported falls incidents, the top 2 areas were Gwendolen Ward who reported 35 (14.34%) incidents, and Coleman Ward who reported 23 (9.43%) incidents.

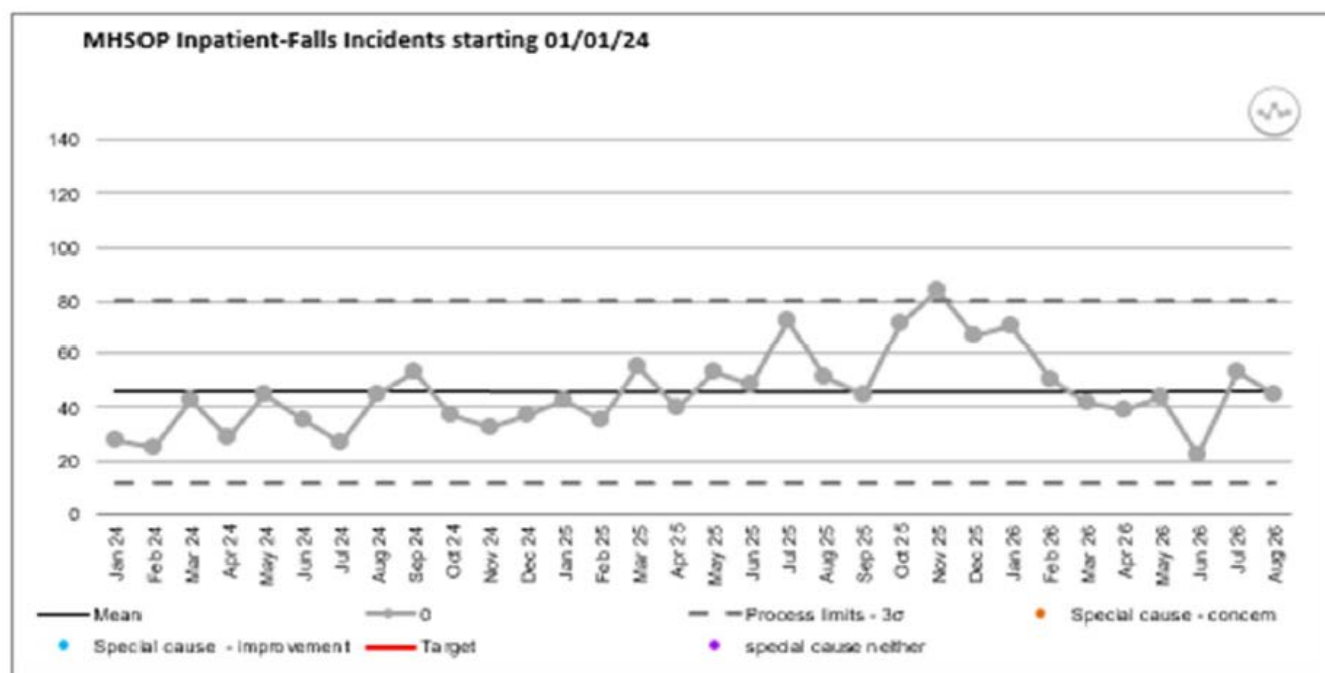
Of the 244 reported falls incidents, 3 (1.23%) incidents were recorded as moderate harm, these were clinically reviewed and have since been re graded to low harm. 113 (46.31%) incidents were recorded as minor/low harm, and 128 (52.46%) incidents were recorded as no harm.

Update from Falls Steering Group

Directorate of Mental Health

Mental Health Services for Older People (MHSOP)

After the significant drop in numbers of falls in MHSOP in June numbers have returned to around the mean.



July's data shows a rise in falls on Kirby and Coleman and Mill Lodge

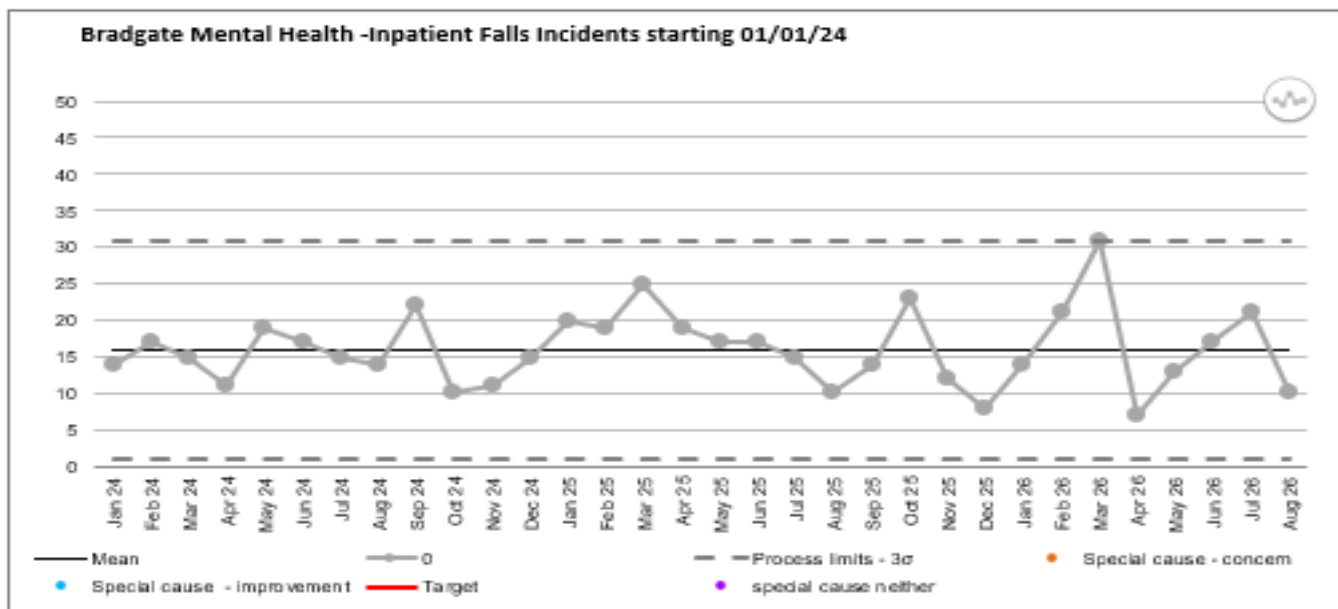
August's data shows a drop on Kirby and Mill Lodge but a rise in numbers of falls on Gwendolen.

2026	Gwendolen	Kirby	Coleman	Langley	Mill lodge
March	10	21	6	4	1
April	6	16	8	8	1
May	23	6	4	10	1
Jun	13	3	3	3	0
July	14	13	11	6	9
August	21	1	12	7	4

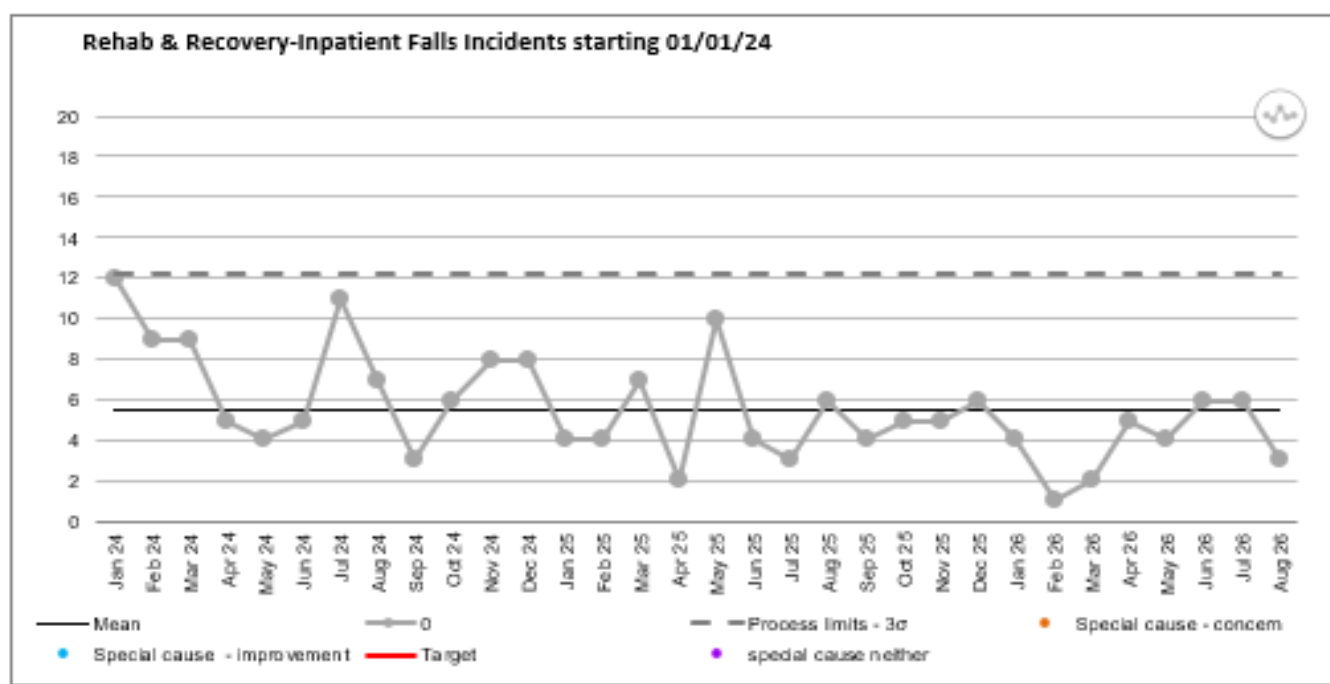
The Falls incidents are reviewed and analysed regularly in the DMH Falls Group and numbers of falls often relate to the patient cohort at the time and their individual presentations. Themes this month from review of incidents include need for improved Multi-Disciplinary Team (MDT) working in identification and planning in regard to medical causes of fall risks. The team are working with medical colleagues on Systmone (electronic patient record) templates to support falls prevention and reviews.

Bradgate Unit and Rehabilitation Wards

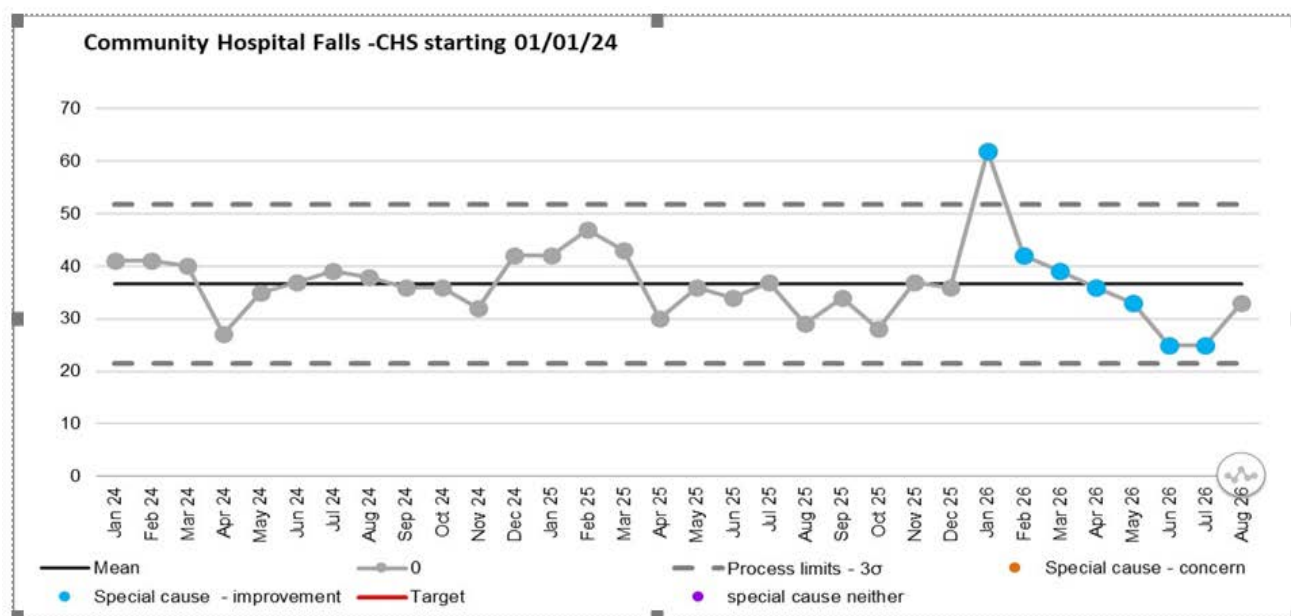
Incidents are reviewed regularly and there are no emerging themes and incidents are reviewed and addressed individually. There is continued work to improve post falls processes particularly on Rehabilitation wards where there are less incidents and staff need to maintain competence with the process.



The mental health directorate reported a younger patient group in acute, forensic and PICU wards (AFPICU) during August and noted less patients placing themselves on the floor and less mirroring of this behaviour in other patients.



Community Hospital Services



Whilst the low numbers of falls incidents were maintained in July, there has been an increase in the number of falls in August 2026. This rise encompasses a small number of falls across all wards, but with no cause for concern on any ward. It is noted that North Ward has been closed in this period for refurbishment.

2026	East	Clarendon	Charnwood	Coalville Wd 1	Switland	Coalville Wd 2	Beechwood	St Lukes Wd 1	Rutland	Dalgleish	Coalville Wd 4	St Lukes Wd 3	North
Mar	5	2	2	8	4	2	1	4	2	2	3	2	2
Apr	2	4	3	3	2	4	2	5	2	3	3	2	2
May	1	5	8	2	2	1	5	2	2	3	1	1	0
Jun	3	5	3	2	1	4	4	0	1	1	0	0	0
July	7	3	0	1	5	2	0	1	2	1	2	1	0
Aug	6	2	2	1	3	2	2	2	4	2	3	4	0

The Weekly falls validation meeting, where each fall is reviewed and learning identified, has been reviewed and reshaped to better support the identification of fall risks and the prevention of falls and repeat falls. Compliance with post falls huddles has improved with evidence that of the 33 falls that occurred in August 31 had a post falls huddle documented, the other 2 have been reviewed later by the team. Post falls huddles are designed to capture the immediate learning post fall with the team on that shift.

Family's, Young People, Children, Learning Disability and Autism Directorate

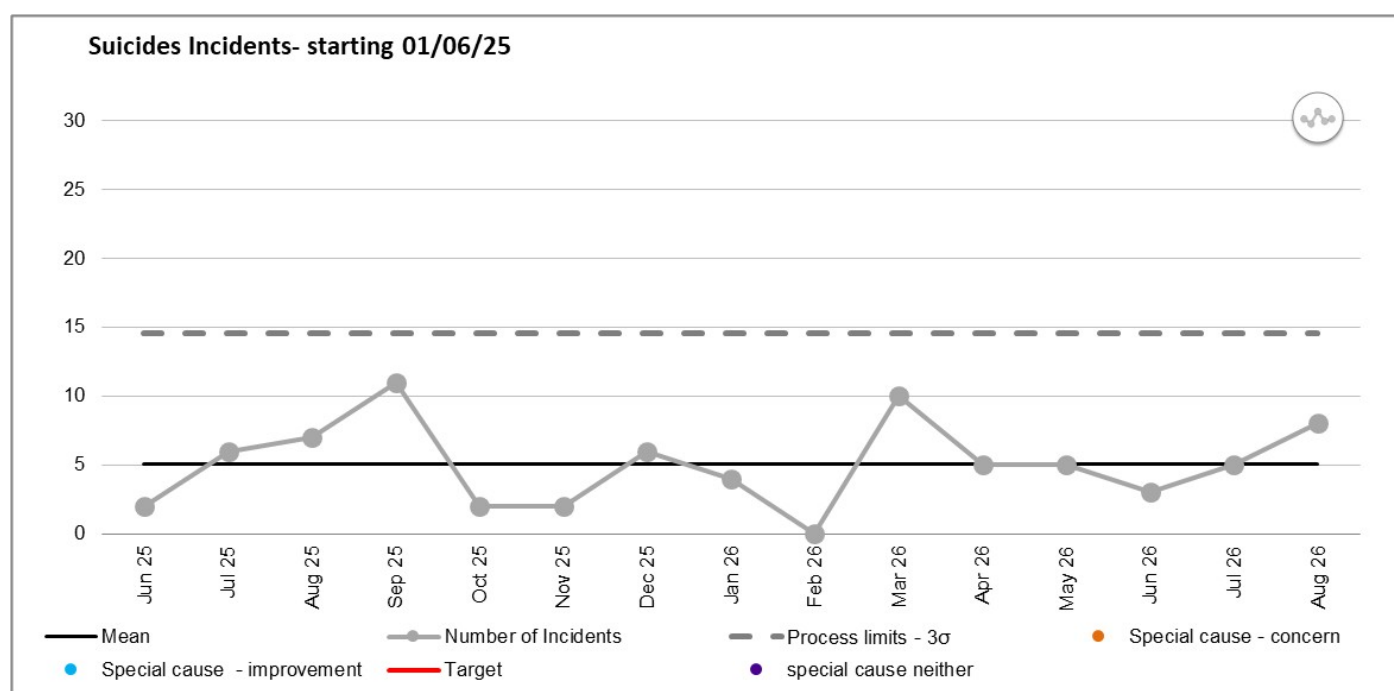
Continue to report low numbers of falls across both inpatient and community areas. Falls mainly related to clinical presentations (e.g. epilepsy) and engagement in physical activity. The teams are working on improving falls risk assessment process to reduce risk as far as possible. Due to low numbers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

Other updates:

- The Review of Prevention of Falls Trips and Slips policy is underway involving representatives from each directorate.
- LPT are now registered for the National Audit for Inpatient Fractures (NAIF)
This audit will retrospectively review the care of any patient over 65 who has sustained a fracture, head injury or spinal injury as a result of a fall on inpatient wards.
- Review of Falls Documentation
Work continues in the 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)



Deaths by Suicide: 2026 Update

Between July and August 2026, there were 13 deaths by suicide among individuals known to LPT services. During the same reporting period in 2025, there were 12 deaths by suicide.

As of 6 September 2026, there had been 50 deaths by suicide among individuals known to or open to LPT services. This is four more than during the same period in 2025.

Across Leicestershire as a whole, there have been 75 deaths by suicide compared with 79 during the equivalent period in the previous year.

Current analysis has not identified any specific time periods, patterns, or clusters that would suggest a significant increase linked to particular dates or events.

Of the 50 individuals known to LPT who died by suicide, 40 were male, with the majority identifying as White British.

Each death by suicide is reviewed through the weekly Rapid Review Meeting to identify immediate learning, themes, and actions. Findings are also shared with the Leicestershire Suicide Prevention Audit Group through its weekly meeting arrangements.

Themes, Learning and Actions Identified Through Rapid Reviews

Key themes identified over the past two months include:

- Alcohol and substance misuse, including the impact of significant drug use on both mental and physical health.
- Social factors, including loneliness and isolation.
- Medication concordance for individuals with severe mental illness and issues relating to Clozapine titration.
- Referral management and caseload.
- The significance of physical health conditions, including chronic illnesses and newly diagnosed serious health conditions such as stroke and cardiac disease.
 - **Action:** Escalate to the Trust-wide group to explore additional opportunities to strengthen support for individuals living with chronic physical health conditions.
- Repeated presentations involving self-harm.
- Student wellbeing and mental health, including effective joint working with university support services.
 - **Action:** Review awareness and utilisation of existing information-sharing arrangements between mental health services and university wellbeing services.
- Challenges in engaging individuals who move between geographical localities.
- The importance of considering historical risk factors in individuals who have not been known to services for extended periods.
- Complex presentations in older adults and the need to fully consider the interaction between physical and mental health.
- Loss of functioning, loss of role, financial pressures, and debt.

Positive Learning Identified

The following examples of good practice were noted:

- Prompt assessments being offered and completed following referral into services.
- High-quality safety assessments and safety planning that reflect current best practice.
- Effective communication between LPT services.
- Timely follow-up and ongoing engagement with individuals receiving care and support.

Medicines Amnesty 2025/26

The Medicines Amnesty initiative has focused on reducing the quantity of excess medication stored in patients' homes, with the aim of limiting access to medication for impulsive overdose. Preliminary data suggest a reduction in reported self-harm by overdose across community services, including among patients known to or receiving care from LPT, over the last two years. Although a direct causal relationship cannot be established, the observed trend is positive and may indicate that the initiative is contributing to a safer environment for patients at risk.

Summary

While self-harm incidents remain elevated on some inpatient wards, current evidence suggests this is influenced by ward acuity and a small number of high-risk patients. Further analysis is planned to identify contributory factors and opportunities for improvement. Suicide numbers among those known to LPT remain slightly higher.

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 3 notifications made by LPT staff to LeDeR related to patients with a known learning disability or autism and who have died for July (1) 2026 and August (2) 2026.
- For City and Countywide reviews, there were 8 patient death notifications in July 2026 and 4 patient death notifications in August 2026.
- Of the total 12 notifications, 3 are focused and 9 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	Date 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 at the Safety Forum.
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/2026/004/MHRA	Resmed Astral 100 And 150 Ventilators: Potential for Patient Harm Due To Unexpected Interruption of Ventilation Therapy	17.02.2027	3 x LPT Resmed ventilators in the Diana service are all labelled TRAINING ONLY and they do not supply or provide them to patients. All of these vents are supplied by UHL only. LPT have completed all actions possible.

LPT Outstanding patient safety reviews: As of 24th August 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.

<i>Overdue learning response stage</i>	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	1	0	0	6
Right to Reply Family	0	2	0	1
Right to Reply Staff	0	3	0	2
Submission to CPST	0	0	0	0
Exec Review	1	0	0	1
With ICB	0	0	0	0
Directorate Post Exec Review	0	0	0	0
Total Learning Responses Overdue	2	5	0	10

Current Position

As of 24th August 2026, there were 56 open investigations. 20 DMH, 20 Corporate, 11 CHS and 5 FYPC/LDA.

- Of these 17 are overdue and of these 6 are in right to reply with patient or family.
- 5 DMH (25%) are overdue, 1 is the legacy STEIS (for incident December 2022) delayed by police and court process; this is now in the sign off process.
- 10 Corporate (50 %) are overdue 8 within the various phases of sign off and still with investigators
- 2 CHS (18.18 %) are overdue
- 0 FYPC/LDA are overdue

Duty of Candour

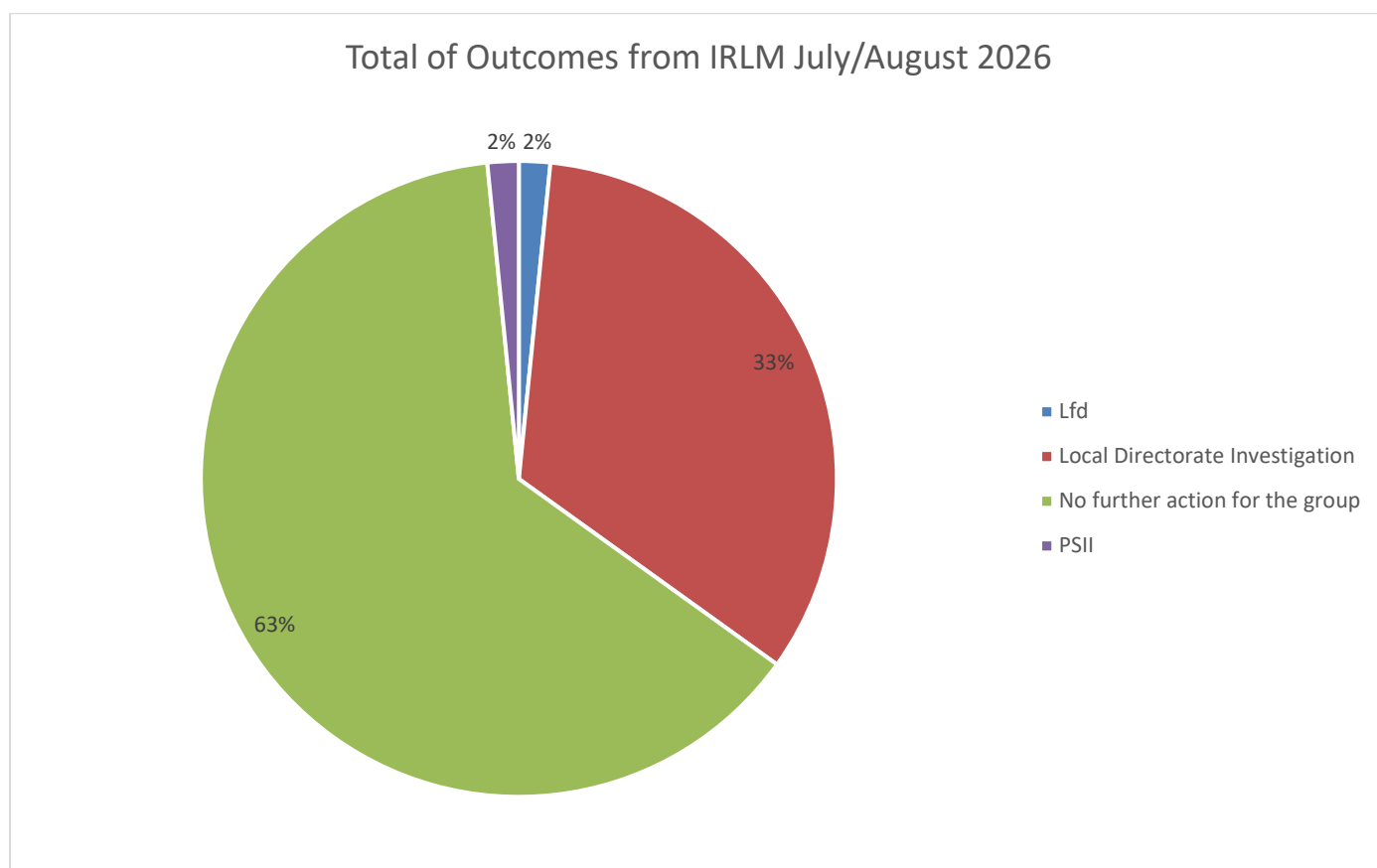
There was no statutory duty of candour breaches during this period. We continue to follow 'being open' which is inbuilt in Patient Safety Incident Response Framework (PSIRF) principles of compassionate and positive engagement with patients/families.

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)

63 cases were reviewed at IRLM during July and August 2026. 1 (2%) Patient Safety Incident Investigation (PSII) was declared during this reporting period 40 (63%) were identified as having already identified any learning and actions put in place. There were 21 (33%) Local Directorate reviews requested to explore appropriate actions, 1 (2%) initial service managers reviews (ISMR's) were shared with Learning from Deaths (LfD) for the themes to be aligned with their own.



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

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 CQC continue to request information about individual patients which are responded to on an individual basis. In addition, they are reviewing patient safety incidents reported by LPT and visible to the CC on the Learning From Patient Safety Events (LFPSE) national system requesting additional information for some incidents as part of their oversight process currently asking for information for May 2026.

Patient Safety Strategy

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

There are further dates available throughout 2026/2027. The next training date is October 2026 and then monthly.

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 2026/2027
DMH	23
CHS	13
FYPC/LDA	19
Enabling	3
TOTAL	58

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).

There is also training for Consultant Colleagues to equip them to participate and support in SEIPS investigations.

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-Dec 2025	7,716	190	7,906
Jan – Feb 2026	96	6	102
March – April 2026	134	5	139
May – June 2026	109	7	116
July -August 2026	127	16	143
Total	8182	224	8406

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:	21/09/2026
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:	November 2026
THRIVE strategic alignment:	☐ Technology ☐ Healthy communities ☒ Responsive ☐ Including everyone ☐ Valuing our people ☒ Efficient 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:	

Public Trust Board 29 September 2026

Emergency Preparedness, Resilience and Response (EPRR) – Annual Report 2026

Purpose of the Report

The purpose of this report is to provide Trust Board with an overview of the Emergency Preparedness, Resilience and Response (EPRR) activities carried out by LPT over the past year. This report is intended to inform relevant committees about our current EPRR capabilities, key activities undertaken, achievements, and areas that require further improvement.

Key aspects of this report include:

- **Assessment of EPRR Resource and Activities:** To evaluate the effectiveness of the EPRR activities and initiatives implemented throughout the year.
- **Review of Incident Management:** To provide a detailed account of incidents managed, response actions taken, and recovery efforts.
- **Training and Development:** To outline the training programs delivered and their impact on enhancing staff preparedness and response capabilities.
- **Compliance/Audits/KPI's:** To report on compliance with relevant EPRR standards and regulations, including findings from internal and external audits.

Analysis of the Issue

Governance and Structure

LPT EPRR have the adequate resources to undertake the requirements as set out by the EPRR Framework 2022. This includes the required personnel which ensures adequate staffing cover to meet the annual needs of the EPRR work programme as set out by the NHS EPRR Framework and NHS EPRR Core Standards.

LPT and NHFT: In 2024, the Northamptonshire Healthcare Foundation Trust (NHFT) EPRR Manager transitioned to the Head of EPRR for both NHFT and LPT. This shared EPRR leadership role across NHFT and LPT brings significant benefits in terms of consistency, efficiency, and strategic alignment. By sharing staffing resource and oversight, both trusts benefit from a unified approach to emergency preparedness and business continuity. This ensures that learning, best practice, and where appropriate, resilience capabilities can be effectively coordinated. This model supports the reduction of duplication, whilst strengthening collaboration across organisational boundaries. This supports a more agile response to system-level risks and incidents. It also enhances the ability to contribute meaningfully to ICS-wide planning and multi-agency engagement, while maintaining the flexibility to address the unique needs of each organisation.

EPRR Steering Group

The LPT EPRR Steering Group meets bi-monthly and reports into the Health and Safety Committee. The group is well represented and includes Assistant Directors and subject matter experts, including Estates, IPC and Cyber Security. Attendance at each group meeting has been consistently positive, which is indicative of the Trust's support and buy-in to EPRR needs.

The Shared Deputy Director of Safety and EPRR will chair and ensures that the group operates in accordance with these Terms of Reference. In addition to this the Head of EPRR will lead on all Business Continuity and EPRR matters to ensure that key responsibilities of the group continue to be aligned to the NHS EPRR Framework.

Incidents

Incident Response

Incident	Type of Incident	Debrief Report
24 th September 2025 – Loss of Power – Coalville Health Centre	Business Continuity Incident	<i>Available on request from the EPRR team</i>

Feedback following the above declared incident was positive, citing inclusion of all stakeholders in the incident management team, the efficient reorganisation of service delivery, and the prompt escalation to the ICB. There were no actions or learning identified following the debrief.

Near Miss Events and Response Activities

The EPRR team have been involved in a number of issues that were close to developing into declared incidents. These near misses and other issues required EPRR input/support which, although not formally declared as incidents, have been supported by the team. These included:

- Coalville HC Power Outage (24th September 2025)
- Loss of mobile internet, Vodafone Issue (13th October 2025)
- Heating issues at Melton and Rutland Hospitals (31st December 2025 - 7th January 2026)
- GP information sharing (2nd Feb- 13th Feb 2026)
- Intermittent power issues at Springfield Road Health Centre (20th Feb 2026)
- Virgin Media Outage (23rd February 2026)
- Loughborough Fire Alarm issues (6th March- 9th March 2026)
- Overheating servers at Bradgate Mental Health Unit (26th May 2026)
- Loss of internet at Coalville Hospital (2nd June 2026)
- Red Heat Health Alert (22nd June 2026)
- Resident Doctor Industrial Action (Various dates)

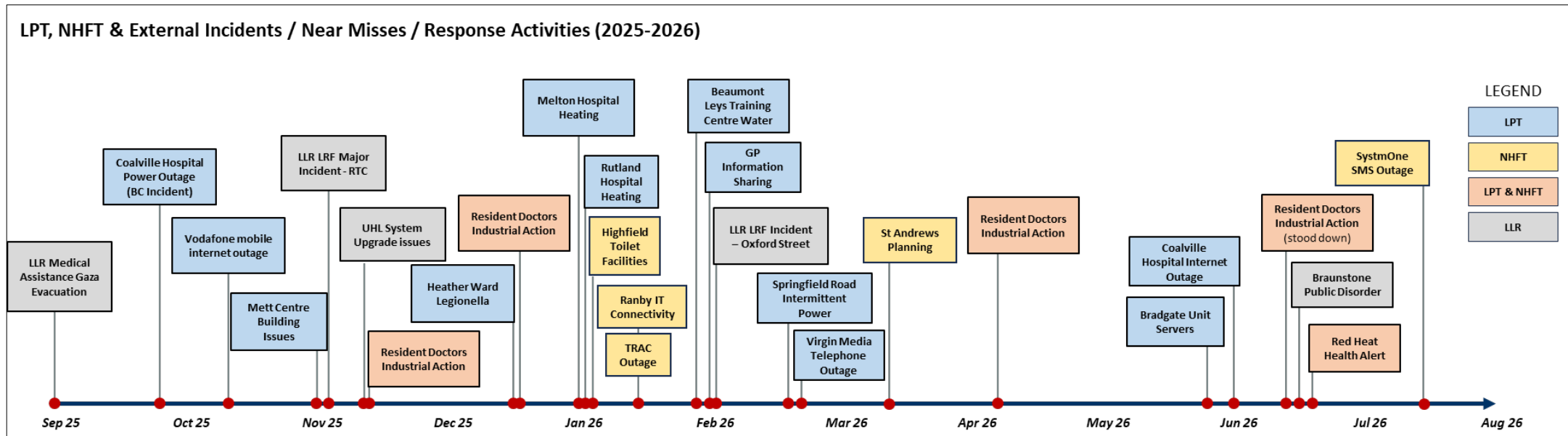
These issues were managed locally without impact on service delivery, and in most cases were resolved within the first hour or it was noted there were no impacts that required a formal trust response. It is also noted that the introduction of the Planned Work Coordination process is likely to have prevented potential business continuity incidents arising from issues with estates work.

The following are incidents that have been declared or put on standby by external partners, or have required EPRR involvement over the last 12 months and have impacted LPT, or LPT have been directly involved in the response:

- Medical Assistance TCG's (27th August 2025 – 2nd October 2025)
- LLR LRF Major Incident - RTC (3rd November 2025)
- UHL System Upgrade Issues (12th November 2025)
- LLR LRF Incident - Oxford street incident TCG (4th February 2026)
- Braunstone area increased risk preparation (18th June 2026)

Response Timeline

Due to the NHFT and LPT shared working model for EPRR, the following chart highlights the response activities the EPRR teams have actively led or been involved in through September 2025 to July 2026.



Risk Management

To ensure relevant risks are managed, EPRR maintain the EPRR Risk Register via the EPRR Steering Group. This register considers those risks aligned to the EPRR work programme. It utilises the Local Health Resilience Partnership (LHRP) Risk Register, ensuring the risks are aligned. As well as this alignment, EPRR also utilise the Leicester, Leicestershire and Rutland Risk Register to ensure local risks to LLR are considered. All risks are discussed, scored, agreed and updated on to Ulysses.

Business Continuity

The following is an overview and analysis of the LPT Business Continuity Management System. It highlights progress, gaps and continued focus.

Overview

Business Continuity continues to be a focus for EPRR, and major work has been taking place to ensure a robust, updated business continuity management system is implemented across the trust. Embedding effective business continuity across LPT ensures resilience at all levels of the Trust against disruptive events and ensure services can continue delivery of activities. Engagement is extremely positive, with directorates and services regularly engaging with, and understanding the importance of bespoke and up to date Business Continuity arrangements across the trust.

The team have continued to work with and support our operational directorates to ensure business continuity arrangements are in place and updated.

Business Impact Analysis (BIA)

Business Impact Analysis (BIA) development continues to be an important element of the Trust's Business Continuity Management System. Over the past year, significant progress has been made in working with services and directorates to develop and enhance BIAs, ensuring a clearer understanding of critical activities, dependencies, recovery requirements and potential impacts arising from service disruption.

The EPRR team continues to support service leads and plan authors through a structured programme of review and development, helping to ensure that BIAs remain current and effectively inform business continuity planning and resilience arrangements across the Trust.

Business Continuity Plans

EPRR maintain the overarching LPT Business Continuity Management Plan which contains the service prioritisation list, developed through Covid and Industrial Action, and updated annually.



Delivery of an effective Business Continuity Management System relies upon robust service-level plans. As part of an established programme of work, the EPRR team works collaboratively with Service Leads and Business Continuity Plan authors to review, update and assure local business continuity arrangements across the Trust. This ongoing process helps ensure plans remain current, accessible and capable of supporting services during periods of disruption.

Compliance and progress are monitored through business continuity key performance indicators, providing assurance that resilience arrangements continue to be maintained and strengthened across NHFT.

Tracking Business Continuity Progress

EPRR continue to monitor progression of all Business Continuity documentation utilising overview trackers. The outputs of these trackers directly feed into Business Continuity Key Performance Indicators (KPIs), which were agreed through the EPRR Steering Group. Managing business continuity in this way ensures any gaps or areas of concern can be identified and escalated where appropriate.

Key Performance Indicators (KPIs) – Business Continuity

The following tables show the overall compliance of each directorate against the Business Continuity KPI's who have existing business continuity arrangements in place.

Overall figure of LPT services with business continuity arrangements in place.

	Community Health Services	Mental Health Services	Families, Young People and Children and Learning Disability Services	Corporate / Enabling Services
Business Continuity Plans	93%	91%	85%	31%
Business Impact Analysis	85%	69%	79%	53%

Going forward, under the renewed Business Continuity system being put into place, there are two core KPIs now reported through the EPRRSG on its progress, and these are also reported to the Health and Safety Committee. These are –

KPI 1 – All LPT services have a fully completed Business Impact Analysis and are updated annually.

KPI 2 – All LPT services, where necessary, have fully completed a Service Business Continuity Plan or have access to a Site Business Continuity Plan; ensuring these are updated annually.

KPIs are measured against the following:

- Below 54% fully (or partially) completed = Non compliant
- 55% - 69% fully completed = Partially compliant
- 70% to 85% fully completed = Substantially compliant
- 86% and above fully completed = Fully Compliant

Site Business Continuity Plans

The EPRR team commenced development of Site Business Continuity plans this year, and a phased rollout is underway to ensure that all key sites have a BIA and BCP in place. This workstream ensures that site-level risks and arrangements are appropriately captured and aligned with Trust-wide resilience planning. The plans are developed with significant input from Estates and Facilities, LHIS, Health and Safety, and key site individuals such as Matrons. The site BCPs, once complete, will also replace the existing/legacy lockdown, evacuation and CBRN plans.

A site BCP training day is implemented on completion of each site BCP and is aimed at key site-based operational staff. The sessions are designed to familiarise staff with the site resilience arrangements, and also incorporate lockdown, evacuation, CBRN and communications exercises. Attendance at the training days is recorded by the EPRR team as part of the existing training monitoring process, and a Training Day / Post Exercise report drafted following each training day to capture learning, recommendations and any areas for improvement.

Progress against plans and training days is reported at EPRR steering group on a bi-monthly basis.

The Site BCP workstream plays a significant role in preparing the Trust for the anticipated implementation of Martyn's Law in 2027 by ensuring eligible sites have tested and documented arrangements for communication cascades, lockdown, evacuation, and broader protective security measures. These arrangements enhance site resilience, support rapid decision-making during security incidents, and contribute to the safety of patients, staff and visitors.

Business Continuity Awareness Week (BCAW)

Business Continuity Awareness Week took place between 18th and 22nd May 2026. A cross-Trust approach was adopted, with communications replicated where appropriate. The focus was on resilience, core concepts of business continuity and how both trusts align to ISO 22301 as well as the NHSE EPRR Core Standards. Key messages were shared with staff by way of blog posts and trust newsletters, and in addition for LPT, a screensaver shown on all LPT computer screens. The communication methods were used to raise awareness of business continuity training available in both trusts, as well as promoting Exercise Grey Cloud, the off-the-shelf cyber incident business continuity exercise. The EPRR team also offered direct support during the week, including



opportunities for one-to-one engagement.

Planned Work Co-ordination

The Planned Work Co-ordination process was introduced in 2025 in order to ensure that any planned work taking place across the trust was communicated, assessed for risk and impact on services, and any contingency plans put in place where impact was deemed likely.

The primary aim of the process is to communicate work to impacted services and to mitigate against potential business continuity incidents arising as a result of planned work. Since its introduction in late summer 2025, progress has been positive, with buy-in from both Estates and Facilities and LHS, and directorates.

Once notified of planned work by way of a Planned Work Notification Form, the EPRR team will co-ordinate and track the process, liaising with directorate leads to ensure an impact analysis is completed, and plans set out where these are deemed necessary. The impact analysis is scored against a set of criteria, the outcome of which will indicate whether a planned work preparedness form is required. Directorates are still able to complete a preparedness form for their own assurance, even if the impact analysis indicates low risk.

Since the start of September 2025, there have been 27 separate planned works notified, including electrical testing and remedials, boiler replacements, IT downtime and solar panel installations.

Looking Ahead 2026/2027

The EPRR Team will continue to work with corporate services and operational directorates to develop business continuity plans into next year. The team will also prioritise those operational directorate teams who do not currently have a BIA or BCP in place.

Site Business Continuity Plans will also continue to be developed collaboratively across the trust, supported by further training and exercising days.

The EPRR team will also continue to work proactively with Estates and LHS, as well as operational directorate colleagues to further embed the planned work co-ordination process.

Emergency Plans

A number of EPRR owned plans are updated annually and monitored for effectiveness. These plans are up to date and aligned to the NHS EPRR Framework and NHS Core Standards for EPRR.

- Adverse Weather Plan
- Seasonal Weather Preparedness Guidance (New)
- Contaminated Self Presenters (CBRNe) Plans
- Evacuation and Shelter Plans
- Evacuation and Shelter Framework
- Lockdown Plans
- Incident Response Plan (previously Major Incident Plan)
- New and Emerging Pandemic Plan



- Fuel Disruption Plan (New)

Existing CBRN, Evacuation and Shelter, and Lockdown plans will gradually be incorporated into the individual Site Business Continuity plans as these are developed, although these will be supported by single trust-wide framework documents, such as the Evacuation and Shelter Framework listed above.

EPRR are also instrumental in the support, development or maintenance of other Trust plans and processes which may not be directly owned by EPRR. These include but are not limited to:

- Cyber Incident Response Plan
- Communications Plan
- VIP Plan
- Infectious Disease and Outbreak Management processes

EPRR Training and Exercising

Training is a key area within EPRR that benefits a cross-trust approach and alignment. As such, both the Principles of Incident Response and Principles of Business Continuity are delivered to the same staff cohort in joint NHFT and LPT capacity. This reduces operational pressure on the team but also ensures consistency in approach across both Trusts

EPRR Training

As per the EPRR Policy and EPRR Training Needs Analysis, and aligned to the National Occupational Standards, EPRR conduct the following training:

Incoming Director On-Call (One-to-One)

The Director On-Call Introduction training centres around the roles and responsibilities of undertaking Director On-Call duties, including elements of incident response training and role expectation. All new Directors On-Call are required to undertake this training. EPRR also provide a refresher version of this training for any Director that requests it.

Principles of Incident Response

Principles of Incident Response has been running successfully across LPT for the past year, having previously struggled to encourage attendance. This is a cross-trust training package delivered to both LPT and NHFT simultaneously on a quarterly basis.

Principles of Incident Response training is available to all staff across LPT who may be involved in an incident response, and therefore all on-call groups, including LPT Directors and Managers on Call, including within Estates and Facilities and LHIS. The training centres around (but is not limited to) multi-agency working, command and control, legislation, information sharing, decision making, risk anticipation, assessment, and debriefing and there is a requirement to attend one session every three years.

The below figures represent both current and forecast attendance for all on call functions who are required to attend the training. The forecasted figures are based on the numbers of staff who have signed up to the training via uLearn.

	Current (June)	Q2 2026 (forecast)	Q3 2026 (forecast)
Directors on Call (23)			
% complete	87%	91%	91%
Operational Directorate Managers on Call (105)			
% complete	80%	87%	93%
LHIS / EFM / CHS Ward Sisters on Call (29)			
% complete	59%	69%	76%

Numbers in brackets denote the number of staff requiring training.

Management of Contaminated Casualties

This training is targeted to staff who are most likely to come into first contact with CBRNe (Chemical, Biological, Radiological, Nuclear and explosive) and HCID (Highly Contagious Infectious Disease) contaminated self-presenters. From 2026, this training is part of the Site Business Continuity plan training days and includes a live exercise

The exercise is a facilitated live exercise designed to provide participants with an opportunity to discuss, review and validate local arrangements for contaminated casualties self-presenting at a hospital site (CBRN). The exercise allows participants to explore decision-making, communication, coordination and operational challenges associated with CBRN incident arrangements safely in an affected area or site.

Principles of Business Continuity

This training is aimed at all staff involved in the BC development process. This training is for all those involved in the Business Continuity plan development process and provides an overview of what business continuity is and what the LPT Business Continuity Management System looks like. Although it is primarily targeted at plan owners or authors, any member of staff can attend the training. This training continues to be promoted across the trust, via eNews, EPRR steering group, and targeted emails.

The numbers below show the actual and forecast attendance for all BCP owners / authors. Forecast figures are based on staff who have expressed interest in attending.



	Current (Actual)	Q2 2026 (Forecast)	Q3 2026 (Forecast)	Q4 2026 (Forecast)
BC Plan Owners / Authors – Ops Directorates (154)				
% Complete	42%	48%	52%	54%
BC Plan Owners / Authors – Enabling Services (50)				
% Complete	46%	54%	62%	64%

Loggist Training internal / external

The Trust currently has twelve trained loggists who can support the Strategic Commanders if a major incident occurs. All loggists have annual refresher training which is up to date.

Key Performance Indicators – Training

The following KPI's are aligned to both the Trust KPI measures as well as the EPRR Framework. These are used to monitor the compliance of all LPT staff who undertake a role within incident response.

- All DoC's to be 100% compliant in all mandatory training
- All other staff (excluding DoC's) to be 85% and over compliant in all mandatory training
- Below 70% (Red) = Non compliant
- 70% to 85% (Amber) = Substantially compliant
- 85% and above (Green) = Compliant

The EPRR team regularly deliver training throughout the year, to ensure compliancy is consistently improving, and that LPT staff feel confident in the areas they are being trained within. EPRR produce a bi-monthly training report for the EPRR Steering Group which details and outlines compliancy figures in detail.

Training - Monitoring

To ensure all staff who undertake EPRR training are fully monitored, staff are required to maintain their own Personal Development Portfolio (PDP) which is aligned to the National Occupation Standards. Any training, or live incident that a colleague has been involved in will trigger the PDP to be updated to reflect. EPRR manage and maintain a full comprehensive list of all staff who have undertaken or due to undertake training. This way EPRR can ensure training is kept up to date and gaps in training can be addressed. In addition, the EPRR team have introduced quarterly audits on PDPs, whereby a random selection of staff are contacted to provide their PDP for review.

EPRR Internal Exercises

EPRR are required to conduct a number of exercises throughout the working year. These exercises provide a safe space to test and validate people, plans and processes and help identify potential improvements, furthering resilience to future disruptive events.

Exercise Medlock – Tabletop – EPRR led (11/03/26)

The EPRR team led a face-to-face tabletop exercise with the LPT Pharmacy team, adapted from Exercise Grey Cloud, which tested the Pharmacy business continuity plan. The scenario, based on a sudden loss of IT systems, supported the Pharmacy service to explore their ability to maintain critical activities during disruption to systems. This identified a number of actions to strengthen the service business continuity plans. Feedback from the exercise was positive, highlighting that this had been a valuable opportunity to test arrangements and identify improvements, with the support of the EPRR team.

Exercise Grey Cloud – Tabletop – Business Continuity (Ongoing)

A successful pilot of the first 'Off the Shelf' exercise, Exercise Grey Cloud took place during March 2025, and was subsequently rolled out later that year. The exercise is designed to test the ability of services to respond to and recover from a cyber-attack scenario and is intended to be used by services independently in order to test and improve their business continuity arrangements. The exercise was promoted across the Trust in various forums, and following a slow start, take up of the exercise has been beyond expectations. Currently, 85 separate responses to the exercise workbook have been received, covering around 64 individual services.

Exercise Pulse 26 - Communications – No Notice (09/04/26)

The aim of Exercise Pulse 26 was to test the ability of those with an on-call responsibility, in the event of an incident occurring out of hours at LPT, to receive, confirm and appropriately escalate notification of an incident. The EPRR team carried out the exercise from 1800 hours on 9th April 2026. The exercise was two-fold: to test response times from notification of incident scenario to escalation call to ICB Director on Call; and to test the on-call capability of other services with on-call responsibility

Exercise Relay - Communications – Notice (29/06/26)

The EPRR team undertook an in-hours 'notice' communications exercise in July to assess LPT's internal on-call communications processes in an emergency. This exercise tested the backup mobile phone facility of inpatient services, to assess access to these emergency phones and response times. It also tested the ability to escalate to the LPT Director on Call in hours using an alternative mobile phone number.

Exercise Tempest – Command Post – (28/07/26)

Exercise Tempest is a command post exercise that was designed to test the activation, operation, and effectiveness of the Trust Incident Coordination Centre (ICC), out of hours. Incident command



roles and responsibilities and associated command arrangements during a prolonged adverse weather incident causing potential widespread operational disruption across LPT services were utilised by the participants, providing staff not usually engaged in an in-hours response, the opportunity to test and validate ICC arrangements and associated plans.

Exercise Signal Chain - Communication Cascade

Exercise Signal Chain is a facilitated tabletop exercise designed to provide participants with an opportunity to discuss, review and validate local arrangements for communication cascade processes following a significant disruption affecting a healthcare facility. The exercise allows participants to explore decision-making, communication, coordination and operational challenges associated with communicating to patients, staff and services safely from an affected area or site. This exercise forms part of the Site Business Continuity Plan Training and Exercise Day.

Exercise Safe Exit - Evacuation and Shelter

Exercise Safe Exit is a facilitated tabletop exercise designed to provide participants with an opportunity to discuss, review and validate local arrangements for the evacuation and relocation of services following a significant disruption affecting a healthcare facility, alongside the LPT EPRR Evacuation and Shelter Framework.

The exercise allows participants to explore decision-making, communication, coordination and operational challenges associated with moving patients, staff and services safely from an affected area or site. This exercise forms part of the Site Business Continuity Plan Training and Exercise Day.

Exercise Secure Shield - Lockdown Exercise

Exercise Secure Shield is a facilitated tabletop exercise designed to provide participants with an opportunity to discuss, review and validate local arrangements for lockdown arrangements following a significant disruption affecting a healthcare facility. The exercise allows participants to explore decision-making, communication, coordination and operational challenges associated with lockdown arrangements safely in an affected area or site. This exercise forms part of the Site Business Continuity Plan Training and Exercise Day.

Exercise Iron Response - CBRN Exercise

Exercise Iron Response is a facilitated live exercise designed to provide participants with an opportunity to discuss, review and validate local arrangements for contaminated casualties self-presenting at a hospital site (CBRN). The exercise allows participants to explore decision-making, communication, coordination and operational challenges associated with CBRN incident arrangements safely in an affected area or site. This exercise forms part of the Site Business Continuity Plan Training and Exercise Day.

External Exercises

LPT has been actively participating in a number of external exercises, including:

Exercise Toucan (NHSE Communications Exercise)

LPT successfully participated in the annual NHSE communication cascade, Exercise Toucan.

Exercise Penelope (NHSE Regional Exercise)

Exercise Penelope is an NHS England Midlands region annual exercise, which is part of the NHSE National 7year exercising programme.

There were two scenarios being exercised, these were flooding and a chemical plume affecting Trust buildings. Each scenario included three injects for discussion regarding the arrangements on site security, evacuation and shelter. LPT played a crucial role in this exercise as the scenarios were affecting all of the Glenfield hospital site. Representatives for Health TCG's and Health SCG's were in attendance to test evacuation, shelter and incident response arrangements.

Exercise Vulcan (LLR LRF Multi-Agency Exercise)

Exercise Vulcan is a series of Multi Agency Tactical Co-ordinating Group exercises which is based on a major incident declaration of a fire in the LRI. LPT consistently provide TCG participants to play as part of this exercise. The TCG participants are provided with a short briefing/ SITREP about LPT's position on the day and are tasked to make decisions utilising the LPT Incident Response Plan (IRP).

Compliance / Audits

NHS EPRR Core Standards

The EPRR Core Standards is an annual piece of work with a legislative background where the Trust is required to evidence around 50+ subjects and a 'Deep Dive' topic within a submitted report. The gathered evidence for each standard is then presented to LLR ICB, who assess and forward on to NHS-Midlands for further review. A confirm and challenge process is undertaken, and additional evidence is submitted as requested, within set timeframes.

- The current process is underway for 2026 and EPRR are regularly reporting on progress to the Local Health Resilience Partnership.
- LPT EPRR scored overall as fully compliant. Out of 58 standards, all 58 were scored as fully compliant

Decision Required

Briefing – no decision required.

Governance Table

For Board and Board Committees:	LPT Trust Board
Paper sponsored by:	Jean Knight
Paper authored by:	Dan Adamson -
Date submitted:	September 2026
Name and date of other committee / forum at which this report / issue was considered:	Health and Safety Committee Quality and Safety Committee
Level of assurance gained if considered elsewhere	☒ Assured ☐ Partially assured ☐ Not assured
Date of next report:	Annual
THRIVE strategic alignment:	☒ Technology ☒ Healthy communities ☒ Responsive ☒ Including everyone ☒ Valuing our people ☒ Efficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	BAF 06
Is the decision required consistent with LPT's risk appetite:	Yes
False or Misleading Information (FOMI) considerations:	No
Positive confirmation that the content does not risk the safety of patients or the public:	Yes
Equality considerations:	

Public Trust Board

Leicester, Leicestershire and Rutland (LLR) LeDeR Annual Report 2025-2026 : Learning from the Lives and Deaths of People with a Learning Disability and Autistic People

Purpose of the Report

- This report presents the findings, learning and recommendations from the LLR LeDeR Annual Report 2025-2026 and provides assurance regarding delivery of the LeDeR programme across LLR. It highlights opportunities for system-wide improvement to reduce health inequalities experienced by people with a learning disability and autistic people.
- The report is being presented to provide assurance regarding the LeDeR review process, share learning across partner organisations, and support implementation of recommendations intended to improve quality, safety and equity of care.

Analysis of the issue

- The LeDeR programme is a national NHS England programme designed to improve care, reduce health inequalities and prevent premature mortality for people with a learning disability and autistic people. National evidence continues to demonstrate significant inequalities in life expectancy, avoidable mortality and access to healthcare for this population. The report highlights that adults with a learning disability continue to die significantly younger than the general population and experience avoidable barriers to healthcare access.
- During 2025-2026, 97 deaths were notified to the LeDeR programme and 82 reviews were completed, including 38 focused reviews, exceeding the national target for focused reviews.
- Key findings identified:
 - Respiratory disease remained the leading cause of death (44% of completed reviews).
 - Cardiovascular disease remained the second leading cause of death.
 - A significant increase was observed in cancer-related deaths, with many people diagnosed at Stage 4 disease.



- Reasonable adjustments remained the most common learning theme.
- Continued concerns were identified regarding compliance with the Mental Capacity Act (2005).
- Delays in recognising deterioration and cancer symptoms were recurrent themes.
- Inequalities remain evident in access to screening, preventative healthcare and diagnostic pathways.
- The LeDeR programme supports the Trust's strategic priorities through:
 - Reducing health inequalities.
 - Improving patient safety and quality of care.
 - Delivering person-centred care.
 - Promoting inclusion and equity.
 - Strengthening partnership working across the Integrated Care System.

Development of the LeDeR Report:

- The LeDeR annual report is developed through local governance arrangements overseen by the LLR LDA Collaborative (led by LPT).
- Learning themes were analysed through thematic review processes and findings were reviewed by the LLR LeDeR Steering Group and partner organisations.
- Action plans have been developed and monitored through provider and system governance structures.
- The report has been informed by the National LeDeR policy and reporting requirements, multi-agency mortality reviews, LeDeR governance panels, national benchmarking data and regional thematic review work

Key Points for consideration:

- The report specifically addresses inequalities experienced by people with learning disabilities and autistic people and seeks to improve equitable access, outcomes and experiences across health and social care services.
- The findings directly relate to patient safety, quality of care and patient experience. The report identifies opportunities to reduce avoidable mortality, improve compliance with legislation and strengthen preventative healthcare delivery.
- Assurance is evident in the following:



- The LeDeR programme remains embedded within LLR
 - Review completion targets have been achieved.
 - Learning is disseminated systematically across partner organisations.
 - Progress has been made in annual health checks, STOMP/STAMP reviews, vaccination uptake and specialist phlebotomy pathways.
 - Multi-agency governance arrangements are established and operating effectively.
 - The LeDeR report informs the LDA Collaborative's Annual Operational Plan and its findings are addressed by the Collaborative through a comprehensive systemwide annual LDA Health Inequalities Plan.
- The report identifies ongoing concerns regarding:
 - Mental Capacity Act implementation and documentation.
 - Late-stage cancer diagnosis.
 - Variable uptake of national screening programmes.
 - Insufficient implementation of reasonable adjustments.
 - Recognition of deterioration.
 - Ongoing health inequalities experienced by people with learning disabilities and autistic people.

Proposal

The board is asked to:

1. Receive assurance regarding the delivery and effectiveness of the LLR LeDeR Programme during 2025-2026.
2. Endorse the findings and recommendations contained within the Annual Report.
3. Support implementation of the 2025-2026 LeDeR priority areas.
4. Continue oversight of system-wide progress to reduce inequalities and improve equity.



Decision required – Please indicate:

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

Governance table

For Board and Board Committees: Paper sponsored by:	Trust Board in Public	
	David Williams, Group director of strategy & partnerships	
Paper authored by:	Siouxie Nelson and Mark Roberts	
Date submitted:	21.09.26	
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):	LDA Collaborative	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	One-off	
LPT strategic alignment:	T - Technology	
	H – Healthy Communities	X
	R - Responsive	X
	I – Including Everyone	X
	V – Valuing our People	
	E – Efficient & Effective	
CRR/BAF considerations (<i>list risk number and title of risk</i>):	BAF2	
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	Nothing identified	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	Reducing inequalities and improving equity	



Leicester, Leicestershire and Rutland LeDeR Annual Report 2026



**Leicester, Leicestershire
and Rutland**
Health and Wellbeing Partnership

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Foreword

Leicester, Leicestershire and Rutland (LLR) continue to demonstrate a strong and unwavering commitment to the LeDeR programme and to improving the care and outcomes for people with a learning disability and autistic people. It is this sustained commitment across the system that has enabled the development of this Annual Report.

We would like to express our sincere appreciation to the many individuals and organisations across LLR whose dedication, professionalism, and compassion have underpinned this work. This includes those who have reported deaths, undertaken reviews, and contributed to the analysis of learning. Most importantly, we acknowledge the individuals at the heart of this report—people with a learning disability and autistic people—as well as their families, friends, carers, colleagues, and everyone whose lives are affected by this work.

We also wish to recognise the vital contribution of our LeDeR Reviewers. Their knowledge, compassion, and commitment have been central to the progress achieved to date. We remember with respect those whose lives are reflected in this report and those who are no longer with us, and we hope this report honours their memory.

This report is not an endpoint, but a catalyst for continued improvement. It calls on every partner within the LLR health and social care system to reflect on the findings and take meaningful action. Only through shared responsibility and collective action can we ensure that people with a learning disability and autistic people receive consistently high-quality care, and that true health equality and equity are achieved.

Prof. Nil Sanganee, Chief Medical Officer Director, Leicester, Leicestershire and Rutland Integrated Care Board.

Santokh Dulai, Assistant Director (Adults & Communities), Leicestershire County Council.

David Williams, Group Director of Strategy and Business Development, Leicestershire Partnership NHS Trust and Northamptonshire Healthcare NHS Foundation Trust.

Acknowledgements

Leicester, Leicestershire and Rutland Integrated Care Partnership would like to acknowledge the support provided to the LeDeR programme by the following organisations, groups and individuals:

NHS England National Team (NHSE)	Primary Care Services
NHS England Regional Team	Leicester City Council
LLR LeDeR Team	Leicestershire County Council
LLR LeDeR Experts by Experience	Rutland County Council
LPT Talk and Listen Group	Leicester, Leicestershire and Rutland Child Death Overview Panel (CDOP)
All family members' contributions	LDA Collaborative
Leicestershire Partnership Trust	DeMontfort University
University Hospitals of Leicester	

Executive Summary

The Leicester, Leicestershire and Rutland (LLR) LeDeR Programme reviewed the lives and deaths of people with a learning disability and autistic people to identify learning that can improve care, reduce health inequalities and prevent avoidable deaths. During 2025/26, 97 deaths were notified to the programme and 82 reviews were completed, exceeding the national target for focused reviews.

Respiratory disease remained the leading cause of death, followed by cardiovascular disease and cancer. This year saw a significant increase in cancer-related deaths, with many people diagnosed at Stage 4 disease. A thematic review highlighted delays in diagnosis, barriers to investigations and missed opportunities for reasonable adjustments, leading cancer to become a key area for system-wide improvement.

The report identifies two continuing priorities for action: improving compliance with the Mental Capacity Act (2005) and ensuring earlier recognition of cancer and deteriorating health. Reasonable adjustments also remained the most common learning theme, reinforcing the need for all services to provide equitable and accessible care.

There were many positive achievements across LLR during the year, including continued high uptake of Learning Disability Annual Health Checks, the development of the specialist Learning Disability Phlebotomy Pathway, progress with the Leicestershire Aspiration Pneumonia Protection Plan (LAPPP), and ongoing success of the STOMP/STAMP programme. These initiatives demonstrate a continued commitment to improving health outcomes and reducing inequalities.

The report concludes with a renewed focus on preventive healthcare, early diagnosis, end-of-life planning, reasonable adjustments, Mental Capacity Act compliance and reducing health inequalities. Through partnership working and shared responsibility, LLR remains committed to ensuring people with a learning disability and autistic people receive high-quality, equitable care throughout their lives. Throughout this report, there are direct quotes from friends and family, taken from the pen portraits of local reviews that are thoughtfully shared. These are shown in coloured bands across the pages, the first is shown at the bottom of this page.

"To those who knew her, she will always be remembered for her sweetness, her vibrant joy, her laughter, her dancing, and above all, her unwavering affection."

Insights from the Author

This year has been one of reflection, challenge and optimism.

Over the past several years, the LeDeR programme in LLR has repeatedly highlighted the same themes: reasonable adjustments, the Mental Capacity Act (2005), communication, preventative healthcare and end-of-life planning. Whilst it can be frustrating to continue reporting similar findings, it is important to recognise that meaningful change across a large health and social care system takes time. This year we have again seen evidence of excellent practice, but also clear reminders that there is still more work to do.

One of the most striking findings from this year's reviews was the increase in cancer-related deaths, although being mindful that we focused on all cancer diagnosis and saw people survive the disease too. Historically, cancer has not featured prominently within our local LeDeR data. This year, however, there was a noticeable rise in cancer diagnoses, often at Stage 4. Although concerning, this may also represent some positive progress in recognising and diagnosing cancer in people with a learning disability who may previously have remained undiagnosed. The challenge now is, ensuring that people are diagnosed earlier through improved recognition of symptoms, equitable access to investigations, and effective use of reasonable adjustments throughout diagnostic pathways.

The Mental Capacity Act (2005) remains a recurring area of concern. Whilst there were examples of excellent, person-centred and legally compliant practice, the same issues were repeatedly identified across reviews. Capacity assessments, best-interest decision making and documentation continue to be inconsistent. It remains my view that the principles of the MCA are generally well understood; however, translating that understanding into everyday practice continues to be challenging across all sectors.

This year has also provided considerable encouragement. The Learning Disability Phlebotomy Pathway and sedation clinic pilot have been genuinely innovative developments for LLR. For many people, access to blood tests has been a long-standing barrier to healthcare. Seeing individuals successfully undergo investigations that were previously not possible has been both rewarding and humbling. The dedication of commissioners and staff involved in the development of this pathway demonstrates what can be achieved when health inequalities are approached creatively and collaboratively.

One of the most inspiring pieces of work undertaken this year was the thematic review of people with learning disabilities who lived into older age. Spending time reviewing the stories of individuals who lived into their 80s was a privilege and a reminder of why the LeDeR programme exists. These were stories of resilience, strong relationships, person-centred support and lives well lived. The review challenged many assumptions about ageing with a learning disability and reinforced the importance of preventative healthcare, stable support networks and maintaining meaningful lives throughout the life course. It also had a profound impact on those involved in the review process, reminding us to celebrate success as well as learn from difficulty.

This year marked a significant achievement for the LLR LeDeR Team, who were honoured with the LPT Celebrating Excellence Team of the Year Award, in recognition of their dedication, hard work, and impact throughout the year.

Finally, I would like to acknowledge the families, carers, professionals, reviewers and experts by experience who continue to contribute to the LeDeR programme. Their honesty, compassion and commitment ensure that every review becomes an opportunity for learning and improvement. Behind every statistic is a person, a family and a story. It is our responsibility to ensure that those stories continue to drive meaningful change across Leicester, Leicestershire and Rutland.

Siouxie Nelson – LLR LeDeR Clinical Lead

Introduction

Learning from Lives and Deaths of people with a LD and autistic people (LeDeR), previously known as The English Learning Disabilities Mortality Review (LeDeR) programme, was established as a pilot in 2015 and rolled out nationally in 2017. The aims are to:

1. Improve care for people with a LD and autistic people.
2. Reduce health inequalities for people with a LD and autistic people and
3. Prevent people with a LD and autistic people dying prematurely.

Since being established, deaths of people with a LD, and from January 2022 deaths of autistic people, have been reviewed with the findings presented in the LeDeR annual reports, where the action from learning has been captured.

The LeDeR Programme continues to complete initial or focused reviews for people. A focused review includes the initial review as well as detailed learning into action which is completed when a review meets the criteria and is presented at the LLR LeDeR governance panel.

Where possible comparisons have been drawn over time but have also highlighted where, due to the transition in the system of data collection, this was not possible. The LeDeR Programme has for the fourth year running, included LeDeR reviews of autistic people. As this is the fourth year, it was hoped there would be some data to draw upon, however the notifications of the deaths of autistic people remain low, both locally and nationally, and therefore, it is important to maintain confidentiality. Notifying a death to LeDeR is not mandatory and, therefore we would not expect LeDeR to have data on all people with a LD and autistic people who have died in LLR. Some data contains relatively small numbers of cases, so some findings must be interpreted with a degree of caution.

"His sister shared that he had a really lovely childhood. He was the youngest of three children and was very much "Peter Pan" for their mum."

National context¹

The final National 2024 LeDeR Annual Report has been published in July 2026 and, whilst it has confirmed that this is the final national academic report, this does not signal an end to LeDeR, the collection of mortality data, or the focus on reducing health inequalities experienced by people with a learning disability and autistic people. The accompanying written Ministerial Statement confirms the Government's ongoing commitment to learning from deaths and improving outcomes for these populations.

The Minister highlighted concerns regarding the high proportion of adults with Down syndrome who die before the age of 65 and reiterated the Government's commitment to improving outcomes through implementation of the Down Syndrome Act 2022. The statement also recognised that suicide, misadventure and accidental death remain the most common causes of death among autistic adults without a learning disability. The Government committed to addressing these inequalities through the Suicide Prevention Strategy for England and the development of a new Mental Health Strategy that considers the specific needs of autistic people and the provision of reasonable adjustments. NHS England has revised the LeDeR review process to strengthen its focus on service improvement, including greater consideration of modifiable factors, barriers to good health, safeguarding concerns and quality-of-care issues. The Minister confirmed that the 2024 report will be the final national academic LeDeR report. Future national learning will be supported through a new patient-level dataset bringing together information on health outcomes for people with learning disabilities, Down syndrome, autism and ADHD, enabling improved understanding of inequalities and supporting local and national service improvement.

The 2024 National LeDeR Report continues to demonstrate significant health inequalities experienced by people with a learning disability. Nationally, adults with a learning disability died at a median age of 62.8 years compared with 81.8 years in the general population. People with profound learning disabilities died at a median age of 40.7 years, more than 20 years younger than those with mild learning disabilities. Treatable mortality was particularly high in this group. Although avoidable mortality has reduced over recent years, 39% of deaths remained avoidable, almost double the rate seen in the general population. Pneumonia, epilepsy and cardiovascular disease continue to be leading causes of avoidable death. Recurring themes include delays in recognising deterioration, barriers to accessing healthcare, diagnostic overshadowing, inadequate reasonable adjustments and challenges in care co-ordination. These findings reinforce the importance of annual health checks, effective implementation of the Mental Capacity Act, proactive management of long-term conditions, and ensuring equitable access to high-quality healthcare for people with a learning disability.

"She was special- not only to her mum, who held a deep and singular bond with her, but to everyone who's life she touched. Her story is one of love, resilience, and the pure, uncomplicated happiness she brought into the world."

Top Ten Learning into Action Points 2025-2026

From the findings detailed in this report the top 10 learning into action points are shown below*.

1. Reporting the deaths of those people with LD and autistic people to the LeDeR Programme is essential, particularly those from Leicester city and from diverse backgrounds.
2. Improve the application of the Mental Capacity Act (2005). All services should undertake a review of their practices to ensure compliance with this important legislation.
3. Incomplete or estimated height and weight measurements remain a risk for people with LD. Wheelchair scales are available across LLR and hoist scales can be accessed via Learning Disability Community Teams to support accurate measurement.
4. People with behaviours that challenge require clear plans including advanced care plans and anticipatory nursing care needs, highlighting the support they require and anticipating the support they are likely to need in the years ahead.
5. Talking about end-of-life matters and having these meaningful conversations at the right time is important. Instigate Advanced Care Plans and ReSPECT forms early enough.
6. National cancer screening uptake remains low for people with LD and autistic people. How cancer screening is communicated to people is important, and so are the reasonable adjustments required. The Reasonable Adjustment Digital Flag (RADF) should be fully implemented.
7. Pain in people with a LD and autistic people can be misinterpreted or missed altogether. There are communication passports and a DISDAT (Disability Distress Assessment Tool) that are readily available.
8. Aspiration pneumonia happens as a consequence of an earlier event. Identification of risk factors and root cause analysis are important. The Leicestershire Aspiration Pneumonia Protection Plan (LAPPP) is being piloted across LLR.
9. Cardiovascular disease is the second leading cause of death among people with a LD in LLR. A healthy lifestyle, which includes a healthy diet, physical activity, and a healthy weight are important preventative factors. The 'Healthy Living Toolkits' are available which include this information in various formats.
10. Funding has been secured and the referral pathway is now being implemented for the specialist Learning Disability Phlebotomy Sedation Clinic. This innovative service will support people who have previously been unable to access blood tests, helping to reduce health inequalities and improve access to preventative healthcare.

Glossary of abbreviations

ALN	–	Acute Liaison Nurse
ASC	–	Adult Social Care
ASD	–	Autistic Spectrum Disorder
BMI	–	Body Mass Index
CDOP	–	Child Death Overview Panel
CoP	–	Court of Protection
DoLS	–	Deprivation of Liberty Safeguards
DNACPR	–	Do Not Attempt Cardio-Pulmonary Resuscitation
DVT	–	Deep Vein Thrombosis
EBE	–	Expert by Experience
ECG	–	Electrocardiogram
GP	–	General Practitioner
ICS	–	Integrated Care System
IMCA	–	Independent Mental Capacity Advocate
LTC	–	Long Term Health Conditions
LeDeR	–	Learning from Lives and Deaths Review Programme
LD	–	Learning Disability
MCA	–	Mental Capacity Act
MDT	–	Multi Disciplinary Team
MHA	–	Mental Health Act
MCCD	–	Medical Certificate of Cause of Death
NHS	–	National Health Service
NICE	–	National Institute for Health and Care Excellence
ONS	–	Office for National Statistics
PBS	–	Positive Behaviour Support
PEG	–	Percutaneous Endoscopic Gastrostomy
PCLN	–	Primary Care Liaison Nurse
RCN	–	Royal College of Nursing
ReSPECT	–	Recommended Summary Plan for Emergency Care and Treatment
SALT	–	Speech and Language Therapy
SJR	–	Structured Judgement Review
SMART	–	Specific Measurable Actionable Realistic Timebound
STAMP	–	Supporting Treatment and Appropriate Medication Treatment in Paediatrics
STOMP	–	Stopping the Over Medication of People with LD and Autistic People
SUDEP	–	Sudden Unexplained Death in Epilepsy
WTE	–	Whole Time Equivalent
WHO	–	World Health Organisation

Reviews of deaths

Deaths notified to the LLR LeDeR programme.

A total of 97 deaths of people with a LD and autistic people were notified to the LLR LeDeR Programme from 1st April 2025 – 31st March 2026, of those people:

- 12 people were autistic.
- 15 people were out of scope as they did not meet the criteria for a LeDeR review.
- 15 people were adults with a LD and autism.
- 55 people were adults with a LD.

Referrals received in year.

shows a total of 97 deaths referred to LLR LeDeR in 2025/26, broken down into initial and focused categories. At end of year, 36 cases remained in progress and 46 had been completed.

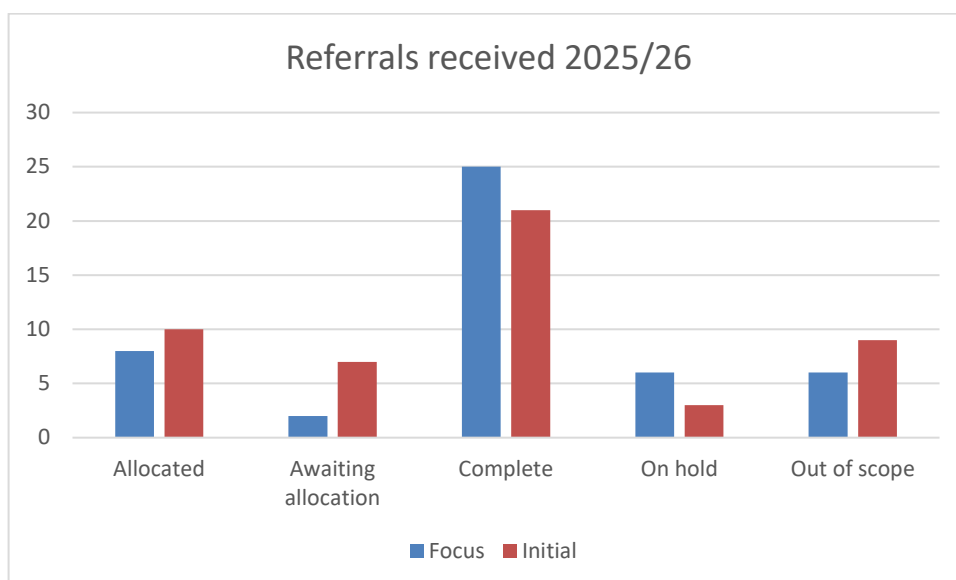


Figure 1. Referrals received by type, 2025/26

Age at death in 2025/26

Median age at death for those who passed away and their deaths notified to LeDeR in 2025/26 was 63yrs. This is a slight improvement on last year which was 61yrs. National LeDeR data (2024),

"He said the compassionate way the LeDeR letter was sent, along with the follow-up phone messages, showed genuine concern and encouraged him to take part in the review to help others who may face similar issues."

shows the median age at death at 62.8yrs.

The median age of death was 50yrs for those from a diverse ethnic background and 63yrs for those from a White British background. 14% (n=10) of those from a White British background were under 30yrs, and half of those (n=5) were deaths by suicide. Only 13% (n=11) of reviews notified to LeDeR were people from a diverse ethnic background, and over half of those were over 60yrs.

The median age at death in 2025/26, was 63yrs.

"He was described as always having sweets in his pocket. He would at times offer a sweet to someone in his hand, then, in a joking way, he would shut his hand and put the sweet away, sometimes he would go on to give the sweet and other times he wouldn't. This was a longstanding joke that he liked to do."

Mean age at death

Mean Age of Death - Notifications received by LLR in Financial year including CDOP*		Mean Age of Death - Notifications received by LLR in Financial year excluding CDOP
2021/2022	56 years	59
2022/2023	58 years	62
2023/2024	59 years	59
2024/2025	56 years	56
2025/2026	59 years	59

*CDOP was removed from LeDeR reviews from 2023 onwards.

The mean age at death in 2025/26, was 59yrs.

Mean age at death in completed reviews

The mean age of deaths in completed reviews in 2025/26 is 59yrs, this is higher than 2024/25 which was 56yrs. Due to the statistically small number of data, this year LLR LeDeR continues to include 3 year rolling averages from 2023-2024 onwards for the mean age at death (this 3-year rolling average includes data from 2021/2022 to 2025/2026), which endeavours to give a more accurate picture and it allows for any annual variations and extreme anomalies.

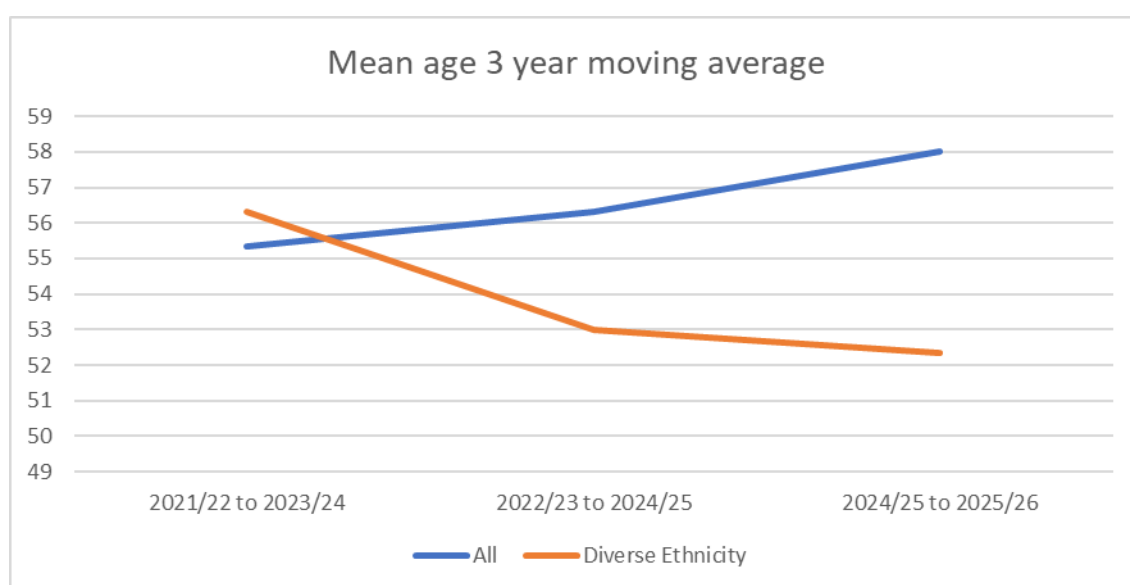


Figure 2. Mean age of death 3 year rolling average

Month of death

The 82 deaths notified to LeDeR in this time-period as shown in [Figure 3. Month of death](#), with more deaths occurring in August than any other month. This is broken down in [Figure 4. Month of death by gender](#). This excludes 10 notifications received in 2025/26, who died prior to this reporting year. It is usually expected in the United Kingdom (UK) to see seasonal differences as sadly more deaths generally occur during the winter period.

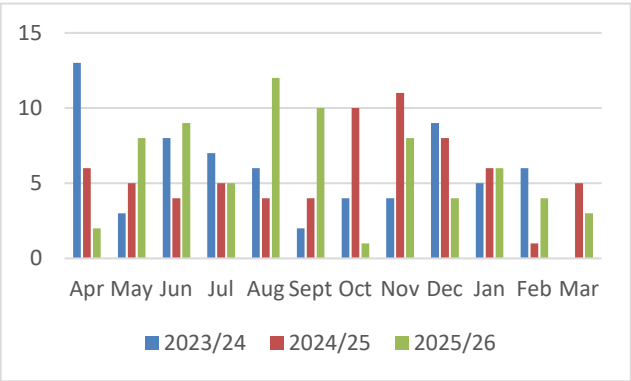


Figure 3. Month of death

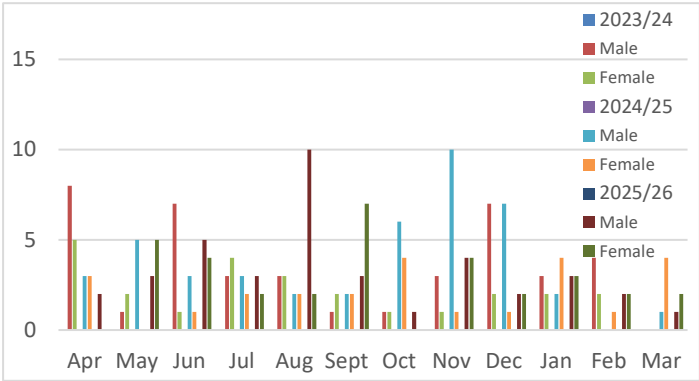


Figure 4. Month of death by gender

"She engaged in a range of sensory activities that she thoroughly enjoyed. These included playing with her belongings—particularly her tambourine, which was her favourite."

Reviews completed in year.

Analysis from this point covers all reviews that were completed within the 12 months from 1st April 2025 to 31st March 2026, rather than those received in that period.

This enables comparison with previous reports, and it is possible only to report accurately on cases that were completed at the time of writing.

In 2025/26, the LLR LeDeR programme completed 82 reviews, 44 of which were initial, 38 focused (*Figure 5. Reviews completed in 2025/26.*) The key performance indicator set nationally is that 35% of LeDeR Reviews are to be focused.

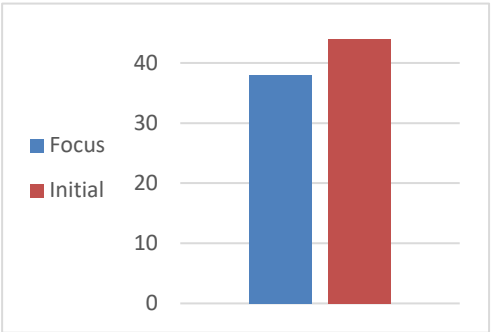


Figure 5. Reviews completed in 2025/26

For LLR LeDeR 46% of reviews were focused during 2025/26.

Equality Impact & Demographic Data

Age Group

Deaths were broken down by age group (see 2024/25, 2025/26), 56% of people who died were aged 61yrs or older, which is an increase since the past year of 4%. By comparison, deaths by age group in 2024/25 in LLR LeDeR shows 52% of people who died were aged 61yrs or older. For wider comparison, the national average age at death for people with a LD is 62.8yrs (National LeDeR Report 2024), for autistic people is 75.7yrs (National Autistic Society 2025) and for the general population this was 81yrs (UK Population Data 2023).

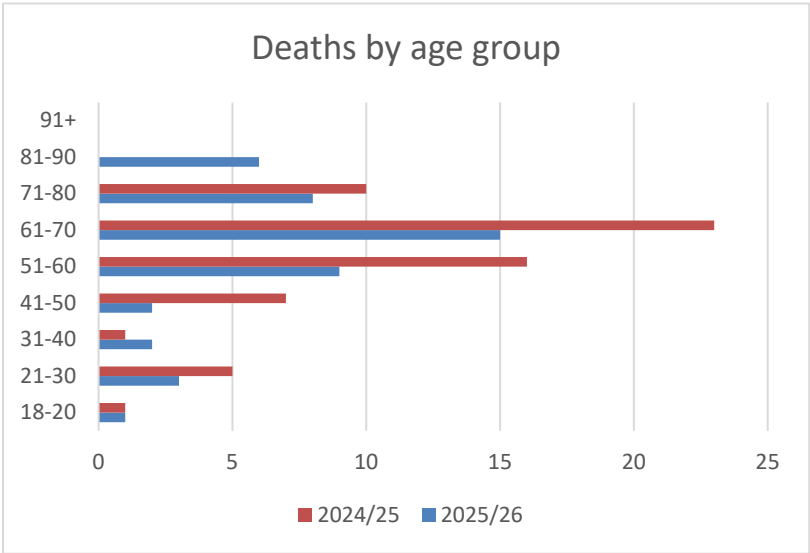


Figure 6. LLR LeDeR Deaths by age group 2024/25, 2025/26

Age of death in completed reviews by group

Due to the statistically small number of data, 3 year rolling averages have been used from 2023-2024 onwards for the age at death (this 3 year rolling average includes data from 2021/2022 to 2025/2026), this endeavours to give a more accurate picture and it allows for any annual variations and extreme anomalies, shown in figure 7.

ONS data is shown in figure 8 for comparison for age at death for England and Wales in 2023

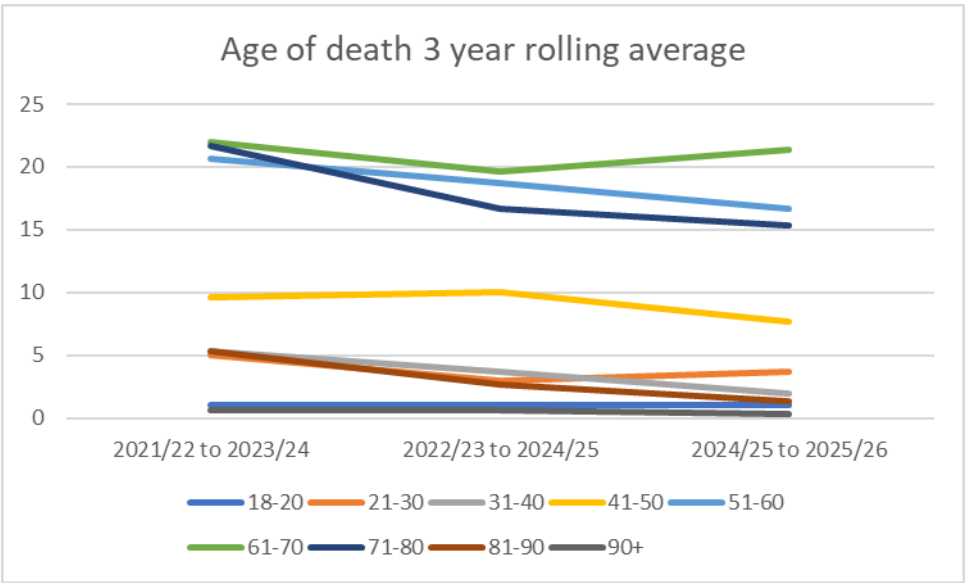


Figure 7. Deaths by age group 3 year rolling average

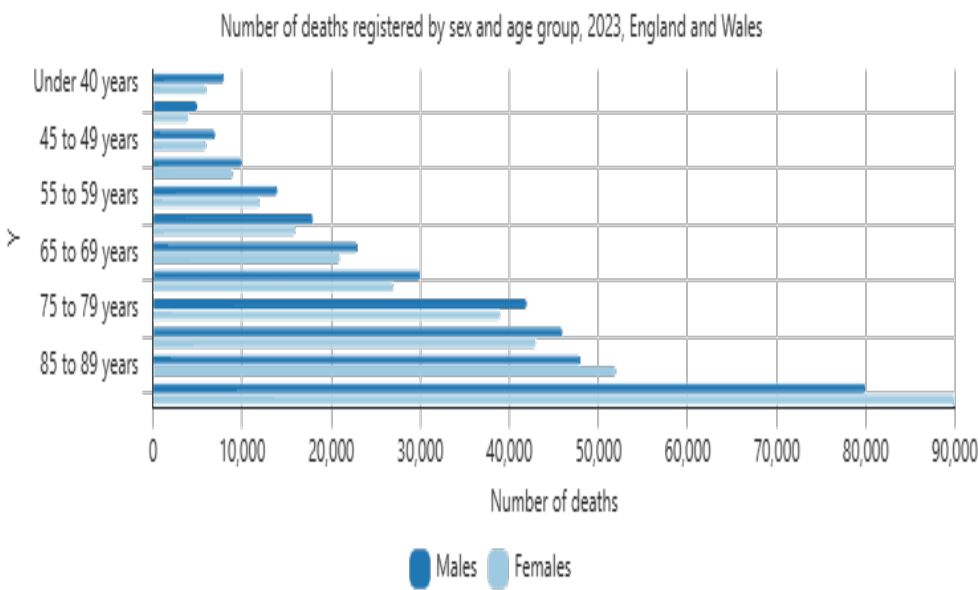


Figure 8. Death registration summary by ONS

Median age at death in completed reviews.

The median age of deaths in completed reviews in 2025/26 is 63yrs, this is only a year higher than 2024/25 which was 62yrs. Due to the statistically small number of data, LLR LeDeR has included 3 year rolling averages. These have been used from 2023-2024 onwards for the median age at death (this 3 year rolling average includes data from 2021/2022 to 2025/2026), which endeavours to give a more accurate picture and it allows for any annual variations and extreme anomalies.

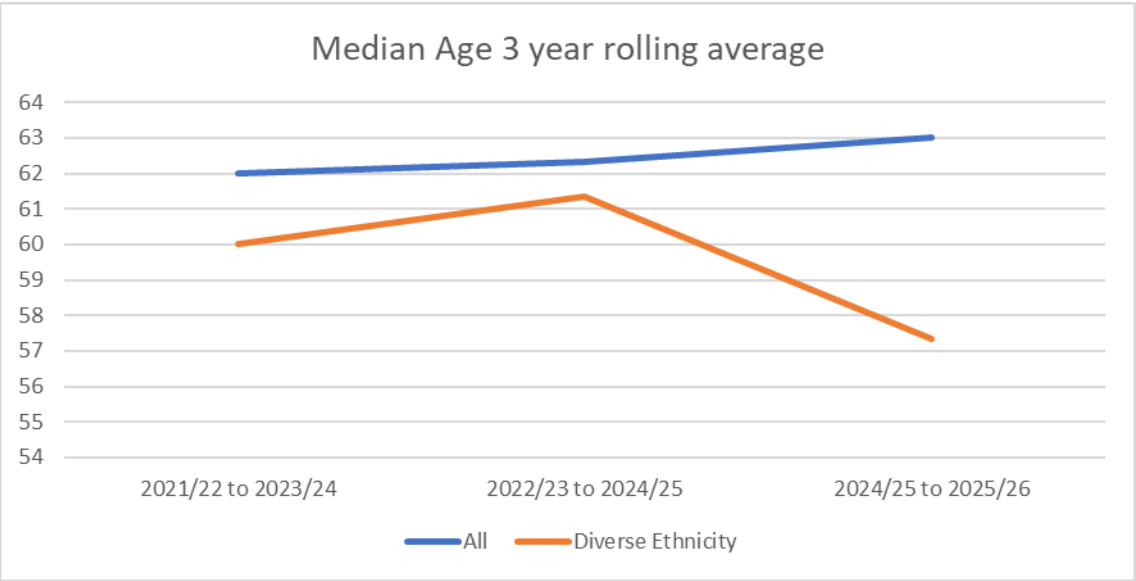


Figure 9. Median age 3 year rolling average.

“She was known to enjoy conversation and was affectionately described as a “lovely gossip” by those close to her.”

Ethnicity

Most of deaths were of 'White British' people (87%), with 9% of people 'Asian or Asian British' and 2% of people 'Black, African, Caribbean or Black British' ethnicity. The remaining 2% of people is 'Other ethnic groups' shown in

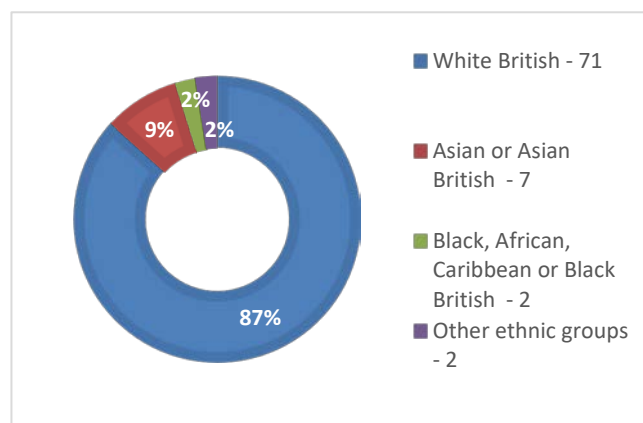


Figure 10. Cases completed 2025/26 by ethnic group.

Breaking this down further and omitting the 'White' ethnic group allows us to see a clearer picture within different ethnicities, as shown in

The median age of death was 50yrs for those from a diverse ethnic background and 63yrs for those from a White British background.

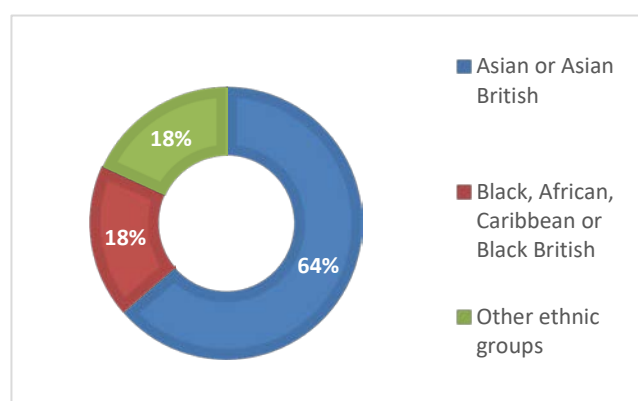


Figure 11. Cases completed 2025/26 by ethnicity.

As shown in *Figure 12. Deaths by gender*, 59% of reviews completed in 2025/26 were male and 41% female, which is in line with national and local gender demographics. Those people were resident across all three ICS places, and deaths were lower in East Leicestershire and Rutland and Leicester City but higher in West Leicestershire as illustrated in *Figure 13. Deaths by ICS place*.

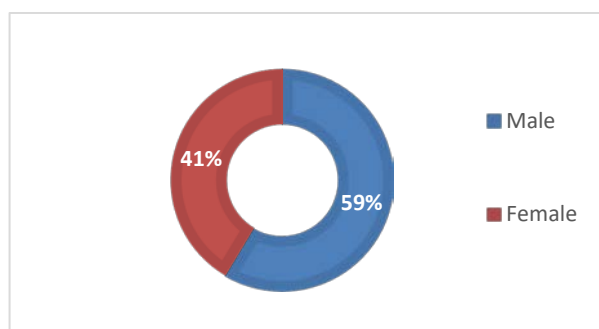


Figure 12. Deaths by gender

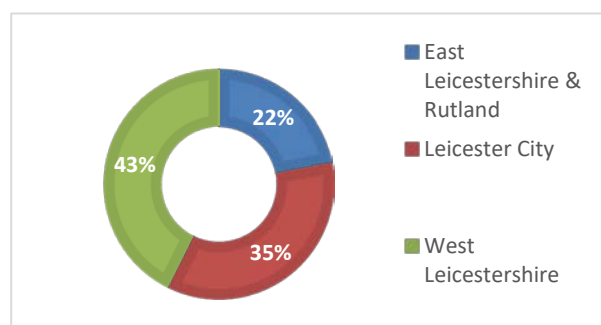


Figure 13. Deaths by ICS place

Reason for focused review

Focused reviews are completed for various reasons, as shown in *Figure 14 Focus by category*. It is a priority set by the National LeDeR programme to conduct focused reviews for the following reasons:

- Autistic people.
- People who are from a diverse ethnic background.
- Being open to the criminal justice system as an offender in the previous 5yrs.
- Being under section of the Mental Health Act (1983) in the previous 5yrs.
- Family request.
- Local priority focused review area.
- Due to safeguarding or concerns in care.

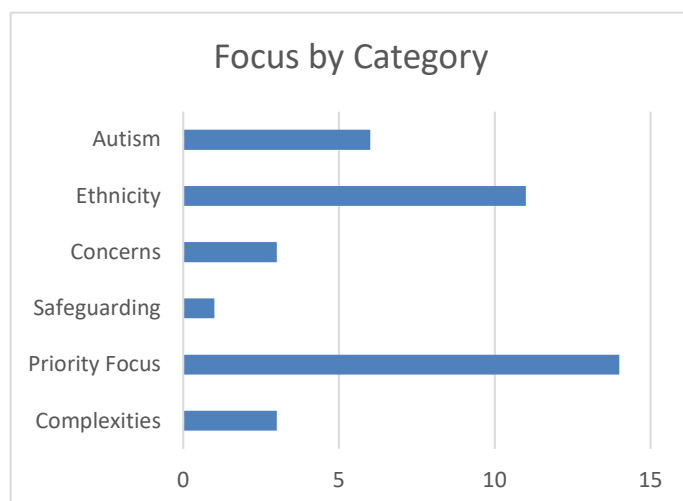


Figure 24. Focus by category

Most focused reviews were carried out due to Priority Focus area. There were no focused reviews carried out due to being open to the criminal justice system as an offender, nor due to being under the section.

Important Statements from LeDeR

Although a great deal of positive, innovative and compassionate work has been evident across LLR during the past year, there remain two areas requiring urgent and sustained system-wide attention. These issues continue to be identified consistently through LeDeR reviews and have the potential to significantly impact health outcomes, individual rights and access to equitable healthcare.

1. Mental Capacity Act (2005): From Awareness to Compliance

Despite increased awareness and examples of good practice, the application of the Mental Capacity Act (2005) remains one of the most significant and recurring concerns identified through LeDeR reviews. Inconsistent completion of capacity assessments, best-interest decision-making, documentation and understanding of legal responsibilities continue to be found across preventative healthcare, investigations, treatment decisions and end-of-life care. LLR LeDeR urges all partner organisations to move beyond awareness and demonstrate consistent legal compliance, audit assurance and workforce competence in MCA practice to ensure the rights of people with a learning disability and autistic people are upheld.

2. Earlier Identification of Cancer and Deterioration

There is increasing concern regarding the number of people with a learning disability and autistic people who are being diagnosed with cancer at a late stage, often Stage 4 disease. LeDeR reviews identified delays in recognition, referral, investigation and access to diagnostic procedures, with additional barriers relating to communication, diagnostic overshadowing and insufficient reasonable adjustments. Alongside cancer, deterioration was frequently not recognised early enough. LLR LeDeR urges the system to strengthen early identification, improve access to investigations through reasonable adjustments, enhance annual health checks and screening uptake, and ensure people receive equitable opportunities for diagnosis, treatment and care.

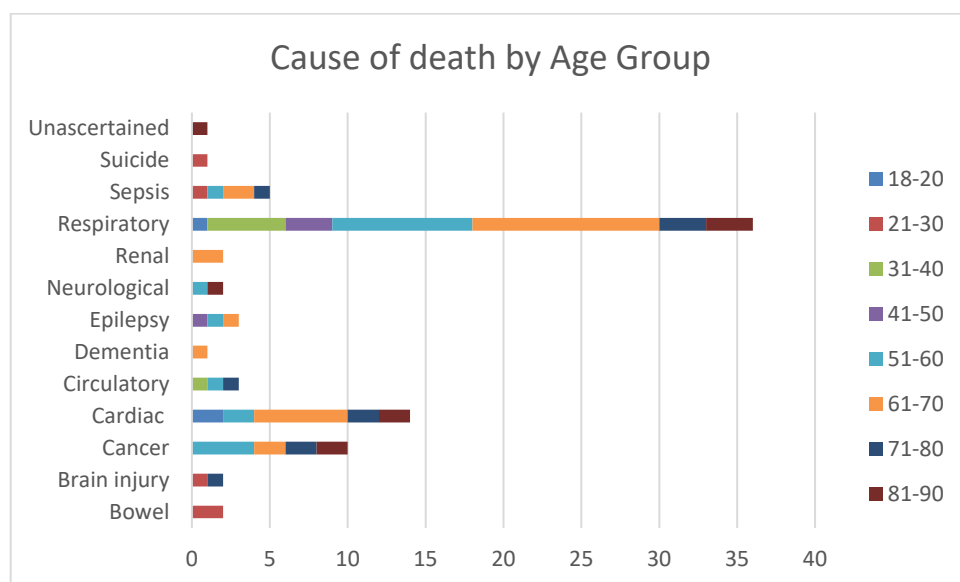
Causes and Circumstances of Death

In this section, the circumstances and most common causes of death are summarised.

Cause of death by demographic group

Age Group

It is shown in



that the most frequent cause of death (CoD) was respiratory illness and that this affected most age groups, notably prominent in people aged between 51yrs and 70yrs.

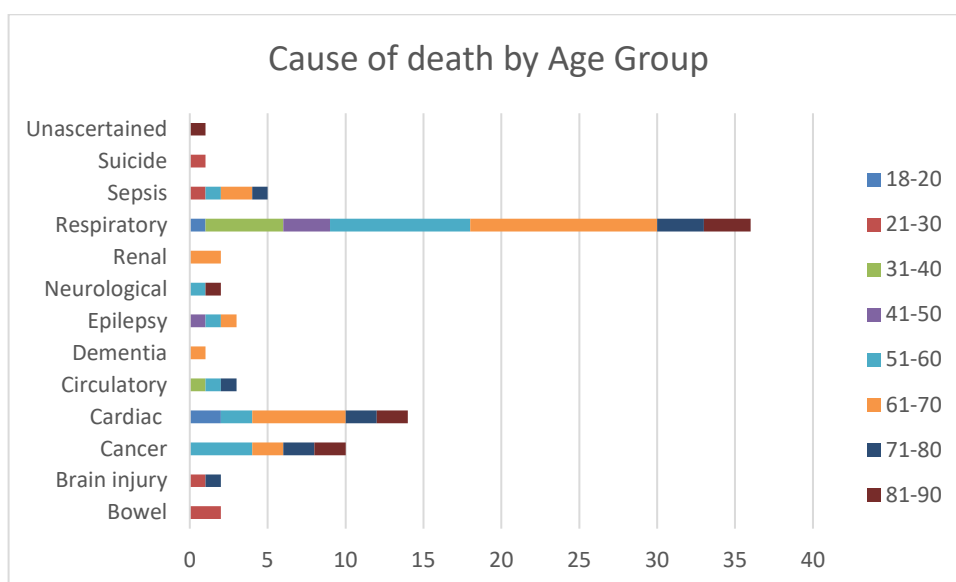


Figure 35. Cause of death by age

Breaking down of cause of death by Ethnicity is shown in

. It should be further noted that only 13% (n=11) of notifications received were those from a diverse ethnic background, implicating generalisation.

therefore statistical

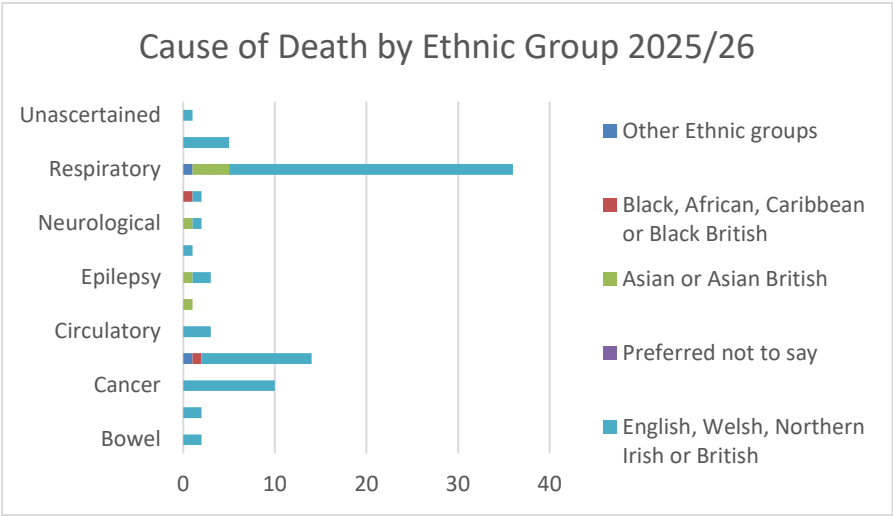


Figure 46. Cause of death by ethnicity

Leading Causes of Death

Causes of death in reviews completed in 2025/26 are shown in *Figure 17. Causes of death* below. Respiratory remains the leading cause of death, followed by Cardiac and Cancer. Respiratory accounts for 44% of deaths in completed reviews in 2025/26.

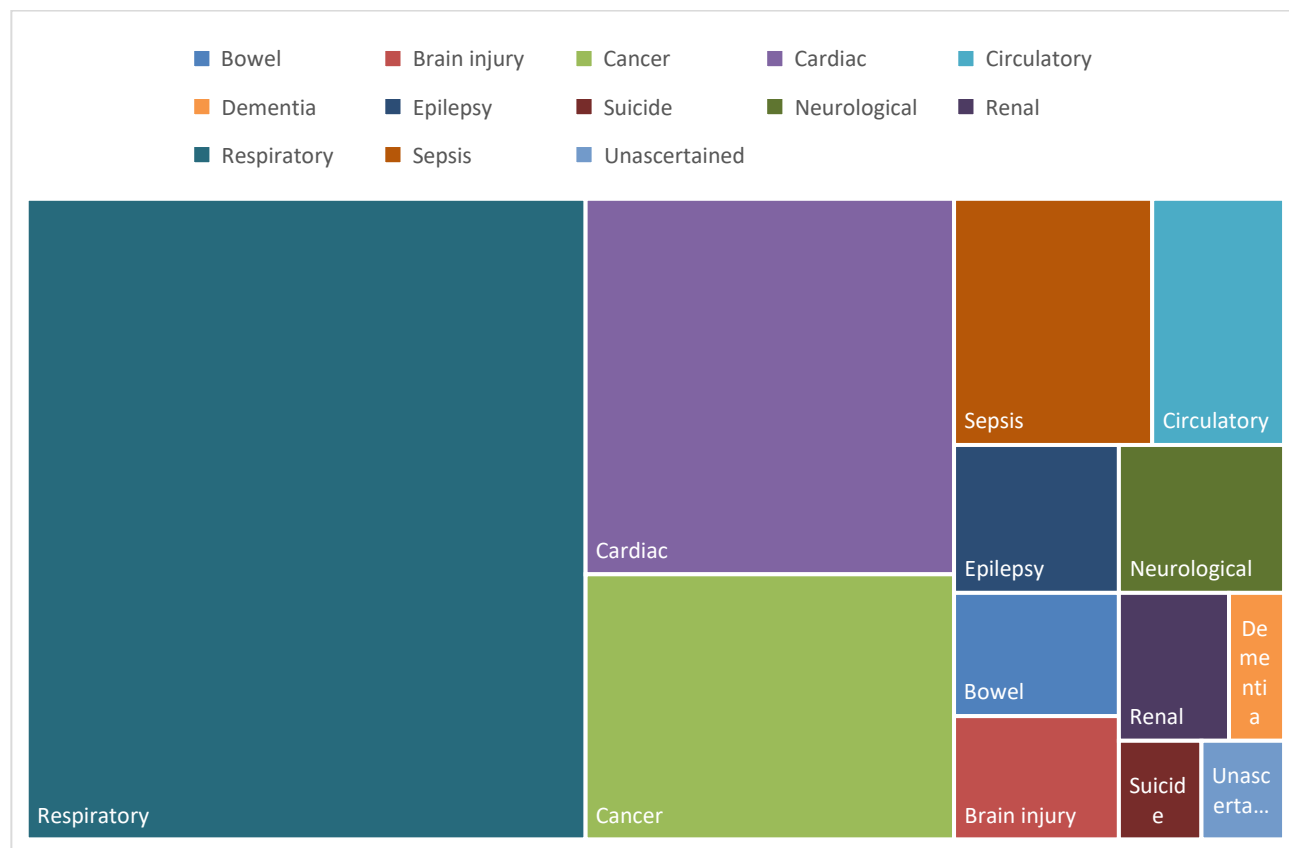


Figure 17. Causes of death

Respiratory Deaths

Deaths from respiratory causes continues to remain the leading cause of death for those in LLR reported to LeDeR. The respiratory thematic analysis can be found in the LeDeR 2022 annual report. The aspiration pneumonia thematic analysis can be found in the LeDeR 2023 report. Respiratory deaths remain an area of focus for LLR LeDeR particularly with regards to deaths where there were avoidable factors highlighted. This year a breakdown of the respiratory deaths has been included.	- Aspiration pneumonia - Recurrent aspiration pneumonia - Bronchopneumonia - Cardiorespiratory arrest - Cardiorespiratory failure - Chest infection - Pneumonia
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Regional Thematic Analysis: Aspiration Pneumonia

Aspiration pneumonia	5
Recurrent aspiration pneumonia	1
Bronchopneumonia	7
Cardiorespiratory arrest	1
Cardiorespiratory failure	1
Chest infection	3
Recurrent chest infection	1
Infective exacerbation of asthma	1
Lower respiratory tract infection	4
Pneumonia	10
Respiratory failure	2

During 2025/26, the LLR LeDeR Programme collaborated with three other Midlands LeDeR programmes to undertake a regional review of aspiration pneumonia deaths in people with a learning disability. The review analysed 47 deaths between April 2023 and January 2025 where aspiration pneumonia was recorded as the immediate cause of death. The purpose was to better understand common risk factors and identify opportunities for prevention and earlier intervention.

The analysis demonstrated that aspiration pneumonia is rarely an isolated condition and is more commonly the culmination of a series of complex health and care factors. The most frequently identified contributory factors were uncontrolled epilepsy (27.5%), congenital conditions (27.5%), constipation (20%), reduced mobility, frailty and dependency on others for activities of daily living. Almost all individuals required support with daily living activities, indicating that dependency and complexity of need may increase vulnerability to aspiration-related mortality.

Most people who died had a moderate or severe learning disability, although aspiration pneumonia deaths occurred across all levels of learning disability. This highlights the importance of considering aspiration risks contributing to aspiration pneumonia for all people with a learning disability rather than focusing solely on those with profound disabilities. The review also found that whilst many individuals had received an annual health check and had end-of-life documentation in place, opportunities remained to identify aspiration pneumonia risk factors earlier and strengthen preventative care planning.

A key finding was that aspiration pneumonia frequently occurred following a period of deteriorating health, rather than as a sudden isolated event. Constipation and epilepsy emerged as potentially modifiable risk factors. Constipation was associated with increased risks of reflux, vomiting and aspiration, which if aspirated can lead to an aspirational pneumonia, whilst poorly controlled epilepsy increased aspiration pneumonia risk through seizures, reduced consciousness and impaired airway protection.

The review concluded that aspiration pneumonia should be viewed as the consequence of earlier health events and multiple vulnerabilities rather than solely a respiratory diagnosis. The findings support the need for proactive management of epilepsy and constipation, early identification of deterioration, improved annual health check processes, robust advanced care planning and integrated multi-agency approaches to aspiration pneumonia prevention and management. These findings support the ongoing development and implementation of the Leicestershire Aspiration Pneumonia Protection Plan (LAPPP) across LLR.

The 'Leicestershire Aspiration Pneumonia Protection Plan (LAPPP)' based on the findings from LeDeR was tested during the pilot year. This work has been written up as a journal article to enable ongoing learning and research in this area and is at peer review stage for publication. This work was presented for oral presentation at the RCN International Nursing Research Conference in Exeter in September 2025. The LAPPP is being considered for a wider grant funding opportunity in order to progress this invaluable work.

Cardiac

Deaths from cardiac causes have decreased since last year but remain the 2nd highest cause of death. This year a breakdown of the cardiovascular deaths has been included:

Acute cardiac dysrhythmia	1
Acute Myocardial Infarction	1
Cardiac failure	1
cardiorespiratory arrest	1
cardiorespiratory failure	1
Congestive Cardiac Failure	1
Exacerbation of Cardiac Failure	1
Heart failure	1
Hypoxic Brain Damage Secondary to Cardiac Arrest due to Multiple Organ Failure	1
Ischaemic Heart Disease	1
Myocardial infarction	1
Obesity related and diabetic heart disease	1

LLR LeDeR are undertaking a thematic analysis of the effects of underweight BMI recordings in people with a learning disability in Summer 2026 using retrospective analysis. The analysis will support the identification of contributing factors and commonalities that may be contributing to low weight and the consequences of underweight.

The healthy living toolkits were produced last year, but this remains an important reminder of this freely accessible online resource:

<https://leicesterleicestershireandrutlandhwp.uk/about/collaboratives/lda-collaborative/new-healthy-living-toolkits/>

Quality of Care

High quality health and social care is of paramount importance for people with a LD and autistic people. However, evidence has demonstrated that this is sometimes not achieved and sadly, the impact of this can contribute to early or avoidable mortality. Focused LeDeR reviews are graded in two areas, in line with the LeDeR Policy (2021), the overall quality of care the person received and the right support. The score is an overall judgement on the care the person received, it is not reflective of one service but of all the services who worked with the person as an entirety.

The breakdown of the grading can be found in

Appendix .

Context for grading of care 2025/26 shown in figure 18.

Scoring of 1 for Quality of Care

This relates to concerns raised may have contributed to death.

Scoring of 2 for Quality of Care:

This relates to concerns of a deteriorating patient, lack of good practice and missed opportunities.

Scoring of 3 for Quality of Care:

This relates to concerns of reasonable adjustments, MCA and concerns around communication.

Scoring of 4 for Quality of Care: This relates to concerns the about deteriorating patient and MCA.

Scoring of 5 for Quality of Care: This relates to positive end of life care planning, appropriate use of MCA, deteriorating patient, communication, and care co-ordination.

Scoring of 6 for Quality of Care: This relates to escalation of care, MDT working and nursing care for people with a learning disability.

There were no gradings of 1 in 2025/26.

If the grading is 2 or lower for quality of care and the right support a referral to safeguarding will be considered.

Grading of the Right Support.

Overall, over 50% of care was found to be satisfactory or good, a further 34% were above average, which is an improvement on last year; however, this still presents LLR with opportunity for improvement.

Some examples of the positive learning found related to **the right support**:

- Reasonable adjustments, family involvement, care coordination, person centred care, MDT working, compassion, proactive care, consistent preventative healthcare including LD Annual Health Checks, vaccinations, screening and early diagnosis and intervention, joint funded care, supported to remain living at home.
- Use of interpreter services, collaborative working, easy read documentation, medication and psychiatry review, timely investigation, metabolic monitoring reminders on electronic

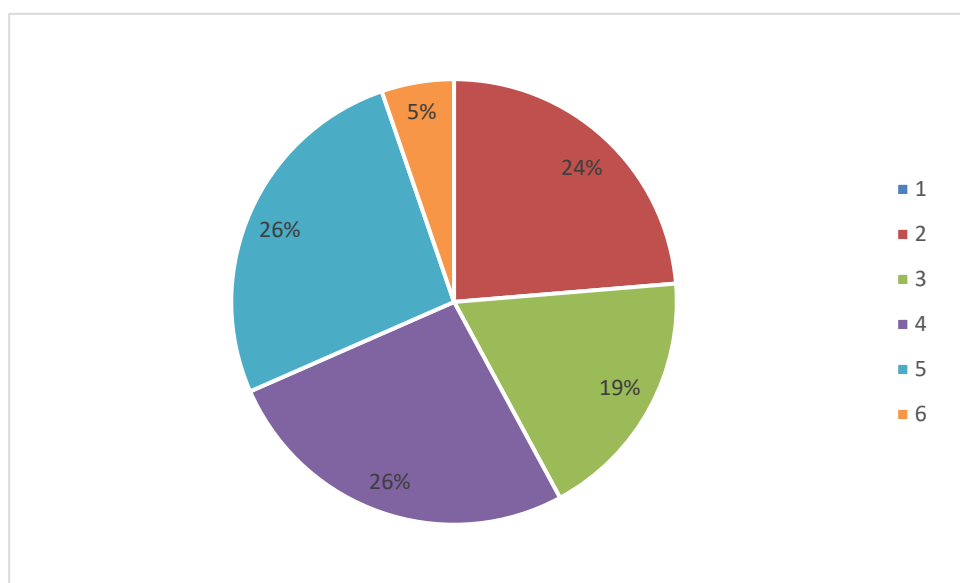


Figure 18. Grading of care

patient record, ALN support, preventing hospital readmission, responding to care needs, person centred care.

As only focused reviews are graded and by nature many cases that require the initial review have fewer areas of concern, a level of caution in the interpretation is required. Although this information has been approved and supported through the LeDeR governance panels.

Ten Key Themes

All learning from LeDeR nationally requires theming.

In LLR, *Table 1. 10 Key Themes - learning points* shows the number of actions (learning points) related to the 10 key themes.

Theme	No. of learning points 24-25	No. of learning points 25-26
Professional practice and provision of care	200	304
DNACPR recommendations and end of life care	65	57
Care Pathways	38	56
Deterioration	26	46
Learning Disability Awareness	47	45
Family and carer awareness of available support	19	28
Training on specific conditions	9	20
Transition	3	12
Safeguarding	22	9
Involving the Coroner	2	1
Grand Total	431	578

Table 1. 10 Key Themes - learning points

The area of highest concentration 2025/26 remains the same as the last 2 years and is with regards to professional practice and provision of care. This is broken down again in *Table 2. Sub-themes - learning points. (Please note only top 10 sub themes included.)*

Sub theme	No. of learning points
Reasonable adjustments	60
Person Centred Care	52
Deteriorating Patient	47
Communication	41
Cancer screening	38
End of Life	33
Care Planning	32

MCA	28
ReSPECT	28
Annual Health Check	18

Table 2. Sub-themes - learning points

Priority areas of learning

This section outlines the priority areas of learning from the LLR LeDeR reviews for the past year. The top 3 priority areas are Reasonable adjustments, End of Life, and MCA, which are all different from the previous year's priorities for learning [*Person Centred Care, Deteriorating Patient and Care Planning*]. Some anonymised information reviews have been included to aid learning and context shown below.

Reasonable Adjustments

Learning [35]

"She had a consultation with a nurse at the practice due to post-menopausal bleeding. She declined a blood test, and the nurse recorded that they were unable to obtain a weight due to the lady being in her wheelchair. There was no evidence found of reasonable adjustments being made to enable her to have her weight measured."

"There was no alert on the electronic patient health records informing health care professionals of his autism diagnosis so they would not have been aware that he may have required reasonable adjustments to engage with health care services." [Autism]

"He was assessed and diagnosed with autism in November 2012, aged 13. There was no alert or flag on his GP record, and the diagnosis was not listed as an active problem. Health professionals accessing his record would not have been aware of his autism diagnosis. As a result, communication needs, sensory needs, anxiety, and barriers to attending appointments may have been overlooked." [Autism]

"There were transport challenges for the ambulance service and care provider when considering hospital admission and safe transportation. His moulded wheelchair could not be accommodated in the ambulance, and care staff were unavailable to assist with transfer in his Motability vehicle due to staffing shortages. Although a hospital admission was ultimately avoided, this may have delayed medical assessment. Planning ahead for specialist transport arrangements is important."

"A male under 20 years, despite a rheumatology consultant highlighting he had an immunocompromised state and was eligible for a one off dose of the pneumococcal vaccine as well as the flu and covid vaccinations, this does not appear to have been actioned by the GP. Discussions happened at his AHC, but no plans were made for him to receive the vaccinations, or follow ups made with regards to him being clinically vulnerable and unvaccinated."

Positive Practice [25]

"As his dementia progressed, he would get more agitated, making it difficult for him to get to and from his dialysis sessions (3 times a week). The ambulance transport escorts were said to have gone above and beyond to make his journeys comfortable and enjoyable e.g. play music, sing his favourite songs with and to him, being patient with him and providing a lot of reassurances. This allowed for his dialysis sessions to continue."

“During his annual health check, the practitioner noted that he required a double time slot for having any vaccinations as well as consideration to be made to offer the Flu vaccination as the spray due to his needle phobia. This was recorded in his electronic records, reasonable adjustment digital flag, so others could see.”

“During the hospital admission prior to her death the LD acute liaison nurse was informed of her admission. They visited her on the ward and were able to give advice around MCA and best interest as well as helping her to understand procedures required, reducing anxiety. This demonstrates good practice in making reasonable adjustments for people with LD receiving care and treatment in hospital in line with the Equality Act (2010).”

“Due to her level of understanding and communication needs, it was recognised that she was unlikely to engage effectively in one-to-one psychology therapy sessions. Instead, psychological input was provided indirectly through the MDT, with a focus on consultation and staff training. This good practice demonstrates how psychological interventions and MDT working were adapted and focused on indirect work, including consultation and training for staff in line with the British Psychological Society Best Practice Guidelines (2015).”

End of Life

Learning [15]

“She was coming to the end of her life and had anticipatory medications prescribed. Governance panel members felt that the medication should have been started a week earlier as she was communicating pain. It is important the district nurses visiting patients with a learning disability at end of life understand how to look for signs and symptoms of pain.”

“His family expressed concerns about his discomfort on the day that he died due to a delay in the district nurse arriving to administer pain relief and staff not being experienced in providing end of life care.”

“He had been accessing short breaks services on a regular basis for the past 20 years, he was also in regular receipt of Community LD Services over a similar time period. He did not have an advanced care plan or DISDAT in place. He had lived at home with parents all of his life.”

“He was prescribed anticipatory EoL medications, but it does not appear that a plan was made for seizure management in EoL. This resulted in him not receiving medication for a seizure in a timely manner and resulted in an ambulance being called and paramedics also not being able to administer any medication. Although he was prescribed rescue medication it was not clear if this could be administered once he was commenced on EoL.”

“His advanced care plan stated that his preferred place of care was his home, but he could not return home after his second admission because his care team felt that this would upset his housemates. However, this contradicts information provided by his sister who stated that the care provider was willing to have him discharged home. These decisions were based on an assumed negative impact on his housemates and not in line with the advanced care plan wishes. He was on

end of life for some time in hospital and there would have been many opportunities for him to be discharged home.”

Positive Practice [18]

“The pharmacist and palliative care nurse completed regular medication reviews towards the end of his life. They also liaised with the palliative care consultant for additional guidance when required. The outcome of this was effective control of his symptoms which included nausea and vomiting and ensured that his symptoms were managed as comfortably as possible during this stage of care in line with NICE guideline NG31 Care of dying adults in the last days of life.” [Autism]

“Diagnosed with rectal cancer in 2023, he was supported and cared for by a consistent staff team who knew him well and had provided person-centred care for many years. His end-of-life care was delivered in the comfort of his own home by his familiar staff team, with support from the community palliative care service, GP, and district nursing team. This ensured he was surrounded by people he knew and trusted. This quality of care reflects NICE guideline NG96 Care and support of people growing older with learning disabilities (2018).”

“As part of her advanced care plan, her family had wished for her to remain at the home she had resided at for 32 years of her life when the time came to die. These wishes were adhered to.”

Mental Capacity Act (2005)

Learning [18]

“Her health had been deteriorating and she was seen on separate occasions by a colorectal consultant and a consultant for her gallstones. Neither professional documented the use of the mental capacity act/best interest within the records they made even though they both deemed her to lack capacity to consent to any treatment options.”

“He received the yearly flu vaccination from 2015 until 2021. Despite being offered the flu vaccination and several reminder text messages being sent to his main carers he was not taken to have any more flu vaccinations. Covid vaccinations were also offered but declined on his behalf by family. There was no rationale for the reason why the flu and Covid vaccinations were being declined and no documentation around MCA or best interest for these decisions.”

“She had covert administration of medication implemented due to concerns regarding missed doses of sodium valproate and increased seizure activity. While there was clear clinical rationale for this approach, documentation did not consistently evidence that covert administration was authorised and reviewed within the framework of the MCA. In particular, there was limited evidence of a documented capacity assessment, best-interests decision-making process, formal treatment plan, and regular review over time, as required by NICE guidance and the Leicestershire Partnership NHS Trust Covert Administration of Medicines Policy.”

Positive Practice [10]

“Capacity assessments were completed, documented, and used to inform decisions about care, residency, finances, and treatment. Risk related behaviours in 2021 and 2022 were escalated, and safeguarding processes were initiated appropriately. DoLS was correctly applied during the 2022 mental health admission and throughout a prolonged 2022-2023 hospital stay. An IMCA was

involved when he was assessed to lack capacity for residence/finances. MDT best interest decision making supported proportionate, lawful planning and resulted in a least restrictive specialist placement that was approved by the courts.”

“During her prolonged hospital admission, multiple teams were involved in her care, working collaboratively to promote her best interests. The MCA and DoLS were applied to support decision-making, protect her and work towards the best possible outcomes.”

STOMP/STAMP

(Stopping Over Medication in People with a LD and Autistic People/Supporting Treatment and Appropriate Medication in Paediatrics)

LLR LeDeR has again seen a reduction in the prescribing of psychotropic medication without a STOMP/STAMP review. This is extremely positive and encouraging. There were 30 people prescribed psychotropic medicine at the time of death, 87% had a STOMP/STAMP review, 13% did not. This is a further improvement on the previous year 82% of people had a STOMP/STAMP review and 10% did not, and no data was available for 8%. Due to more accurate data being available *figure 19* shows an increase in the numbers having a STOMP/STAMP review. This improvement reflects the hard work of our GP and Psychiatry colleagues and the STOMP/STAMP workstream.

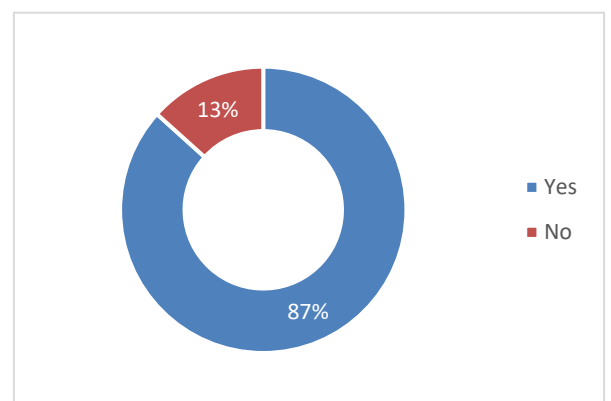


Figure 19. STOMP/STAMP review carried out for people on psychotropic medication at time of death.

Learning

- A young female with a diagnosis of multiple and profound LD, during a hospital admission, she was seen by the respiratory consultant who advised that care must be taken with regards to changes to the prescribed Benzodiazepine due to their sedative effect, small increases in doses over a number of days was recommended. However, this advice was not continually followed contributing to avoidable negative outcomes.

Positive Practice

- A male, in his late 70's, at his last mental health review, the LD consultant psychiatrist reduced his prescribed antipsychotic medication as the gentleman's mental health was settled. This is in line with STOMP and the NHS Long Term Plan. He also received health checks including heart and blood monitoring as part of a thorough review.
- A male with a severe learning disability and autism, he experienced behaviours that challenge when unwell, frustrated or upset and was prescribed antipsychotic medication. Following a review of medication by LD psychiatry it was felt medication could be reduced

in dosage, as behaviours had reduced in intensity and frequency, and the reduction was successfully achieved.

- A female with severe LD and Down syndrome. A STOMP review completed by the LD psychiatrist was successful in weaning off the prescribed antipsychotic, Haloperidol. This demonstrates good practice in the unnecessary prescribing of psychotropic medication and demonstrated that she had regular, person-centred, holistic and structured medication reviews from professionals who understand people with a LD and autistic people.
- A male with LD and autism and complex physical health conditions, following review of his mental health and medication the LD consultant psychiatrist stopped prescribing antipsychotic medication as it was no longer required.

Health Inequalities Group STOMP/STAMP Annual Report 2025/26

The LLR STOMP/STAMP Working Group project aims for 25/26 were:

- Increasing STOMP/STAMP reviews in secondary care (linked to STOMP/STAMP framework)
- Training and Education in relation to STOMP/STAMP
- Rationalisation of medication prescribing- polypharmacy for people with a learning disability and autism, focusing on those taking 5 different psychotropic medications
- Reducing melatonin prescribing levels for young people across LLR, linked to the introduction of Sleep Clinics as alternatives to medication

The project is a continuation and development of the work that has been taking place, over several years, to implement best practice in relation to STOMP/STAMP to support individuals in LLR, so they take less psychotropic medications, or none at all.

Impact and outcomes:

There has been a further increase in the number of people with a learning disability and autistic people receiving an annual review of their psychotropic medication. During 2024/25, a total of 3097 reviews were completed, and the year-to-date data indicates that 2241 people have had a review during 2025/26. The outcome data indicates that during 2024/25, 103 people had psychotropic medication stopped because it was ineffective/inappropriate, compared to 49 during 2025/26 to date. During 2025/26 a total of 42 people have had a dosage reduced for their psychotropic medications, positively impacting the quality of life for these individuals.

The quarterly prescribing data received confirms that progress is maintained in relation to prescribing rates for people with a learning disability, prescribing below national rates and against the trend of increasing antidepressant prescribing and have particularly low benzodiazepine prescribing in children.

Work has taken place nationally, through the Action Learning Set events, to share LLR's work in relation to STOMP/STAMP and were highly commended at the PrescQIPP Awards during 2025/26 for the work in implementing the regional STOMP/STAMP Framework and increasing the number of medication reviews taking place.

Through the MedSIP programme mapping the existing LD pathways went ahead and have held a system wide action planning session to inform the groups plans for 2026/27. A summary report has been produced which recognises the work of the STOMP/STAMP group in driving forward this important area of work.

A Sleep Hygiene working group has been established and a sleep pathway for CAMHS/Community Paediatrics has been developed. CPD sessions with Sleep Practitioners have been established.

Our Lived Experience Partner worked with the Autism Space Team as mentioned last year and this sets as a reminder for this useful resource: [STOMP and STAMP - making sure medication is safe for autistic people | Autism Space | Leicestershire Partnership NHS Trust](#). This includes a video and a guidance document with visuals.

A scenario of a STOMP outcome is shown in Appendix 3.

Behaviours that challenge.

This year LLR LeDeR has seen a decrease in the number of people notified with behaviours that challenge. In 2025/26 78% had a PBS plan where behaviours that challenge were present and 22% did not. Last year 90% of people had a PBS plan and 10% did not. The previous year 81% of people had a PBS plan and 19% did not. This is still a significant increase from 2022/23 where only 37% had a PBS plan for behaviours that challenge and 63% did not.

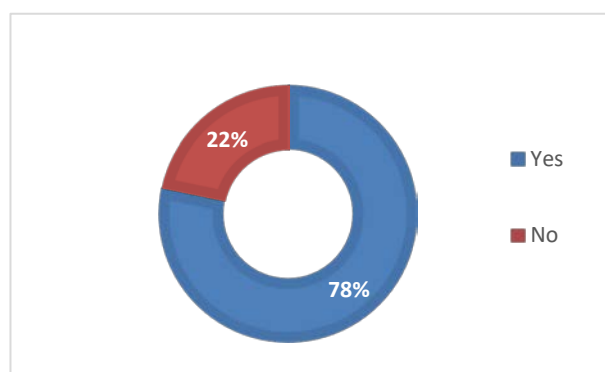


Figure 20. People with behaviours that challenge who had a PBS plan in place.

This remains extremely positive and demonstrates the enormous amount of work from the PBS practitioners and LD services. It should also be noted that not all behaviours that challenge present risks and support needs that require PBS input

The LLR LeDeR Programme recommends continued commitment to PBS work and increasing the knowledge across LLR of behaviours that challenge, and the importance of meeting people's communication needs on improving care experiences and reducing admission to hospital. It is also important to consider how people with behaviours that challenge will be supported into older age and the potential of nursing care needs and how these will be addressed, including place of residence.

Learning

“A gentleman of Caribbean descent with a severe LD and complex health needs. As his health deteriorated, his anxieties and frustrations increased, resulting in him displaying behaviours that challenged. He had involvement from his family and many services who knew and supported him

well, but there was no positive behavioural support (PBS) plan in place to ensure there was consistency in place.”

Positive Practice

“A gentleman diagnosed with autism and dementia. PBS strategies led to improved emotional stability and reduced behavioural challenges. Removing 1:1 supervision, guided by PBS principles, helped him feel more at ease and improved his engagement with staff. This positive practice highlights how specialist placements significantly improve outcomes for individuals with complex needs.”

Repeated hospital admission at End of Life

Last year the number of people who experienced repeated hospital admissions at the end of their life was 31%. This has decreased to 26% this year. Through the LDA Collaborative and LDA Health Inequalities group, LLR have been determinedly working to improve end of life care and respond to identified concerns about the care provided to people with a LD and autistic people when their health is deteriorating. The impact in this area is difficult to measure. It is recognised that there may often be some requirement for hospital admission, however repeated admissions should be avoided.

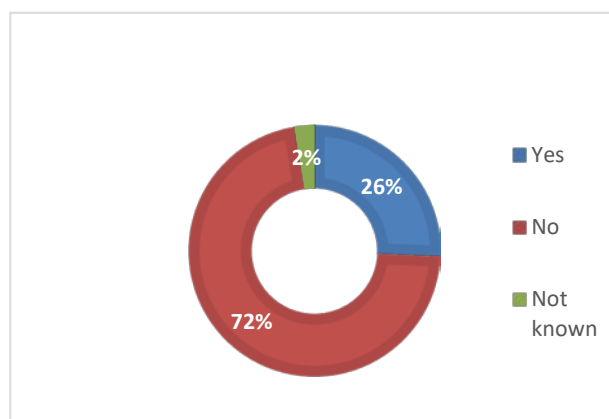


Figure 21. People on EoL pathway who had repeat hospital admissions.

Specialised nursing care provision for people with a LD remains an ongoing gap in service provision. Some people are having either their behavioural and LD needs met, or their nursing care needs met. This is consistent with the findings from the previous year.

Safeguarding in LeDeR Reviews

LeDeR is supported through safeguarding supervision from the Designated Safeguarding Adults Lead for LLR. This external supervision helps maintain the independence and integrity of the LeDeR programme, ensuring objective oversight and challenge where required. Reviews that are graded 1 or 2 are discussed at safeguarding supervision, and it is then agreed if further escalation, if not already considered, is processed. In line with this process 2 letters to the safeguarding team have been sent regarding 2 x LeDeR reviews graded between 1 and 2 for quality of care and right support. It has since been agreed that letters are no longer required and the safeguarding supervision is sufficient.

The threshold for safeguarding are used and considered within LeDeR reviews and at LeDeR governance panel.

Across the LeDeR reviews where safeguarding was identified in the learning into action, the findings are listed below. Safeguarding practice shows both effective multi-agency responses alongside some opportunities for improvement at a system level. Four safeguarding themes emerged:

1. Neglect and Poor Care Environments:

- Early signs of neglect in care settings
- Patient placed in unsuitable environment (wheelchair facing away from TV, overstimulating setting)
- Inadequate engagement and person-centred care
- lack of dignity
- poor environmental adaptation
- unmet sensory and communication needs

Positive aspect:

- OT recognised “early indicators of concern” and escalated appropriately.

Learning identified the importance of:

- early identification
- professional curiosity
- acting on “low-level concerns” before harm occurs.

2. Social Isolation and Insufficient Support for Independent Living:

- Individuals living alone with insufficient care packages and monitoring
- 70-year-old man with epilepsy:
 - only 1 hour support/week
 - died alone after 2 weeks of non-attendance
- Lack of escalation after missed contact
- Underestimation of risk in:
 - epilepsy
 - LD/autism
 - social isolation
- No robust escalation pathway for:
 - missed visits
 - disengagement
- “Invisible vulnerability”
- increased risk of:
 - unattended death

- o untreated deterioration

Learning identified:

- risk-based care planning especially as people grow older and/or needs are changing
- clear escalation procedures for:
 - o missed visits
 - o loss of contact

3. Failure in Communication and Accessibility

- Barriers to accessing care due to:
 - o language
 - o unclear communication
 - o family reliance
- Referral follow-up unclear and possibly not in preferred language
- Written information (leaflets) may not have been accessible

When communication is not accessible:

- people cannot engage with care
- risks are not understood
- appointments are missed
- This is a failure of reasonable adjustments
- Working in accordance with equality and safeguarding duties is essential

Learning identified that services must ensure:

- accessible information (easy read, translated materials)
- active follow-up, not passive reliance on families

4. Missed Opportunities for Escalation and Safeguarding Intervention.

- Concerns identified but not escalated early enough
- Missed appointments not followed up promptly
- Lack of proactive welfare checks
- Inconsistent response to disengagement
- Reactive rather than proactive safeguarding
- Delayed identification of:
 - o deterioration
 - o crisis situations

Learning identified that safeguarding requires:

- proactive risk management
- structured escalation pathways
- curiosity about “why” someone disengages

Positive Practice

Effective Safeguarding Practice and Multi-Agency Working with strong examples of safeguarding done well are outlined below

1. Coercive control case:

- Risks identified early
- Safeguarding enquiry initiated
- Multi-agency collaboration (police, social care, advocate)
- Person supported to remain safely at home

2 . Medication risk:

- GP and pharmacy:
 - o identified overdose risk
 - o implemented safe prescribing controls
 - o maintained access to essential meds

3. Police safeguarding referral:

- Mental health risk identified
- Shared with GP → led to intervention

4. Financial abuse:

- Concerns escalated
- Police involvement
- Legal safeguards (deputyship)

These cases demonstrate high-quality safeguarding aligned with Care Act principles:

- Protection → preventing harm
- Partnership → agencies working together
- Accountability → clear action taken

Learning identified effective safeguarding requires:

- professional curiosity
- information sharing
- coordinated multi-agency action

Preventative Healthcare

Venepuncture

Venepuncture is one of the easiest and the most widely used medical tests to diagnose and manage people's health. However, this can be extremely challenging if a person is not compliant with the blood taking procedure. This is reflective of both the local and national findings. Learning from the LLR LeDeR programme is listed below.

Learning

"A British Asian male diagnosed with severe learning disability and autism. He also experienced behavioural problems that challenge and obsessive-compulsive disorder. He had been displaying weight loss and found it very distressing to have any medical intervention including having bloods taken or receiving a vaccination. This identified that there should be further discussion/pathways on applying restrictive practice in relation to taking bloods and other healthcare procedures when a least restrictive approach has been unsuccessful."

Positive Practice

"A British Indian male diagnosed with moderate to severe learning disability. The GP practice was always responsive when family requested advice or for him to be seen. Reasonable adjustments around health appointments were adhered to. Bloods were taken regularly and at home due to his mobility issues and family feeling he accepted blood tests better in a familiar environment. The appropriate referrals were made on several occasions to the community phlebotomist by the GP. This evidences good practice in the application of reasonable adjustments in line with the Equality Act (2010)."

Health Inequalities Group LD Phlebotomy Team Annual Report 2025/26

Project aim:

- Improve access to venepuncture for people with a learning disability across LLR.
- Create a sustainable and equitable pathway that meets individual needs.
- Reduce failed attempts and improve patient experience.
- Ensure clear legal and clinical processes, including capacity assessments, best-interest decisions and appropriate use of restrictive interventions.
- Strengthen system collaboration between primary care, community services, CHS, UHL and the ICB.

Approach:

A structured pathway was designed across primary care, CHS Phlebotomy, Community LD Teams, PCLNs and acute services. This includes roles, responsibilities, triage criteria, and escalation routes. Introduced a tiered model of support:

- Tier 1: Reasonable adjustments and support within primary care.
- Tier 2: Community LD nursing input (blood test preparation, communication planning, sensory regulation, MCA support).

- Tier 3: Specialist intervention including the Midazolam sedation clinic for individuals where more restrictive intervention is indicated.

Multi-agency collaboration.

Extensive engagement took place with CHS, UHL anaesthetics, Community LD MDTs, PCLNs, psychology, OT, SALT, psychiatry, and the ICB to ensure alignment and shared responsibility. Process mapping and system design.

A full mapping exercise described the journey from referral to discharge, identifying gaps, pressures and opportunities for improvement across the system.

Sedation clinic development

A specialist sedation pathway was created at Loughborough Hospital to provide a last-resort option for people requiring blood tests who were unable to tolerate standard or community approaches.

Impact and Outcomes:

Successful blood tests for people previously unable to access them

- Nine successful blood tests completed across the system.
- Community preparation and reasonable adjustments enabled several patients to avoid escalation to sedation.
- Six patients have already successfully used the Midazolam sedation clinic, with additional clinics planned.
- Five additional patients have been identified for future clinics and are awaiting scheduling.

Positive patient and family experience

Families reported relief after years of unsuccessful attempts, improved trust in services, and reduced distress for the individuals involved.

Improved system coordination

The pilot strengthened relationships between CHS, LD services, UHL and primary care, helping clarify roles and reduce duplication.

Early identification of health risks

Successful blood tests allowed identification of previously unknown health needs, such as pre-diabetes or clarification of suspected clinical conditions.

Summary and Next Step:

Significant progress has been made this year to improve access to blood tests for people with a learning disability. The two sedation clinics successfully supported four patients, and further clinics are scheduled. The pathway has demonstrated that equitable and safe venepuncture is achievable when the right support is in place.

Priorities for 2026/27

- Embed the system-wide venepuncture pathway into routine practice.
- Secure sustainable staffing as the long-term funding for the sedation clinic is now secured.
- Strengthen reasonable adjustments and support within primary care.
- Expand preparation support to reduce reliance on sedation.
- Continue evaluating outcomes, patient experience and equity.
- Ensure the model evolves into a sustainable, long term LLR offer.

Health Inequalities Group LD Deteriorating Patient Update 2025/26

Diabetes

Project aim:

People with a learning disability are at a higher risk of developing type 2 diabetes, as they are more likely to experience a sedentary lifestyle, higher rates of excess weight, and the use of medications (e.g., second generation antipsychotics) that can contribute to weight gain. This increases their susceptibility to obesity related health conditions, including diabetes.

The project aimed to establish the current diabetes care provision for people with a learning disability and identify the prevalence of diabetes within this group.

Approach:

- Diabetes and prediabetes data requested to identify prevalence and higher prevalence areas.
- Establish uptake of people with diabetes attending their learning disability annual health check, and diabetes annual health check.
- Scope existing services and gaps.

Impact and Outcomes:

The primary outcome of this project was to scope out the current prevalence and services offered. The data found:

- 11% of people with a learning disability in LLR are living with diabetes.
- Age % of people living with type 2 diabetes ~ 3-4% 18-25yrs, 8% 26-35yrs, 18% 36-45yrs, 19% 46-55yrs, 27% 56-65yrs, 25% 66yrs +.
- Adults with a learning disability more likely to be living with type 2 diabetes at a younger age compared to people without a learning disability.
- 12.9% of people with LD + diabetes have not had their learning disability annual health check
- Leicester City and West higher prevalence of diabetes type 2.
- Services available/offered were identified as part of a mapping process.

Vaccinations

There are preventative healthcare measures that are available on rolling NHS programmes, the aim is to prevent avoidable mortality through vaccinations and screening for early detection of changes. Everyone should be given the opportunity to partake in and be aware of the available programmes. There are a number of factors that can affect engagement and reduce opportunities for vaccinations for people with a LD and autistic people and therefore, reasonable adjustments are often required.

Flu Vaccine

People with a LD, their family carers and paid supporters are entitled to a free flu vaccination. The person's choice, history and informed consent are important. Respiratory illness continues to remain the leading cause of death for people with a LD in LLR. It is also known that if those around the person are vaccinated against flu, then the person themselves is less likely to contract it. Reasonable adjustments are pivotal in increasing the uptake of the flu vaccination for people, where required the nasal vaccine can be considered as an alternative with the planning and agreement of the GP practice and the person and support network. In LLR 72% of people with LD had their flu vaccine in the last year of life, which is slightly higher than in the previous year [70%], this should continue to be encouraged and increased. People should also be encouraged to attend their LD AHCs where further reasonable adjustments and opportunities can be agreed, recorded, and shared with other care providers.

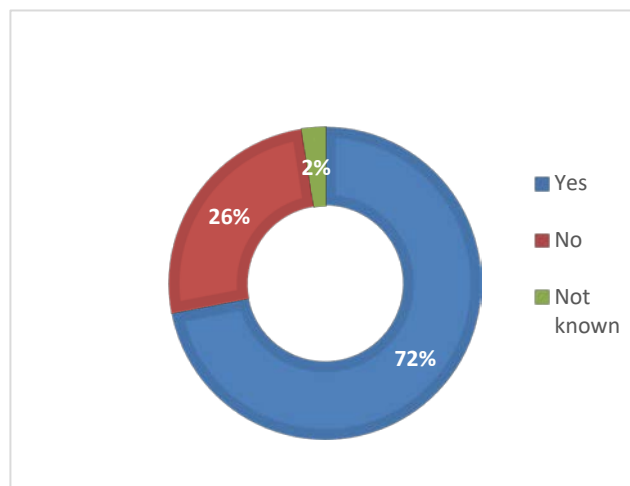


Figure 22. Flu jabs received.

Pneumococcal Vaccine

This year 17% of people who died had received the pneumococcal vaccine. The pneumococcal vaccine helps protect against serious illnesses like pneumonia and meningitis. It's recommended for people at higher risk of these illnesses, such as babies and adults aged 65 and over. Respiratory is the leading cause of death for people with a LD in LLR and it is therefore recommended to encourage vaccination in those who are at risk of serious illness related to respiratory.

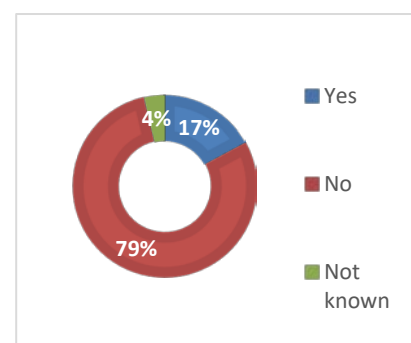
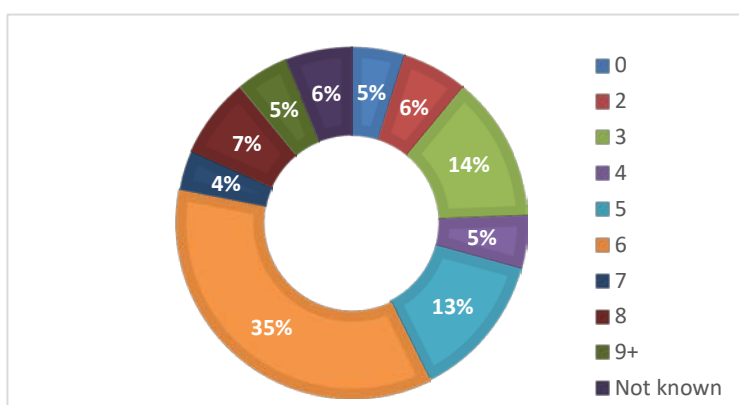


Figure 23. Pneumococcal vaccine

COVID-19 Vaccine

This year there were no deaths solely from COVID-19 and 2 deaths with COVID-19 secondary to cardiovascular and respiratory tract infection causes. The chart shows that most people have had either 5 or 6 COVID-19 vaccines, with 4 people having had zero vaccines. It is noted that there is a group of people for who this information is unknown. It is encouraging that more people this year have had 5 or 6 COVID-19 vaccines and fewer people have had 0, 2 or 3.



Health Inequalities Group LD Vaccinations Annual Report 2025/26

Project aim:

This project aims to ensure that individuals with LD and autistic people across LLR to have fair, equal and convenient access to all mainstream vaccination programmes throughout the life course. This includes flu, COVID-19, HPV and routine childhood immunisations.

It seeks to remove structural, communication and accessibility barriers by embedding reasonable adjustments - such as flexible appointment times, desensitisation visits, accessible communication formats, LD-specific clinics, and personalised support - to reduce vaccine hesitancy and improve the overall vaccination experience.

It aims to reduce health inequalities by working collaboratively across NHS England, ICB partners, Primary Care, Public Health, and VCSE organisations, ensuring that vaccination services are co-produced with people with lived experience, carers and families, and delivered in a way that is inclusive, person-centred and responsive to community needs.

Our impact & outcomes:

Seasonal Vaccine Uptake (Qualitative Improvement)

While LD-specific numerical uptake data is still being refined due to data-quality challenges, multiple reports indicate that uptake among LD cohorts increased across winter 2025/26 through targeted clinics, mobile outreach and proactive recall.

- LD vaccine uptake was actively monitored, with LPT identifying improvements following targeted actions.
- Winter targeted-work updates describe increased engagement and improved clinic attendance among LD patients following personalised outreach.

Service Accessibility Improvements

People with LD were successfully vaccinated in low-stimulus environments and at home where required—demonstrating that accessibility interventions directly removed historical barriers.

Co-Production Outcomes

Resources co-designed with people with LD (easy-read materials, animations, website updates) were shown to improve understanding and reduce anxiety.

Reduction of Missed Opportunities

Roving units in communities and at LD events captured people who would not have otherwise presented in traditional healthcare settings.

Summary and next steps:

To consolidate progress and address outstanding gaps, we will prioritise the following actions over the next reporting period:

- Strengthen LD data quality and reporting
- Expand accessible and LD-friendly vaccination models

- Complete co-produced resources and communication improvements
- Enhance workforce capability
- Strengthen multi-agency coordination
- Evaluate impact and shared learning

The roving healthcare unit can visit groups to offer vaccinations.

Screening

Cancer screening is an extremely valuable and important preventative healthcare measure. However, there remain some barriers to access and even more so for people with a LD and autistic people.

Cervical Screening

In 2025-26, 21% of people eligible for cervical screening attended regularly over their life course (where a LeDeR review was carried out). This is a significant increase from last year which was only 5%

Cervical screening is known to be one of the more challenging of the screening services offered in terms of uptake, due to the intimate nature. Nevertheless, people should always be offered the appointment, never be removed from the screening register due to having a LD or autism, and if required should be offered alternative checks such as, abdominal checks and menstrual tracking. This is unless people are making an informed choice to be removed from the register.

It was noted that 'not sexually active' has historically been recorded in notes for people with LD and carers are declining on behalf of the person, without any consideration of best interest under the MCA. It should also be considered that some people would need to be taken to their appointments, and 'was not brought' safeguards are important.

It is recommended by the LLR LeDeR programme that exploration of the contractual services for cervical screening are reconsidered to reduce the inequalities seen here.

It should be noted that from 1st July 2025 changes were made to cervical screening; for Ages 25-49 the screening interval will move from every 3 years to every 5 years due to more advanced testing.

System updates:

- Two specialist cervical screening clinics have been held with great success.
- Data collection is underway.

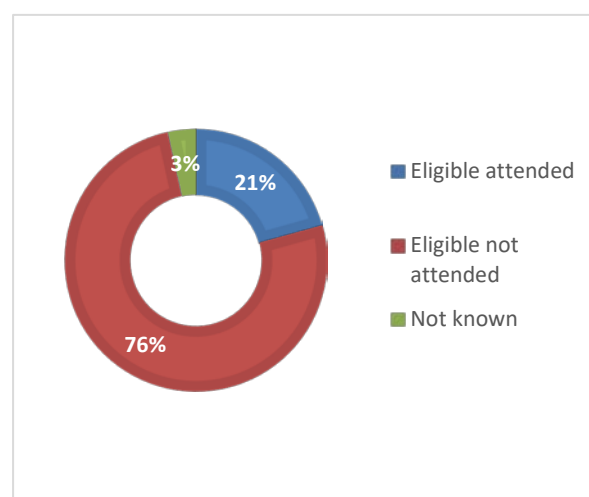


Figure 25. Cervical cancer screening attended (Where eligible)

- Training offered within the last 12 months has included providing LD awareness sessions to NEPSEC (new sample taker training) and the plan for this to continue for rolling new staff.
- PCLN attending working group for cervical screening project group. Part of discussion around self-sampling and planning how this can be

The PCLN team has adopted a proactive and collaborative approach to improving cervical screening uptake for people with a learning disability across LLR. Our current and recent activities include:

Data collection and analysis

The team gathered cervical screening data from LHMIS for 2024/25, with the intention of tracking improvements over time and identifying individuals with a learning disability who had not yet accessed screening. This would support targeted intervention.

Ongoing partnership working with primary care

Continue to meet quarterly with the core primary care group in North West Leicestershire to plan and coordinate specialist learning disability smear clinics.

These clinics have been successful previously, and planning is now underway for delivery in summer 2026, dependent on staffing capacity.

Training and workforce development

The PCLN team provides training on the specific needs of people with a learning disability as part of the national sample taker training programme.

This ongoing contribution helps improve confidence, understanding, and reasonable adjustments within primary care.

Targeted individual interventions

Continue to support individual patients who may need additional help to access cervical screening. This includes personalised interventions, capacity-related guidance, reasonable adjustments, and liaising with primary care teams.

[Cervical screening myth busting: Question and answer \(youtube.com\)](#)

[Cervical screening myth busting: Cali's story \(youtube.com\)](#)

Press release can be found here:

leicspart.nhs.uk/wp-content/uploads/2024/07/BBC-Radio-Leic-090724-Cervical-screening.m4a

"He was described by those who knew him as a much-loved gentleman with a warm personality and a cheeky sense of humour. Staff who had supported him for several years spoke very fondly of him and said he was well known for his funny side and gentle nature!"

Breast Screening

In 2025-26 of all the LeDeR Reviews, 46% of people eligible for breast screening attended regularly over their life course. This is an increase on the previous year which was 35%.

Breast screening along with breast checking are imperative for preventative healthcare and people should be adequately supported with relevant reasonable adjustments, reminders and prompts where required. The easy read video on checking your breasts and breast screening developed by LPT is still available on the website and should be used and promoted.

<https://www.youtube.com/watch?v=HphkoUbfNQQ>

As part of the drive to increase equality for people with a LD, the LD PCLN team are working with the Breast Screening Service in LLR. The aim is to improve access by ensuring that the breast screening service are aware of individuals that have a LD and can offer them appointments at their Equality Access Clinic by using accessible letters that are more easily understood. The AHC template has also been revised and now alongside all screening questions are the links for the easy read information which can be printed and given during the check. LLR LeDeR recommend that contractual mechanisms are put into place to support real drive in changing and increasing how people with a LD and autistic people are accessing and supported with breast screening.

Bowel Screening

In 2025-26 of all the LeDeR Reviews, 66% of people eligible for bowel screening attended regularly over their life course which is a more than double last year (31%).

Bowel screening usually yields one of the highest attendance rates due to its less invasive nature and it would be expected this figure continue to rise. There has been some encouraging positive practice seen again this year in LLR LeDeR with regards to supporting people with a LD to respond to the bowel screening invitation and on occasions work has been undertaken to support people in their best interests where this has been deemed necessary and appropriate.

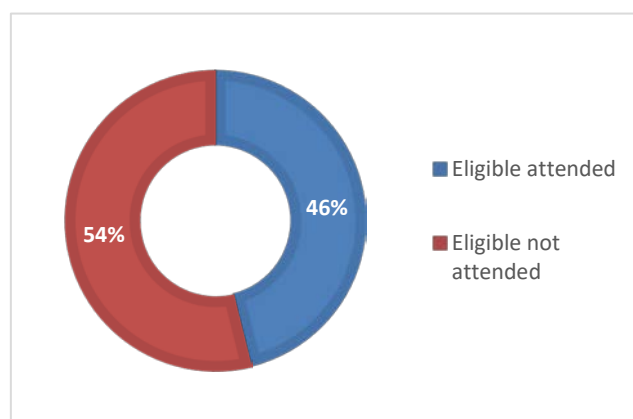


Figure 26. Breast screening attended (where eligible)

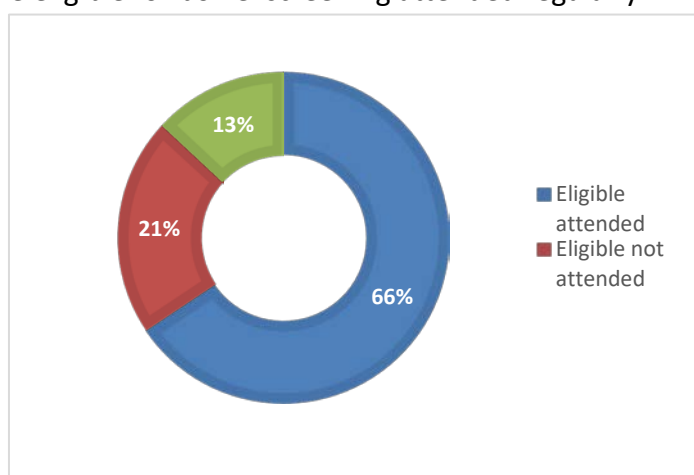


Figure 27. Bowel screening attended (where eligible)

PCLN team undertook a pilot project that commenced in the East area of LLR and was rolled out across West Leicestershire and Leicester City. Working with Eastern Bowel screening hub to identify eligible cohort of patients on the LD register to add additional care notes that reasonable adjustments were to be offered at the point of invitation for FIT test.

Initial finding show that the PCLN intervention pathway has had an impact on the uptake of bowel screening in people with a learning disability.

There has been opportunity to increase health promotion activities to include bowel screening at engagement events.

The project is planned to be rolled out to all eligible people with a learning disability across the whole of LLR and will be evaluated for the impact in terms of the number of FIT kits returned.

Abdominal Aortic Aneurysm (AAA) Screening

AAA screening shows that that only 27% of the eligible people through the LeDeR programme are attending compared to 81.9% of the general population of LLR. This is up from 5% last year. Further work is required to address this significant difference. UHL LD team identifies and notifies the AAA screening team on a yearly basis of those held on their database who become eligible for screening.

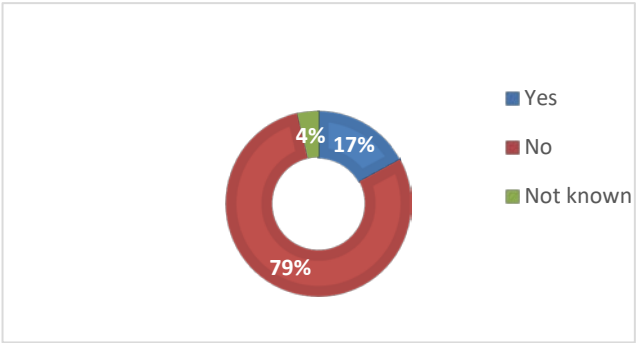


Figure 28. AAA screening attended (where eligible)

LD Annual Health Check

The past year has seen the LD AHCs within LeDeR at 86% again this year.

The GP practices, LD PCLN team and the Health Equity Lead this year, as well as others including people with a LD and their families, friends and carers should be commended on the success in driving forward this agenda.

Seasonally it is observed there are more deaths during winter months and therefore, it is worth considering the timing of the LD AHC and winter planning for people with a LD.

Overall, LLR continue to perform very well in this area.

Continue to offer regular support and training on AHCs for primary care, social care partners and care providers – including GP practices – to improve access to health care and reduce health inequalities for people with a LD.

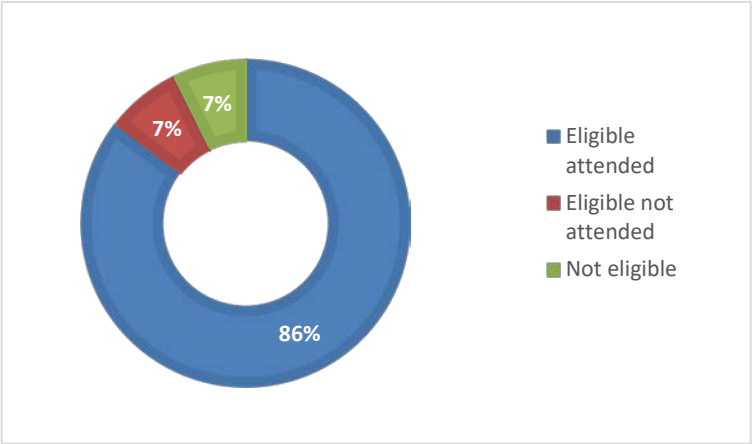


Figure 29. LD Annual Health check attendance

PCLN team have established the Primary Care LD Ambassador Network which aims to:

Work together to improve access to primary care for people with LD and promote health equity for this patient group.

- Brings together GP ambassadors, PCLN's and people with specialist knowledge about LD.
- Work together to understand how better to support people with a LD to live happy healthier lives.
- Consider ways to improve the accuracy of the LD register to ensure that the correct support can be offered.
- Share good practice and challenges and disseminate this back to your area of work.
- Opportunity to meet CPD requirements.
- LD Friendly practice award continue to promote and celebrate success.
- The PCLN team are successfully working on reducing did not attend appointments and declined appointment coding.

"She liked to be 'very well turned out' wearing hair clips, enjoyed having her nails done and pamper sessions."

Thematic Analysis

Thematic analysis is a qualitative research method that can be widely used across a range of epistemologies and research questions. Lincoln and Guba's (1985) criteria for trustworthiness during each phase of thematic analysis is widely used and often viewed as the "gold standard" for qualitative research. This ensures reliability, credibility and trustworthiness in our analysis process. This framework has been adopted in LLR for the purposes of the LeDeR Learning into Action and demonstrates the systematic structure of thematic analysis undertaken for the LeDeR reviews in LLR.

LLR LeDeR Focused Priority Review Area 2025-2026

All diagnoses of cancer

As per national guidelines and recommendations, LeDeR programmes always select an area for local focused priority review area on an annual basis. The LLR LeDeR programme ensures that the focused priority review area for the financial year is cognisant with the wider LLR system plans to enhance, compliment and feed into learning into action for LLR with regards to people with LD and autistic people. Although notifications remain very low for the deaths of autistic people, we were able to include reviews of autistic people in this analysis. In agreement with the LLR LDA Collaborative the following was agreed upon as the focused priority review area for 1st April 2025 – 31st March 2026:

"All diagnoses of cancer."

It was identified by the LLR system a priority to understand what the demographics, care needs and intersectionality nuances were of the people who died in the past year that had received a diagnosis of cancer or a positive FIT test. The following analysis summarises the key findings and recommendations.

Demographic Analysis of Priority Review Area

This section presents key demographic insights from the priority review area, based on completed reviews. The data highlights patterns in gender, age, disability level, living arrangements, and ethnicity, and congenital conditions.

As shown in *Figure 12. Deaths by gender*, 64% of reviews completed were of males and 36% of females.

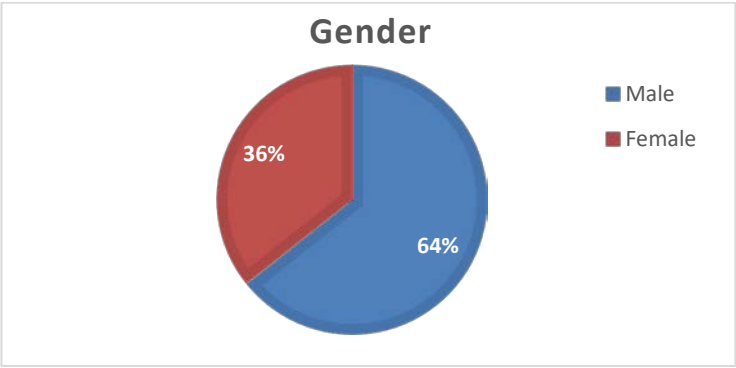


Figure 30. Deaths by gender

Figure 31, Level of learning disability shows that most people had Mild LD, there were no people with a Profound LD

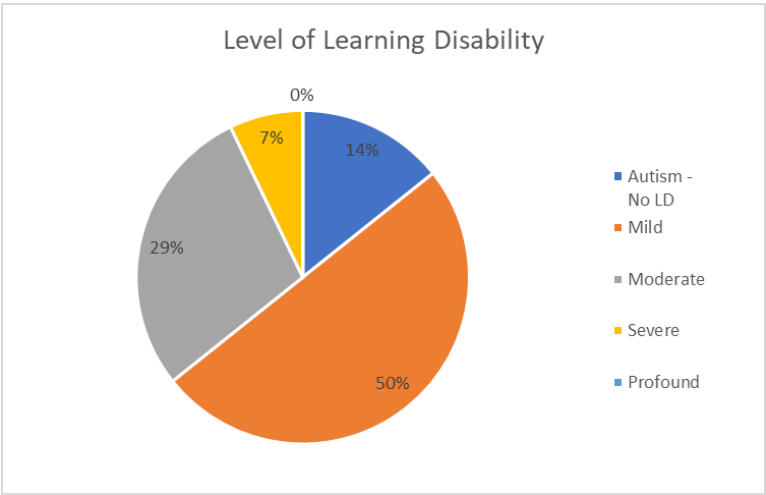


Figure 31. Level of learning disability

Figure 32. Age at death shows that 50% of deaths were age 56-70.

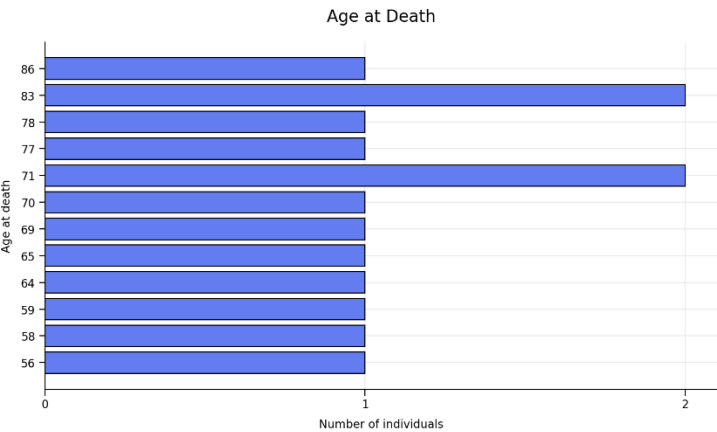


Figure 32. Age at death

Figure 33. Where did they live identified that most people were in residential care or their own home, with less in supported living or with family.

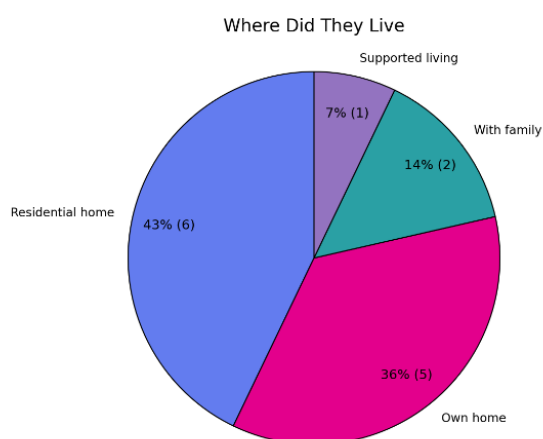


Figure 33. Where people lived

The ethnicity of the people in the priority review area were all White British with no cancer diagnoses for those from a diverse ethnic background.

Figure 34 Type of cancer shows most had bowel cancer followed by prostate cancer.

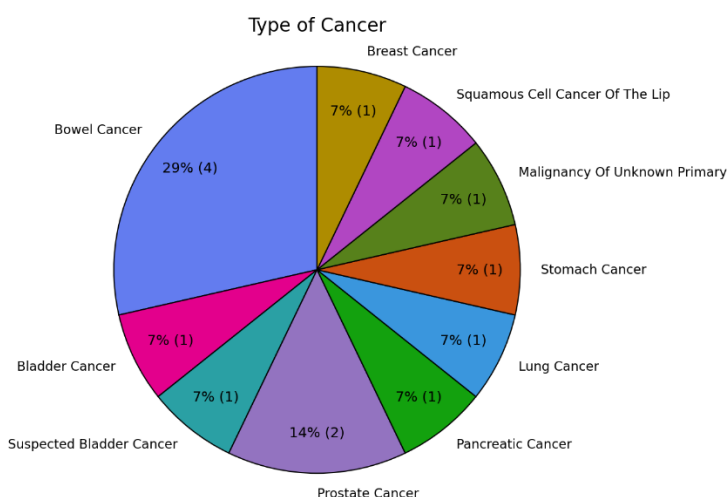


Figure 34. Type of cancer

This part of the thematic review highlights significant inequalities in cancer diagnosis and care for people with learning disabilities and autistic people within LLR. Across the cohort (aged 51–86 years), there was a high prevalence of **late-stage cancer diagnosis**, often at Stage 4 or presumed advanced disease, particularly in cancers with poorer survivability such as lung, stomach, and pancreatic.

A key finding was **delay in diagnosis and limited access to the 2-week wait (2WW) pathway**, with referrals frequently not initiated or delayed despite the presence of concerning symptoms. These delays were multifactorial and included **diagnostic overshadowing, reduced clinical suspicion of cancer, misinterpretation of behavioural changes, and system-related barriers** such as poor coordination and difficulties accessing investigations. In several cases, symptoms had been present for prolonged periods prior to referral.

Barriers to investigations were also significant, with individuals often unable to tolerate diagnostic procedures without additional support, leading to delays, incomplete staging, and reduced treatment options. The need for **anticipatory reasonable adjustments**, including sedation, longer appointments, and adapted approaches, was consistently identified.

Communication was a critical factor influencing engagement and outcomes. Where communication was adapted and person-centred, individuals were more likely to tolerate investigations and engage in care. Conversely, poor communication contributed to distress, refusal, and delay.

Carer involvement emerged as a key determinant of outcomes. Proactive and informed advocacy supported early identification, access to services, and continuity of care, while reduced engagement or limited support contributed to missed opportunities and delays.

The involvement of **specialist learning disability services (CLDT, LD PCLN, ALN teams)** was inconsistent but demonstrably beneficial when in place, particularly in facilitating reasonable adjustments and coordinated care.

Further contributing factors included **complexities surrounding mental capacity and consent**, under-recognition of important clinical indicators such as **family history**, and the **masking of symptoms** due to communication difficulties, behavioural presentation, or high levels of independence. These factors often resulted in delayed recognition of deterioration and late presentation.

Overall, the findings demonstrate that delays in cancer diagnosis for people with LD and autistic people are **systemic and multifactorial**, but also **potentially avoidable**. Where **reasonable adjustments, effective communication, carer advocacy, and specialist input** were present, outcomes and experiences improved.

This analysis highlights the need for a **coordinated, system-wide approach** to ensure equitable access to timely cancer diagnosis. Priorities include improving early recognition and referral, embedding anticipatory reasonable adjustments (including RADF), strengthening pathway coordination, enhancing clinical awareness, and ensuring consistent involvement of specialist LD services.

LeDeR Thematic Analysis Summary

Living Longer with a Learning Disability

The LDA Collaborative agreed that analysis would be beneficial to understand what contributors the LeDeR programme could identify with regards to the oldest population of people with a LD for the purposes of learning through positive case study. Therefore, this retrospective thematic review examined the deaths of 12 adults with learning disabilities who lived into older age (80–87 years), with a focus on understanding factors contributing to longevity, quality of life, and care experiences.

The findings demonstrate that **people with learning disabilities can live into later life, including their 80s**, across all levels of disability, when supported by consistent, person-centred care and access to appropriate services. High levels of **multimorbidity** were observed, reflecting typical ageing patterns, with respiratory disease identified as the most common cause of death.

Proactive healthcare was a key protective factor, with most individuals receiving regular learning disability annual health checks and vaccinations. Where preventative care and monitoring were in place, this supported early identification of health needs and better management of long-term conditions.

Stable living environments and strong support networks were strongly associated with positive outcomes. Most individuals lived in long-term placements with consistent staffing and care arrangements, often spanning many years. Support was generally described as responsive and well-coordinated, with multidisciplinary input from health and social care services. Involvement of specialist learning disability services further enhanced care through reasonable adjustments, advocacy, and support for decision-making.

Advance care planning was evident in many cases, although formal documentation (such as ReSPECT plans) was not consistently in place but it was clear that discussions were had. Where advance care planning was established, individuals were more likely to die in their preferred place, with reduced hospital admissions and a greater focus on comfort.

Importantly, **quality of life was consistently high across the cohort**. Individuals were supported to maintain meaningful lives, including social relationships, activities, routines, and personal identity. Reviewers concluded that all individuals lived lives aligned with their preferences and values, with autonomy and positive risk-taking respected.

Overall, this review highlights that **longevity for people with learning disabilities is achievable and is associated with stable, well-coordinated, and person-centred systems of care**. Key contributing factors include proactive healthcare, strong relationships and advocacy, sustained support arrangements, and respect for individual choice.

Key learning points include the need to strengthen **ageing and frailty pathways**, support **relationship based care**, improve **respiratory and dysphagia management**, ensure **end-of-life discussions are consistently formalised**, and maintain **specialist learning disability input across the life course**.

The Mental Capacity Act (2005)

As highlighted in successive LeDeR reports, further progress is needed to improve the application of the Mental Capacity Act (MCA) for people with a learning disability and autistic individuals. Key learning from this year has been identified, themed, and outlined below.

Decision Making

- Over-reliance on family members to make decisions
- Lack of clarity around legal responsibility of the decision-maker

LeDeR Reviews:

- Flu vaccination decisions left with family (58-year-old male)
- COVID/flu vaccinations declined by family without challenge or MCA process
- Clinicians not taking responsibility for best interest decisions

The MCA outlines:

- Family opinion is important; however, family do not make decisions unless they hold Health & Welfare LPA
- The clinician is the legal decision-maker (Best Interest decision)

Pattern identified:

- Staff defer to families, especially in preventative care (vaccinations)

It is important to consider consequences of decisions:

- avoidable harm (e.g. pneumonia, COVID deaths)
- inequality in access to treatment
- on balance with how the procedure if it is to go ahead would be achieved.

Learning identified, clinicians should:

- take ownership of decision-making
- ensure informed discussions with family
- clearly document rationale

Documentation

- MCA often applied in practice but not recorded
- Lack of evidence of:
 - capacity assessments
 - reasoning
 - best interest processes

LeDeR Reviews:

- Consultants failed to document MCA despite lack of capacity
- End-of-life surgical decision not clearly recorded under MCA
- Cancer diagnostics: no formal best-interest documentation
- NICE NG108 requirement (recording reasons) not followed

This is one of the **strongest recurring themes** from the MCA analysis.

Decisions clinically appropriate but not meeting legal compliance standards because of insufficient record-keeping.

This can lead to:

- Non-compliance with the MCA
- Safeguarding concerns
- Lack of transparency and audit trail

Learning identified that documentation is not optional:

- capacity decision-specific assessment
- why the person lacks capacity
- best interest reasoning
- who was involved

Inconsistency with capacity assessment

- Failure to:
 - assess capacity for specific decisions
 - involve the person where possible

LeDeR Reviews

- Denture removal plan – no evidence of consent or MCA
- Weight monitoring declined – unclear capacity assessment
- Dental care – good example of structured assessment
- Speech & language involvement supporting decision-making (good practice).
- Capacity is often:
 - o assumed rather than assessed
 - o not decision-specific

Learning identified capacity assessments must always be:

- decision-specific
- time-specific
- supported with:
 - o communication adjustments
 - o specialist input (e.g. SALT)

Best Interest Decision

- Best interest decisions
 - o Absence of best interest decisions or lack of documented evidence
 - o Decision making applied inconsistently
 - o Challenges were identified with regard to high risk or complex decisions
 - o Lack of coordinated MDT input delays decisions

LeDeR Reviews

- Vaccination refusals not explored via best interest
- Colonoscopy declined due to lack of “consent” (incorrect legally)
- Cancer investigation not pursued without BIM
- Covert medication used without proper MCA framework and not reviewed through MDT
- PEG decision delayed due to lack of MDT involvement
- Cancer pathway unclear due to lack of formal meeting

Learning identified that best interest must include:

- risks vs benefits
- least restrictive option
- multidisciplinary input
- documented rationale

- ensuring that where capacity is lacking, care decisions are guided by best interests rather than non-provision of treatment
- MDT collaboration
- clear leadership

Legal Literacy:

- Challenges identified in demonstration of understanding of MCA legal frameworks

LeDeR Reviews:

- LPA not recorded or misunderstood (finance vs health)
- Failure to recognise no LPA → clinician decision
- Failure to involve IMCA when required
- Missed DoLS considerations in restrictive practices
- Confusion around:
 - **who legally decides**
 - when to escalate decisions

Some examples:

- Brother had LPA but not recorded → missed care opportunities
- Sister had finance LPA only → correctly clarified (good practice)

Learning identified that staff awareness on:

- The differences between Next of kin and LPA (health vs finance)
- When to involve IMCA and apply DoLS

Inequalities in Preventative Healthcare (Vaccinations and Screening)

- People with LD not receiving:
 - flu vaccines
 - COVID vaccines
 - Screening

LeDeR Reviews:

- Multiple cases of missed vaccination
- No challenge to refusal
- No MCA or best-interest assessment
- Missed screening due to communication failures

Preventative care appears to be one of the lowest areas of MCA compliance and most influenced by family/carers decisions.

Learning identified that the MCA must be applied to:

- routine and preventative care
- not just major treatments

Positive Practice

Several cases demonstrated high-quality MCA application:

- Comprehensive capacity assessments
- Formal best-interest meetings
- Family involvement (but not decision-making control)
- DoLS and IMCA use
- Person-centred approach

LeDeR Reviews

- Dental GA decision with full BIM
- Social worker-led discharge planning
- Dementia case with MCA + DoLS compliance
- Communication support enabling decision-making

These show what “gold standard MCA practice” looks like.

“She had an incredibly positive relationship with her paid support workers, who she described as her “friends” during social care reviews.”

Autism

This year there were 11 deaths of autistic people notified to the LLR LeDeR Programme, 3 of which were completed within this financial year, 4 remain ongoing and 4 on hold waiting for outcome of coroner's inquest(2) and safeguarding(2). The notifications of deaths of autistic people although has increased, it remains low and must be a priority. However, the issues will likely remain with low notifications to LeDeR because there is not an autism register at this time where an electronic reporting notification can be added to the health and social care system, like there is for people with a LD. Therefore, it is much more reliant on word of mouth and individual notifications. This is reflected nationally and LLR LeDeR are in line with national notifications in this area.

In total there were 6 reviews of autistic people's deaths completed in LLR LeDeR during 2025-26, 4 individuals were male, and 2 were females. Areas of learning are highlighted below.

The review of six deaths of autistic adults identified consistent and recurring system-level issues contributing to health inequalities and poorer outcomes. These were not isolated incidents but reflect wider patterns in service delivery.

Key themes:

1. Failure to identify and respond to autism

In all cases, autism was either not clearly recorded, not flagged, or not considered in care planning.

This resulted in reasonable adjustments not being implemented, limiting patients' ability to engage with services.

2. Barriers to engagement with healthcare

All individuals experienced difficulties engaging with services, including non-attendance and limited follow-up.

Despite repeated attempts by services, approaches were not adapted to meet individual needs, leading to continued disengagement.

3. Lack of reasonable adjustments

There was no consistent evidence that services met their duties under the Equality Act (2010).

Care delivery remained largely standardised rather than personalised, particularly in communication, appointment systems, and follow-up.

4. Missed opportunities for prevention

Across all cases, there were missed opportunities to deliver preventative care, including:

- Weight management
- Screening (e.g. bowel, cervical, AAA)
- Vaccination

Preventative interventions were often offered but not actively followed through or tailored, leading to worsening health outcomes.

5. Reactive rather than proactive care

Care was often episodic and reactive, with limited proactive monitoring or follow-up.

When patients did not engage, there was no escalation or alternative approach, increasing risk of deterioration.

6. Fragmented and poorly coordinated care

Multiple services were involved in each case, but there was no clear coordination or oversight.

The absence of a named lead professional contributed to gaps in care and missed opportunities for intervention.

7. Workforce knowledge and awareness gaps

There was limited evidence of consistent understanding of:

- Autism and neurodiversity
- Communication needs
- Co-existing conditions (e.g. ADHD, mental health, dementia)

This contributed to missed risks, delayed care, and reduced quality of engagement.

8. Over-reliance on patient self-management

Care systems relied heavily on individuals to:

- Initiate contact
- Attend appointments
- Manage complex care

This approach did not take account of autism-related differences in communication, organisation, and engagement.

Additional Findings

- **Delays in access to services** (e.g. therapy, specialist assessment) were common and not actively risk-managed.
- **Mental health needs** were often under-recognised or insufficiently addressed, including one case of suicide.
- **Social care provision** was, at times, insufficient or not aligned with complexity of need.
- **Data quality issues** (e.g. inaccurate clinical records) and inconsistent application of frameworks (e.g. STOMP, MCA) were identified.

Examples of Good Practice

- Persistent attempts to engage individuals using multiple methods
- Strong involvement of family and carers

- Effective safeguarding processes
- Positive impact of specialist placements and multidisciplinary input
- Good palliative and end-of-life care, including respect for patient wishes

Conclusion

These reviews demonstrate **systemic challenges in delivering equitable care to autistic people**.

The most significant learning is the need to move from **standardised, reactive models of care** to approaches that are:

- **Proactive**
- **Coordinated**
- **Personalised**
- **Autism-informed**

Addressing these themes is essential to reduce health inequalities and prevent avoidable deaths.

"He was described as a 'larger than life character, intelligent, funny, cheeky, and endlessly creative. He had a wonderful imagination, and talents that amazed all'."



Learning Disability Child Death Reviews

LLR CDOP LeDeR Themed Review

Definition:

Individuals with a LD are those who have:

- A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with
- A significantly reduced ability to cope independently (impaired adaptive or social functioning), and
- Which is apparent before adulthood is reached and has a lasting effect on development.

Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) Policy 2021

Deaths of all people with learning disabilities aged 18 years and over are reviewed as part of LeDeR Programme, aiming to identify learning to reduce the increased mortality and morbidity rates seen for this population. In 2023, LeDeR stopped reviewing the deaths of children with a learning disability under 18 years of age due to duplication between LeDeR & CDOP. In LLR, it was agreed that we continue to collaborate, by carrying out a joint annual themed review. During 2025-26, 6 case reviews were completed for children with a Learning Disability who had died. A review group was convened with representation from Public Health, Childrens Social Care, UHL, LPT, ICB and the LeDeR Programme to look at these cases collectively, identify themes and learning, and to generate actions.

Update on actions from 2024/25 Review:

1. Collaboration between UHL, LPT, the ICB & the LDA Collaborative to develop an LLR-wide Care Passport for children & young people with a Learning Disability.

An LLR-wide Hospital Passport is in place currently; a 'Healthcare Passport' that can be used in any care setting would reduce the need for families to repeat information, and support joined-up care, ensuring reasonable adjustments can be made in all healthcare settings that a child or young person may access.

2. Ongoing work across LLR (led by the Learning Disability Primary Care Liaison Nurse team), to ensure children & young people with a Learning Disability are included on the GP Practice Learning Disability Register, and for all agencies to promote participation in the Annual Learning Disability Health Check for young people (aged 14yrs onwards) and their families.

A Quality Improvement project within LPT led by the Primary Care LD Liaison Nurses has led to successful IT system changes, to make it much easier for children & young people with a Learning Disability to be flagged to primary care.

3. For Public Health in Leicester City & Leicestershire to explore expanding smoking cessation inreach services to parents and carers of children and young people with a Learning Disability.

Links have been shared between the Step Right Out campaign, and the Paediatric Respiratory Team.

4. The LDA Collaborative to evaluate whether the Aspiration Pneumonia tool used for adults with a Learning Disability would be clinically appropriate for use in the paediatric population across LLR. This has been incorporated into a larger piece of work, with a bid for NIHR funding to evaluate its use in children as well as adults.

5. Paediatric services across UHL and LPT to continue to ensure that all children and young people with a life-limiting condition are offered a Children & Young People's Advanced Care Plan (CYPACP), with informed, timely, sensitive, and clear discussions, and that (wherever possible) wishes of children, young people & families are accommodated.

Training has been delivered in both LPT & UHL settings, however, there remains no commissioned specialist Paediatric Palliative Medicine input within the East Midlands.

6. For paediatric services across LPT & UHL to ensure that every child & young person with a Learning Disability & medical complexity has an allocated lead medical consultant.

The Children with Medical Complexity team within UHL now provides oversight & supports coordinated MDT care and discharge planning for this cohort of children and young people. The NCMD have updated data collection forms to ask about Medical Leads in every case, enabling monitoring of this locally.

Case characteristics of the 6 cases with reviews completed in 2025/26: -

The most common category for cause of death was:

- Chromosomal, genetic, or congenital anomalies (67%).
 - o Other categories included chronic medical condition and perinatal/neonatal events.
- No modifiable factors were identified.
- Positive aspects of service delivery were noted in 5 cases.
- Median age at death was 11 years (5-17 years)
- 100% were on the GP Practice Learning Disability Register (compared to 83% in 2024/25, 80% in 2023/24 and none of the 10 cases in 2022/23).

Table 1. Key learning themes identified during the 2025-26 review



Children & young people with a Learning Disability and their families often describe challenges with navigating and accessing health and care systems, often having to repeat their stories. Healthcare Passports can provide a single summary of a child's health and care needs, and reasonable adjustments to enable them to access the care and support they require.



All children whose cases were reviewed during 2025-26 were appropriately on the GP Learning Disability Register. This is a significant improvement from 2022/23 where none were. The Learning Disability Primary Care Liaison team have been instrumental in driving forwards quality improvement work, education, and training for both primary and secondary care, to ensure that every opportunity is taken to optimise the long-term health outcomes for both children and adults with a learning disability.



Excellent collaborative working between EMAS, Leicestershire Police, Coroners and Acute/Emergency Paediatrics meant that in two cases, the Joint Agency Response was appropriately commenced, but was then able to be rapidly stepped down as more information became available. Children & their families were able to then access the local hospice bereavement suite, for ongoing care.



For those with a life-limiting condition, children, young people & their families benefit significantly from timely, clear and sensitive advanced care planning, including being offered choice around their preferred place of death, and information about practical considerations, before and after bereavement. Discussions around advanced care planning can be complex, and family wishes should be accommodated wherever possible, whilst recognising the needs of the child remain paramount.



Due to a national workforce shortage of specialist paediatric pathologists, there are delays in postmortems being undertaken, which can increase the distress to families, particularly if it impacts on cultural mourning practices. Whilst the issue has been raised at a national level, locally the Child Bereavement Specialist Nurse and Child Death Review Nurses (in conjunction with the Coroners Offices) ensure that families are supported and kept regularly updated.

"He was described as a gentleman who would want to go out in all weather conditions, come rain or shine, snow and ice."



Fig 2. (Left) Family voices – family feedback received as part of reviews for 2025/26:

Ongoing recommendations & actions:

1. For CDOP Chair to write to the Chair of the LDA Collaborative, recommending the development of 'Healthcare passports' for children & young people with a Learning Disability.
2. For continuation of the ongoing work across LLR, led by the Learning Disability Primary Care Liaison Nurse team, to identify children & young people with a Learning Disability, to ensure they are included on the GP Practice Learning Disability Register, and for all agencies to promote participation in the Annual Learning Disability Health Check for young people (aged 14yrs onwards) and their families, as a key part of transition to adulthood.
3. For Public Health in Leicester City & Leicestershire to continue to explore expanding smoking cessation in reach services to parents and carers of children and young people with a Learning Disability.
4. For paediatric services across UHL and LPT to continue to ensure that all children and young people with a life-limiting condition are considered for a Children & Young People's Advanced Care Plan (CYPACP), that discussions around advanced care planning with families are informed, timely, sensitive, and clear, and that (wherever possible) the wishes of children, young people & their families are accommodated in end-of-life care planning.
5. For LLR CDOP to routinely collect information from primary care about participation in Annual Health Checks, as part of the review of deaths of children & young people with a Learning Disability, and to include this information in future thematic reviews.

Learning into Action

The learning into action for LLR LeDeR is reviewed on a quarterly basis and sent to the respective service provider in order for them to develop SMART actions. The service provider then reports back to the LeDeR steering group.

Top 3 Highlights of LLR LeDeR Learning are shown below:

GP and Primary Care:

- Cancer - Improved cancer diagnosis rates reflect the system's increasing ability to recognise and diagnose cancer in people with a learning disability through effective cross-organisational and multidisciplinary team (MDT) working. Work is now underway to strengthen reasonable adjustments across fast-track cancer pathways and increase primary care awareness of these adjustments, encouraging clinicians to refer people with a learning disability through mainstream cancer pathways where appropriate.
- Mental Capacity Act (MCA) - Appropriate use of the MCA is evident across many cases. The focus now is on improving the consistency of documentation for MCA assessments and Best Interests decisions within primary care, supported by education on the minimum documentation expectations.
- Advance Care Planning (ACP) and the ReSPECT process - Earlier identification of individuals who would benefit from Advance Care Planning (ACP) and the ReSPECT process is supporting more timely, person-centred conversations. Positive examples of early care planning and multidisciplinary team (MDT) involvement have demonstrated the benefits of this approach. The End-of-Life Care Working Group is developing a new ACP section within the personalised LLR Learning Disability Annual Health Check Template, with key prompts to help health professionals identify when an ACP discussion is appropriate.

LPT FYPCLDA

- A specialist Learning Disability Venepuncture Pathway has been introduced across LDA teams to improve access to safe, person-centred blood testing for adults with a learning disability. Using a multidisciplinary approach, the pathway provides specialist assessment, reasonable adjustments and personalised support to maximise successful venepuncture within mainstream healthcare settings, with escalation to the Learning Disability Phlebotomy Sedation Pathway when required. This helps reduce health inequalities, supports STOMP/STAMP and LeDeR priorities, enables effective health monitoring, and improves long-term health outcomes through timely and accessible blood testing.
- Following the introduction of the Learning Disability Physical Health Pathway and Physical Health Matron secondment, a range of improvements have been embedded across community services to address health inequalities and improve physical health outcomes for people with learning disabilities. These include a new holistic physical health assessment process, enhanced waiting list reviews to identify deterioration and enable timely intervention, a formal Physical Health Deterioration MDT process with clear escalation pathways, and a Pressure Ulcer Prevention SOP. Together, these initiatives strengthen risk identification, care coordination and prevention of avoidable harm, while

targeted training and education, improving staff confidence and competence in recognising, monitoring and responding to physical health needs.

- Early findings show that the PCLN intervention pathway is improving bowel screening uptake for people with a learning disability, with an initial 12% increase in FIT kit returns. Feedback suggests that the personalised and proactive PCLN approach is more effective than other engagement methods for this population group. Key learning highlights the importance of accessible information, practical support, and reasonable adjustments in helping people with a learning disability participate in bowel screening and reducing health inequalities.

University Hospitals Leicester

- Work is underway to look to reduce the number of falls within hospital for people with a learning disability and the associated harm and reduction in this area.
- A priority has been set to reduce the number and severity of Hospital Acquired Pressure Ulcers (HAPU) people with learning disabilities experience when in hospital.
- Work is set with the discharge planning team to ensure timely, safe and coordinated discharges for people with learning disabilities.
- A key area of focus is looking to increase the number and quality of ReSPECT forms completed for those with a learning disability, ensuring they are appropriately in place.

Leicestershire & Rutland County Councils

- One-page profile sessions were completed with staff to promote improved communication, engagement, and person-centred approaches when working with people who use our services. These sessions were identified from a learning need relating to effective communication with people we work with. The sessions were very well received, with strong levels of engagement and positive feedback from participants. As a result, the initiative has been adopted and is now being delivered within in-house services. The primary target audience is Learning Disability and Autism (LDA) teams; however, there has also been uptake from staff outside of these teams, demonstrating wider interest and recognition of the value of this tool.
- Regular Sign Along training sessions were offered to all frontline staff. The programme focused on enhancing communication skills, increasing staff confidence in the use of effective communication strategies, and supporting more accessible interactions with people who use our services. The training also promoted inclusivity and reinforced the importance of adopting communication approaches that enable meaningful engagement and participation for all individuals.
- A review identified the need to strengthen staff knowledge and application of good and legally literate practice when working with carers. The Engagement Panel and Steering Group have played a key role in the comprehensive redesign of the Carers Strategy, policies and associated staff training programme. This work has been co-produced, co-led, and co-delivered with members of the Engagement Panel, ensuring that the lived

experience and perspectives of carers are embedded throughout the development and delivery of a key area of practice.

Leicester City Council

- Continue to strive to ensure that carers are consistently offered a Carer's Assessment as part of a holistic approach to meeting the needs of the cared-for person. Recognising and supporting carers is essential in maintaining individuals safely at home or within their chosen environment, helping to sustain wellbeing and prevent unnecessary escalation of need.
- Throughout the year, there has been a strong focus on ensuring ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) forms are completed during assessments and reviews as part of ongoing care planning. Moving forward, the aim is to maintain and further improve the consistency of this practice to ensure individuals' wishes and preferences are clearly documented and reflected in their care.
- Safeguarding Assistive Technology continues to be considered and implemented where appropriate to maximise independence while ensuring that care and support needs are responded to effectively. This person-centred approach promotes dignity, choice and autonomy, enabling individuals to remain as independent as possible while feeling safe and supported within their preferred living environment.

"His sister shared that he had a really lovely childhood. He was the youngest of three children and was very much "Peter Pan" for their mum."

Response to the Top Ten Learning into Action 2025

This section aims to give an update on the responses to the top 10 learning into action points from LLR LeDeR Annual Report 2024 – 2025:

No.	Learning into Action 2025–2026	Response / Update 2026
1	Improve reporting of deaths to LeDeR, particularly autistic people and people from diverse ethnic backgrounds.	Notification numbers for autistic people have improved but remain low. Continued work is underway to increase awareness and reporting through provider engagement, primary care and partnership forums. Diverse ethnicity notifications continue to require further improvement.
2	Improve compliance with the Mental Capacity Act (2005).	MCA continues to be a system priority. ICB-led workshops, provider training, governance discussions and LeDeR learning have been shared widely. Positive practice has improved, although recurrent issues remain around documentation, best interest decision-making and legal responsibilities.
3	Ensure accurate physical health monitoring through reasonable adjustments.	Healthy Living Toolkits have been successfully launched across LLR. Wheelchair scales and hoisting scales are available, and physical health remains a key focus through the LD Physical Health Pathway and annual health checks.
4	Develop future-focused care plans for people with behaviours that challenge and increasing nursing needs.	PBS planning continues to improve and remains significantly higher than previous years. However, challenges remain regarding future specialist nursing provision and support for ageing people with learning disabilities and complex needs.
5	Start end-of-life discussions, Advance Care Planning and ReSPECT processes earlier.	End of Life remains a priority workstream. An LD-specific End of Life working group has been established and work is aligned with the DAPPLE research programme. Training and accessible resources continue to be developed across health and social care.
6	Improve access to cancer screening, investigations and early diagnosis.	Cancer was selected as the priority thematic review area for 2025–26. Learning has been shared across cancer pathways, primary care and screening programmes. Work continues to improve reasonable adjustments, early recognition and access to diagnostic investigations.
7	Recognise pain, distress and deterioration earlier.	Significant progress has been made through the LD Physical Health Pathway and deteriorating patient workstream. Competency frameworks, escalation processes and physical health initiatives are being implemented across services.
8	Reduce aspiration pneumonia through earlier identification of risk factors.	The Leicestershire Aspiration Pneumonia Protection Plan (LAPPP) remains in pilot phase. A regional thematic review of aspiration pneumonia deaths has now been completed and findings are informing future pathway development.
9	Improve cardiovascular health through healthy	Healthy Living Toolkits have been launched and adopted across LLR. The Health Inequalities Group continues to focus

	weight, activity and preventative healthcare.	on obesity, healthy weight, diabetes and preventative healthcare interventions.
10	Fully implement and utilise the Reasonable Adjustment Digital Flag (RADF).	RADF implementation has progressed significantly across LLR. Training is available, usage is being monitored and work continues to strengthen utilisation within primary care and acute settings.

LeDeR High Impact Action Plan 2025/26

*RAG Rating = Red (Not started), Amber (in progress), Green (Complete).

Priority Area	Action	Outcome Measure	*RAG Rating
Mental Capacity Act (2005)	Improve MCA compliance, documentation and best-interest decision-making across all sectors.	Reduction in MCA-related learning identified through LeDeR reviews.	
Cancer and Early Diagnosis	Increase awareness of cancer symptoms, improve screening uptake and support earlier referrals through reasonable adjustments.	Reduction in late-stage cancer diagnoses identified through LeDeR.	
Reasonable Adjustments	Strengthen implementation of RADF and improve reasonable adjustment recording and utilisation.	Increase in documented and utilised reasonable adjustments.	
Deteriorating Patient	Embed physical health competencies and deteriorating patient pathways across LD services.	Earlier recognition and escalation of deterioration.	
Aspiration Pneumonia	Implement and evaluate the Leicestershire Aspiration Pneumonia Protection Plan (LAPPP).	Reduction in avoidable aspiration pneumonia factors identified within reviews.	
Preventative Healthcare	Improve vaccination uptake, cancer screening and annual health check quality.	Improvements in uptake and compliance data.	
Cardiovascular Health	Continue roll-out of Healthy Living Toolkits, healthy weight interventions and multiagency staff training (primary focus on LD service, and carers (care home, nursing, and supported living etc).	Increased recording of healthy weight interventions and monitoring.	
End of Life Care	Improve uptake and quality of Advance Care Plans, ReSPECT forms and end-of-life discussions.	Earlier and more personalised end-of-life planning.	

Appendix 1

Governance Group

Grade of Care 1-6	Grade	Quality of Care	The Right Support
	6	This was the excellent care (it exceeded expected good practice). Please identify in learning and recommendations what features of care made it excellent and consider how current practice could learn from this.	Responsiveness of ICS services to the person's needs was excellent and exceeded the expected standard.
	5	This was good care (it met expected good practice). Please identify in learning and recommendations what features of care that current practice could learn from	Responsiveness of ICS services to the person's needs was good and met the expected standard.
	4	This was satisfactory care (it fell short of expected good practice in some areas, but this did not significantly impact on the persons wellbeing). Please address these issues in your recommendations for service improvement and identify in learning and recommendations any features of care that current practice could learn from.	Responsiveness of ICS services to the person's needs fell short of the expected standard in some areas but this did not significantly impact on the person's wellbeing.
	3	Care fell short of expected good <u>practice</u> and this did impact on the persons wellbeing but did not contribute to the cause of death. Please address these issues in your recommendations for service improvement and identify any features of care that current practice could learn from.	Responsiveness of ICS services to the person's needs fell short of the expected standard and this did impact on the person's wellbeing but did not contribute to the cause of death.
	2	Care fell short of expected good <u>practice</u> and this significantly impacted on the person's wellbeing and/or had the potential to contribute to the cause of death.	Responsiveness of ICS services to the person's needs fell short of the expected standard and this significantly impacted on the person's wellbeing and/or had the potential to contribute to the cause of death.
	1	Care fell far short of expected good <u>practice</u> and this contributed to the cause of death.	Responsiveness of ICS services to the person's needs fell far short of the expected standard and this contributed to the cause of death.



Consider referral to safeguarding if grading lower than 2 in both areas

Appendix 2



Improving notifications of the deaths of autistic people to the LLR LeDeR Programme



The aim of the project

The aim of the project was to improve the notifications of the deaths of people with a diagnosis of autism to the local LeDeR Programme, as the notifications are very low locally but also nationally.



The rationale for the project

This improvement matters as the number of notifications of the deaths for people with a diagnosis of autism is very low. Nationally, since autism was added to the LeDeR Programme in Feb 2022, there have only been 406 notifications, 36 of these were for the Midlands of which 9 were for LLR. We cannot review the deaths of autistic people if they are not notified to the LeDeR programme, and so, we cannot learn from their deaths and make improvements in the future care that autistic people receive.

What we did

LLR LeDeR met with the Midlands LeDeR Peer Support Group who are working on the rollout of the Reasonable Adjustment Digital Flag (RADF)

Our baseline was established on the number of notifications received to the LLR LeDeR Platform.

Communications published information on how to make notifications to the LeDeR platform for those with a diagnosis of autism.

By working with other professionals in the 'learning from deaths' field, and with regional LeDeR colleagues, IT technicians and the LDA Collaborative We requested a SNOMED report for the deaths of people that had a diagnosis of autism.

How we measured change

At the start, LLR had records of only 4 deaths of people with autism notified to the LeDeR platform.

To date LLR LeDeR have now received a total of 10 notifications.

LLR LeDeR has been able to review the lives and deaths of these 10 case of autistic people and these will contribute to service level improvements and mortality review findings.

A further effect has been improved communication and working with other 'learning from deaths' groups and systems (i.e. suicide prevention group, drug and alcohol related deaths group), and presenting at health and wellbeing board (City).

Impact of the project

Due to improved communications and working with other agencies to promote the LeDeR programme via trust boards and panels, there is now a wider knowledge of the LeDeR programme.

We have recruited a lived experience partner to join and support the LLR LeDeR programme to progress change.

The learning has provided the much-needed evidence to support the roll out of the RADF and combined annual health check pilot.

Initial steps have been made to better understand the challenges faced by autistic people in managing their health and social care.

Notifications have doubled; LeDeR has a clear plan to build on this further. The QI plan has been a success.

Next steps

LLR LeDeR Programme work is ongoing, looking for ways of improve notifications and avoid unnecessary deaths. The Programme is working towards an online electronic alert to further improve notifications.

Continue to promote LeDeR notifications, specifically autistic notifications, through as many channels as possible.

LeDeR is a national programme and LLR routinely share positive practices with the Midlands LeDeR Peer Support Group.

Details of all findings are published in the LLR Annual Report

Appendix 3



STOMP and STAMP are two programmes created by NHS England to stop the inappropriate prescribing of psychotropic medications.



Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

J who is next of kin for her sister, has told us her sister's story: 'C', has a diagnosis of a mild learning disability and bipolar affective disorder.



Background

C has a mild learning disability and bipolar affective disorder. She was sociable from a young age enjoying school and various community groups. After falling in with the wrong crowd, C committed a crime (petty theft) which then led to her being diagnosed with schizophrenia. The court ordered her to be sectioned and C ended up in a lock up facility where she became withdrawn spending days in bed. It was evident that the facility was not suitable and C was transferred to a residential care home.

STOMP outcome

C was seen by the learning disability psychiatry team in Leicester. Her doctor always saw the real C even when she was experiencing her lowest moods and was a beacon of light for her at the end of a dark tunnel.

C had been taking high doses of medication for many years. C was taking lithium and varying doses of fluoxetine and then olanzapine.

Her medication was reduced (cautiously) because C's social environment was having the largest impact on her mental health and within a few years, C's lithium had been withdrawn.

More recently, C's psychiatrist reduced her dose of olanzapine.

Today, C takes no other medication for her mental ill-health. C's psychiatrist continues to stress that C mental ill-health is predominantly influenced by social factors and medication use for behavioural needs should be minimised.

C also had input from community nurses to monitor mood, sleep, food and fluid intake - they provided behavioural guidelines for staff to follow to support her when she would isolate herself. She also received extensive input from occupational therapists around activities of daily living assessments and help with maintaining personal hygiene.

There are many positive examples of C finding her voice since her medication was reduced:



For her 70th birthday, C hosted a lunch at a local pub for 12 of her friends (some with and some without a learning disability).



C no longer has long spells when she retreats to her bed now that she is relearning to speak up for herself and say what is on her mind.



C independently goes to the local pub most days, attends a coffee/tea social twice a week and often attends the church service on Sunday mornings. She has developed her own circle of friends which is not an easy task for anyone let alone someone used to developing those friendships at a day centre. She is very popular at home and in the community.

For more information around STOMP and STAMP, please visit:

<https://www.leicspart.nhs.uk/autism-space/health/stomp-stamp/>

Find out more

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Trust Finance Report
for the period ended
31 August 2026

For presentation at the
TRUST BOARD meeting
29th September 2026

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Executive dashboard - overall performance against targets

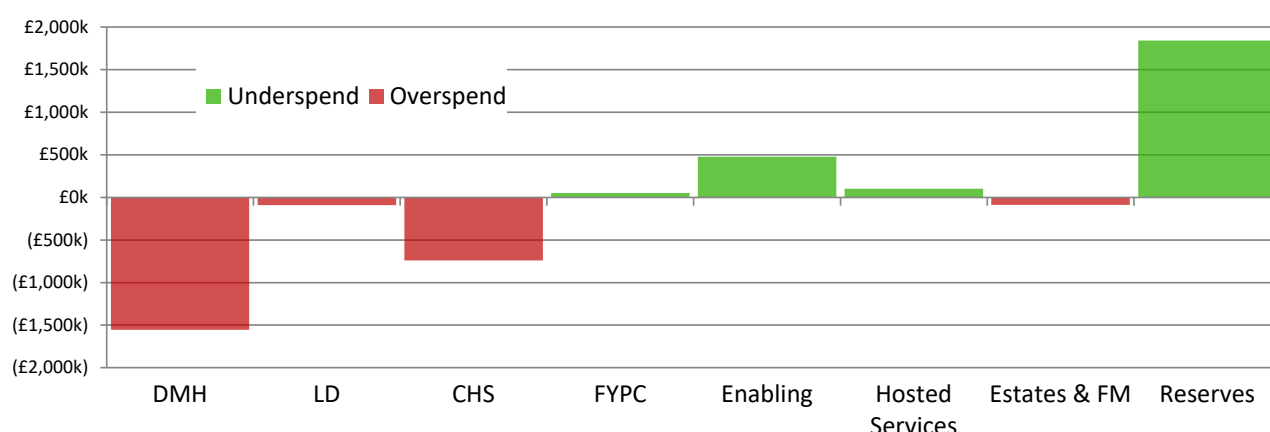
Statutory targets	Year to date	Year end f'cast	Comments	Further detail
1. Income and Expenditure break-even.	A	G	The Trust is reporting a YTD deficit of £1.99m at the end of August (in line with plan). The forecast year end position is currently a breakeven, also in line with plan.	APP. A
2. Remain within Capital Resource Limit (CRL).	G	G	The YTD capital spend for August is £2,871k, 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 August 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 5 (August) are £8.9m, 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	G	G	YTD agency spend at the end of August is £2,252k. This is lower (£8k) than planned YTD spend, and remains within the NHSE agency spend cap (on pro-rata basis).	APP. C
7. Comply with Better Payment Practice Code (BPPC).	G	G	Cumulatively the Trust achieved all of the 4 BPPC targets but in month achieved 3.	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 £21.3m at the end of August. This is £5m 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. August's cash level of £21.3m was 18 days.	APP. F
10. Deliver capital investment in line with plan	A	G	YTD capital expenditure is £2,871k. This is below planned spend for the month. See 'Capital Section' in summary report.	APP. E

Summary report – financial position as at 31 August 2026

YEAR TO DATE POSITION

- The overall year-to-date income and expenditure plan - being a planned YTD deficit of £1,985k - has been achieved at the end of August (month 5).
- Within the wider position, the collective year-to-date operational (directorates) budget position shows an overspend of £1,841k.
- Central reserves are underspent by £1,841k, 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 overspent by £1,554k at the end of month 5. Pay budgets are overspent by £1,543k, with the main pay pressures continuing to be medical locums, plus high bank staff costs due to high acuity, observations, patient escorts and sick leave cover. Non-pay budgets are overspending by £622k – including a £434k overspend in private beds costs. Income budgets are over-recovering by £611k due to increased out of area activity.
- **The Community Health Service** reports a £739k overspend for the first five months of the year. This is a £78k adverse movement from last month, driven by unachieved non-recurrent Cost Improvement Plans (CIPs) from last year, current scheme slippage, and non-pay pressures such as drugs and medical supplies. However, the run rate is stable—helped by deploying staff from the temporarily closed North ward to reduce bank and agency reliance—and this has improved the year-end deficit forecast from £1.84m to

£1.6m. Bank and agency expenditure for the period to date stands at £3.08m, which is a significant reduction from the £4.48m spent at this stage last year, and monthly nursing agency spend continues to be monitored to ensure ongoing savings targets are met.

- **The FYPC** month 5 position was a £52k underspend, a £19k adverse movement from month 4. The pay position was overspent despite reductions in agency and bank costs. Non-pay also showed an overspend, although lower than last month, with the main pressures being linked to Medical Equipment purchases, VPN costs and the purchase of Healthcare Services. Income reported an over recovery (linked to Welford ward and smaller non ICB contracts) which was sufficient to drive the overall directorate underspend.
- **The LDA** month 5 position was a £92k overspend which represented a favourable movement in the month. The main pressures continue to be in relation to the Agnes Unit, with other pressures linked to this year's CIP delivery and the creation of negative budgets where savings identified are cash only savings. The forecast out-turn position still shows an overspend, but it is hoped this will be reduced from the current run rate.
- **Enabling budgets** are underspent by £478k as at M5. This is a positive movement of £72k compared to M4. Vacancy slippage, savings from group roles and income from Education and Training are contributing towards this favourable movement. The run-rate is expected to continue at approximately the same rate across the remainder of the year.
- **Estates budgets** are overspent by £87k as at M5. This is a negative movement of £12k compared to M4. There has been a small increase in facilities staffing costs, otherwise the run-rate is now largely break-even.
- **The Central Reserves position** is underspent by £1,841k. The phasing of reserves budgets allows for a level of deficit in the first half of the year which is sufficient to 'fund' the current level of directorate overspend.

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). The forecast continues to be based on a best case scenario that factors in recovery actions that require further development. A best/likely/worst case risk adjusted forecast outturn is included in **appendix G**.

MEDIUM TERM FINANCIAL PLAN

- The formal timeline for the national planning round for 2027/28 (and beyond) has still not yet been confirmed. However, NHSE requested summary planning narrative during August and they have already responded with initial high level feedback to the region as a whole. This feedback suggests that Trusts need to quickly build on the initial planning

work to better articulate how they intend to address the many challenges, at a more granular level.

- The Trust is now focussing on more detailed CIP planning for 27/28 and 28/29. CIPs are likely to become the primary focus of financial planning given the 'flat cash' (no growth) assumption underpinning the planning approach.
- A national 'Deconstructing the Block' exercise has recently been completed. Providers and commissioners worked together to analyse block income contracts (in the case of LPT this covers 89% of income). The exercise has been undertaken to understand what activity is being delivered under block contracts, and how much this activity would cost if funded using national prices. The national prices have been subject to a 'productivity deflator' which seeks to adjust for perceived deterioration in post Covid NHS productivity. LPT – in common with the vast majority of non-acute Trusts – would currently be being overpaid by c. 16% if comparing current block income with national prices used in this exercise.
- NHSE stated aim is to introduce activity based contracts for non-acute provider contracts in some form from 1st April 2027. The process has already been implemented for acute Trusts in the current financial year, albeit the negative impact on contract values has initially been capped at 2.5% of contract values.

Finance Report for the period ended **31 August 2026**

APPENDICES

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 31 August 2026	YTD Actual M5 £000	YTD Budget M5 £000	YTD Var. M5 £000
Revenue			
Total income	188,197	182,493	5,703
Operating expenses	(188,053)	(182,349)	(5,703)
Operating surplus (deficit)	144	144	(0)
Investment revenue	250	250	0
Other gains and (losses)	0	0	0
Finance costs	(825)	(825)	0
Surplus/(deficit) for the period	(431)	(431)	(0)
Public dividend capital dividends payable	(1,175)	(1,175)	0
I&E surplus/(deficit) for the period (before tech. adjs)	(1,606)	(1,606)	(0)
NHS Control Total performance adjustments			
IFRIC 12 adjustment (PFI interest adj - excl. from Con.Total)	(200)	(200)	0
Donated/government grant asset reserve adj	(179)	(179)	0
Technical adjustment for impairments	0	0	0
NHS I&E control total performance	(1,985)	(1,985)	(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:	(1,606)	(1,606)	(0)
Trust EBITDA £000	5,073	5,073	(0)
Trust EBITDA margin %	2.7%	2.8%	-0.1%

APPENDIX B – Efficiency savings performance

At the end of month 5, CIP performance is reported in line with the year-to-date plan which is delivery of £8.9m total savings. There is a net YTD shortfall of £0.9m within directorate schemes however this is offset by additional gains within corporate schemes.

Overall, forecast savings for the year deliver the planned £27.6m savings target. The forecast year end gap in directorate schemes of £0.9m has increased since last month. This is mainly due to further worsening of the DMH forecast – including slippage relating to the private beds reduction scheme which was originally anticipated to start delivering savings from month 3.

The main drivers of the CHS YTD and FOT shortfall include slippage on the medical workforce/ geriatrician contract savings and continence products savings. The Estates YTD shortfall relates to the phasing of the actual savings being different to plan, and the year end FOT assumes that full savings will still be achieved by the end of the year.

The wider forecast outturn shows central reserves schemes continuing to over-deliver to a level sufficient to offset the directorate shortfalls. However, this assumes that the directorate shortfall does not worsen and remains at the current £0.9m level. If directorate forecasts worsen further, it is unlikely that central reserves will be able to fully cover the shortfall.

CIP year-to-date performance and forecast by directorate

Directorate	M5 YTD PERFORMANCE (£000)					FORECAST (£000)				
	YTD plan	YTD recurrent actual	YTD non-recurrent actual	TOTAL YTD actual	YTD variance	Annual target / plan	FOT recurrent	FOT non-recurrent	TOTAL FOT	Variance
DMH	2,059	1,823	51	1,874	(185)	6,795	6,063	122	6,185	(610)
CHS	2,360	1,035	900	1,935	(425)	5,434	2,929	2,105	5,034	(399)
FYPCLDA	1,788	1,788	0	1,788	(0)	4,980	4,980	0	4,980	0
Enabling	692	165	527	692	0	1,630	1,265	395	1,660	30
Hosted (HIS)	217	209	8	217	0	489	530	20	549	60
Estates	1,073	607	171	778	(295)	2,574	1,764	810	2,574	(0)
Corporate Schemes	681	0	1,586	1,586	905	5,726	0	6,646	6,646	920
Unallocated Trust plans-in-progress	0	0	0	0	0	0	0	0	0	0
Total	8,869	5,627	3,243	8,869	0	27,628	17,531	10,098	27,628	0

APPENDIX C – Agency expenditure

Dir.	2026/27 Agency Expenditure	25/26 Outturn £000s Actual	25/26 Avg mth £000s Actual	26/27 M1 £000s Actual	26/27 M2 £000s Actual	26/27 M3 £000s Actual	26/27 M4 £000s Actual	26/27 M5 £000s Actual	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	-290	-212	-263	-266	-263	-166	-234	-194	-187	-1,262	-2,835
	Nursing - Qualified	-1,419	-118	-65	-48	-74	-58	-43	-38	-38	-38	-52	-67	-61	-61	-288	-643
	Nursing - Unqualified	-79		0	0	-1	1	0	0	0	0	0	0	0	0	0	-1
	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	-348	-255	-301	-304	-301	-218	-301	-255	-248	-1,550	-3,479
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	-15	6	0	0	0	0	0	0	0	-85	-85
	Nursing - Unqualified	-19		-7	6	6	-1	0	0	0	0	0	0	0	0	4	4
	Other clinical staff costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sub-total - LD	-123	-9	-52	10	-29	-15	6	0	0	0	0	0	0	0	-80	-80
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	-55	-49	-50	-50	-50	-80	-70	-70	-70	-388	-828
	Nursing - Unqualified	-179		-16	-11	-5	-2	-2	-2	-2	-2	-5	-5	-5	-5	-37	-63
	Other clinical staff costs	-112	-9	-5	-7	-7	-6	-5	-7	-7	-7	-7	-7	-7	-7	-30	-76
	Sub-total - CHS	-3,127	-246	-125	-113	-98	-64	-57	-59	-59	-59	-92	-82	-82	-82	-456	-968
FYPC	Consultant Costs	-139	-12	0	-20	-22	-43	10	0	0	0	0	0	0	0	-75	-75
	Nursing - Qualified	-601	-50	-29	-1	-25	-18	2	-2	-2	-2	-2	-2	-2	-2	-71	-85
	Nursing - Unqualified	-29		-3	-1	-2	-8	-2	-2	-2	-2	-2	-2	-2	-2	-17	-31
	Other clinical staff costs	-4	0	0	0	0	-3	0	0	0	0	0	0	0	0	-3	-3
	Sub-total - FYPC	-773	-62	-32	-21	-49	-73	10	-4	-4	-4	-4	-4	-4	-4	-166	-194
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
	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	-334	-202	-263	-266	-263	-166	-234	-194	-187	-1,337	-2,910
	Nursing - Qualified	-4,803	-400	-242	-139	-219	-147	-84	-90	-90	-90	-134	-139	-133	-133	-831	-1,640
	Nursing - Unqualified	-300	-25	-26	-6	-2	-10	-4	-4	-4	-4	-7	-7	-7	-7	-50	-91
	Other clinical staff costs	-130	-11	-5	-7	-7	-9	-5	-7	-7	-7	-7	-7	-7	-7	-34	-80
	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	-500	-296	-364	-367	-364	-314	-387	-341	-334	-2,252	-4,721
	Total plan:			-476	-465	-452	-440	-427	-415	-403	-390	-377	-366	-351	-339	-2,260	-4,901
	Variance to plan:			-76	36	-23	-60	131	51	36	26	63	-21	10	5	8	180
	Var* to annual cap of £6,749k (monthly in12ths):			11	133	87	62	267	199	196	199	249	176	222	229	560	2,028

Agency spend for August (month 5) is £0.30m. This is lower than the planned spend of £0.43m. 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 below plan (better than plan) by £0.2m.

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 NHSE cap would equate to spend of £0.56m per month, putting the M5 YTD spend also well within the cap if applied on an equal 12ths basis.

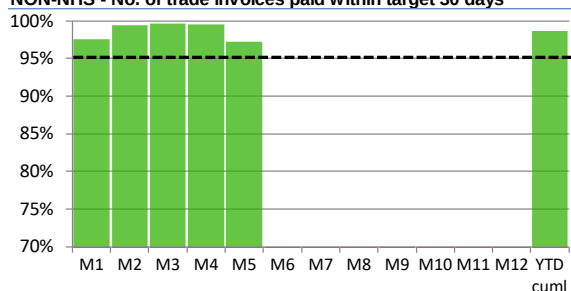
APPENDIX D – BPPC performance

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. The in-month performance deteriorated this month with 3 of the 4 targets being achieved. The number of NHS invoices paid within the target period was 92.31% - 9 invoices were paid late, with reasons currently being investigated.

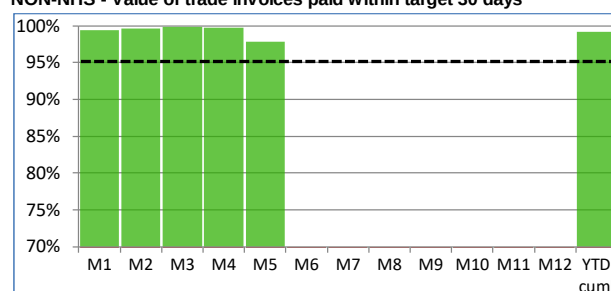
Better Payment Practice Code	August (Cumulative)		July (Cumulative)	
	Number	£000's	Number	£000's
Total Non-NHS trade invoices paid in the year	13,934	58,130	10,323	44,250
Total Non-NHS trade invoices paid within target	13,752	57,673	10,243	44,095
% of Non-NHS trade invoices paid within target	98.69%	99.21%	99.23%	99.65%
Total NHS trade invoices paid in the year	353	31,659	236	25,818
Total NHS trade invoices paid within target	340	31,389	232	25,670
% of NHS trade invoices paid within target	96.32%	99.15%	98.31%	99.43%
Grand total trade invoices paid in the year	14,287	89,789	10,559	70,068
Grand total trade invoices paid within target	14,092	89,062	10,475	69,765
% of total trade invoices paid within target	98.64%	99.19%	99.20%	99.57%

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

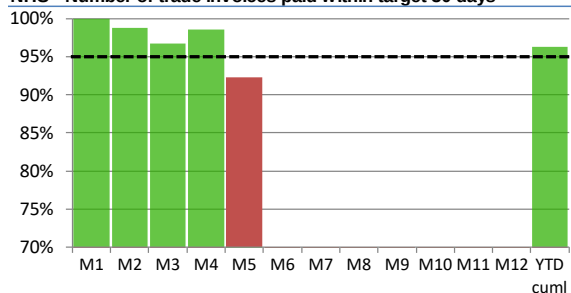
NON-NHS - No. of trade invoices paid within target 30 days



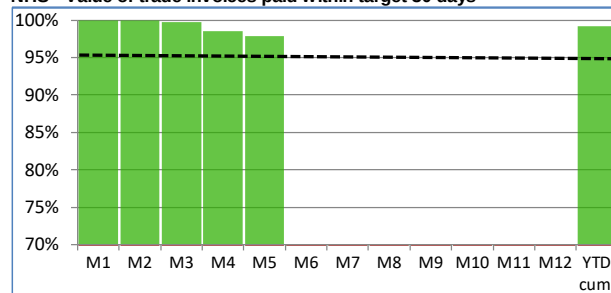
NON-NHS - Value of trade invoices paid within target 30 days



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	August Actual	Year End Forecast	Revision to Plan
<u>Sources of Funds</u>	£'000	£'000	£'000	£'000
Depreciation	11,817	4,924	11,817	0
Cash reserves	1,179	(244)	1,179	0
Capital borrowings repayments	(4,517)	(1,882)	(4,117)	400
Capital grants	0	0	188	188
Total System operational capital	8,479	2,798	9,067	588
IFRS-16 new leases	1,040	0	1,040	0
MH OAPS - Deferral from 2025/26	1,800	23	1,800	0
Constitutional Standards/Left Shift	6,821	456	6,821	0
Estates Critical Infrastructure Risk (CIR)	1,550	9	1,550	0
National Programmes (PDC)	10,171	488	10,171	0
PFI capital lifecycle costs	131	51	131	0
Total Capital funds	19,821	3,337	20,409	588
<u>Application of Funds</u>				
Estates	£'000	£'000	£'000	£'000
Capital staffing	(510)	(114)	(571)	(61)
Estates backlog programme	(3,784)	(910)	(3,693)	91
Estates rolling programme	(1,420)	(428)	(1,447)	(27)
Medical devices	(170)	0	(170)	0
Directorate investment	(11,010)	(940)	(11,631)	(621)
PFI Agnes Unit capital lifecycle costs	(131)	(85)	(131)	0
	(17,025)	(2,477)	(17,643)	(618)
IM&T investment	(1,756)	(860)	(1,726)	30
Operational Capital	(18,781)	(3,337)	(19,369)	(588)
IFRS16 - Right of Use Leases	(1,040)	0	(1,040)	0
Total Capital Expenditure	(19,821)	(3,337)	(20,409)	(588)
(Over)/underspend	0	0	0	0

Capital expenditure to date:

Capital expenditure up to the end of August totals £3.3m. This is £4.4m below planned spend of £7.8m at Month 5. 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, mainly the Constitutional Standards/Left Shift schemes (CS/LS). The following table shows the current status of all schemes over £500k, the current spend, and the annual forecast against each one:

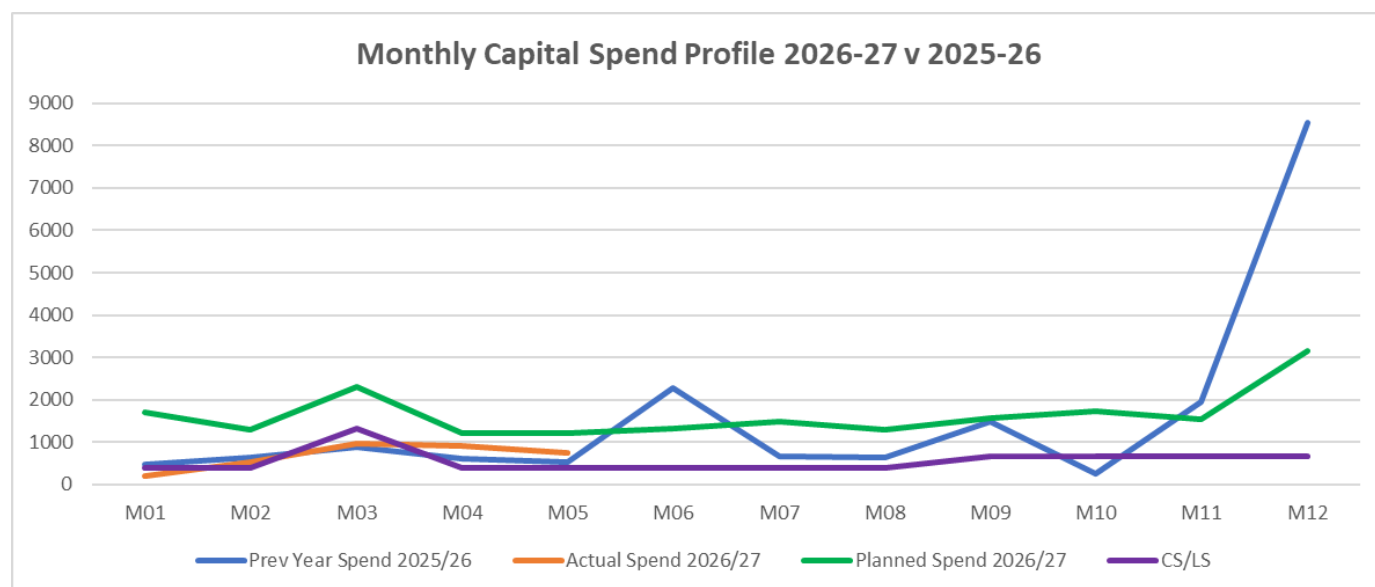
Schemes over £500k	M05 Planned Spend £'000	M05 Actual Spend £'000	M05 Variance £'000	Opening Plan £'000	Annual Forecast £'000	Current Status
Capital Staffing	(218)	(113)	(105)	(510)	(571)	Slow start on schemes therefore Principal designer/Cost advisor costs are currently lower than planned
Estates Backlog - Valentine Roof	(293)	(787)	494	(630)	(806)	Valentine roof construction progressing during June, with solar panels being installed. Costs in excess of plan to date. Scheme is phased monthly but Works expected to complete in Sept.
Estates Backlog - Site Electrical Supply	(215)	0	(215)	(500)	(500)	High voltage Cable installation for supply to New MH Hospital - 26/27 works not yet commenced
Estates Backlog - Lough Generator replacement	0	0	0	(500)	(500)	Generator replacement phased in late 26/27. Works being scoped by contractor
Estates Rolling Programmes	(584)	(428)	(156)	(1,420)	(1,447)	£250k Replacement taps at Hinckley Hospital commenced £188k spend accrued for works completed in July, Fire stopping scheme at Bradgate started £12k accrued costs for July, Patient staff call system commenced installations
IM&T - IT Rolling Replacements	(435)	(580)	145	(1,040)	(1,040)	Variance relates to phasing of orders placed
IM&T - On-going configurations	(300)	(280)	(20)	(716)	(716)	
Directorate Schemes						
Soundproofing Audiology Hynca Lodge	(275)	(139)	(136)	(656)	(656)	Work commenced on pod in July, Scope and drawings underway for alterations to consulting rooms Initial figures being reviewed by capital team Signing off drawings Phased in from June - low spend likely late 26/27 due to relocation of staff from Valentine Scope to be determined - initial meetings with service in August - drawings to be agreed & to be progressed to costing Scope to be determined - potential site viewed Scope to be determined - phased in late 26/27 - UHL leading works
Acacia Full refurbishment	(651)	0	(651)	(1,570)	(1,570)	
Thornton Ward Refurbishment	(537)	0	(537)	(1,300)	(1,300)	
Wakerley Ward Refurbishment	(270)	0	(270)	(900)	(774)	
Coalville Ward 3 Refurbishment	(312)	0	(312)	(930)	(930)	
24/7 Neighbourhood MH Centre (City)	(925)	0	(925)	(925)	(925)	
MH Emergency Department	0	0	0	(1,000)	(1,000)	
IFRS16 Leases	(433)	0	(433)	(1,040)	(1,040)	
Other Schemes value less than £500k	(2,325)	(1,010)	(1,315)	(6,184)	(6,634)	
	(7,773)	(3,337)	(4,436)	(19,821)	(20,409)	
						66 schemes

The original capital plan assumed receipt of all CS/LS funding at the start of the financial year. As funding approvals have been received later than anticipated, the current expenditure profile is no longer fully reflective of scheme delivery timelines.

Delays in funding confirmations and approval requirements present a risk to delivery of schemes within the current financial year, particularly for the £3m of CS/LS schemes over £1m requiring Programme of Works (POW). There is a risk that some expenditure and associated funding may need to be deferred should approvals and capital works not be undertaken within the required timescales. These risks have been discussed with NHS England and continue to be actively monitored. NHSE have requested a capital reforecasting exercise this month, and

the results of this will allow a greater understanding of what level of spend can be managed within the system and what may still need NHSE support to manage.

As the graph below indicates, capital expenditure is historically slow at the beginning of each financial year, with a significantly higher spend in month 12. The Month 5 spends shows a slight down-tick in profile.



CS/LS = Constitutional Standards/Left Shift schemes

Capital changes since last month:

There we no major changes since last month.

Several smaller transfers between schemes <£20k were made to reallocate funds for catering equipment purchases at Willows and Bradgate units.

APPENDIX F SoFP, cash and working capital

PERIOD: August 2026	2025/26 31/03/26 Draft £'000's	2026/27 31/08/26 August £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	135,011	134,389
Intangible assets	3,310	2,709
IFRS16 - Right of use (ROU) assets	19,421	18,435
Trade and other receivables	821	821
Total Non Current Assets	158,563	156,354
CURRENT ASSETS		
Inventories	461	469
Trade and other receivables	7,155	11,795
Short term investments	0	0
Cash and Cash Equivalents	20,941	21,289
Total Current Assets	28,557	33,553
Non current assets held for sale	0	0
TOTAL ASSETS	187,120	189,907
CURRENT LIABILITIES		
Trade and other payables	(26,927)	(35,103)
Borrowings	(4,958)	(4,959)
Provisions	(5,031)	(4,787)
Other liabilities	(7,701)	(6,077)
Total Current Liabilities	(44,617)	(50,926)
NET CURRENT ASSETS (LIABILITIES)	(16,060)	(17,373)
NON CURRENT LIABILITIES		
Borrowings	(39,040)	(37,503)
Provisions	(704)	(704)
Total Non Current Liabilities	(39,744)	(38,207)
TOTAL ASSETS EMPLOYED	102,759	100,774
TAXPAYERS' EQUITY		
Public Dividend Capital	112,834	112,834
Retained Earnings	(28,595)	(30,580)
Revaluation reserve	18,520	18,520
Other reserves	0	0
TOTAL TAXPAYERS EQUITY	102,759	100,774

Non-current assets

Property, plant, and equipment (PPE) amounts to £134.4m, and includes capital additions of £2,871k, offset by depreciation charges.

Right of Use (ROU) leased assets total £18.4m.

Current assets

Current assets of £33.6m mainly includes cash of £21.3m, and receivables of £11.8m.

Current Liabilities

Current liabilities amount to £50.9m with trade and other payables making up £35.1m of this balance.

Other liabilities of £6.1m mainly relate to deferred income carried over from 2025/26.

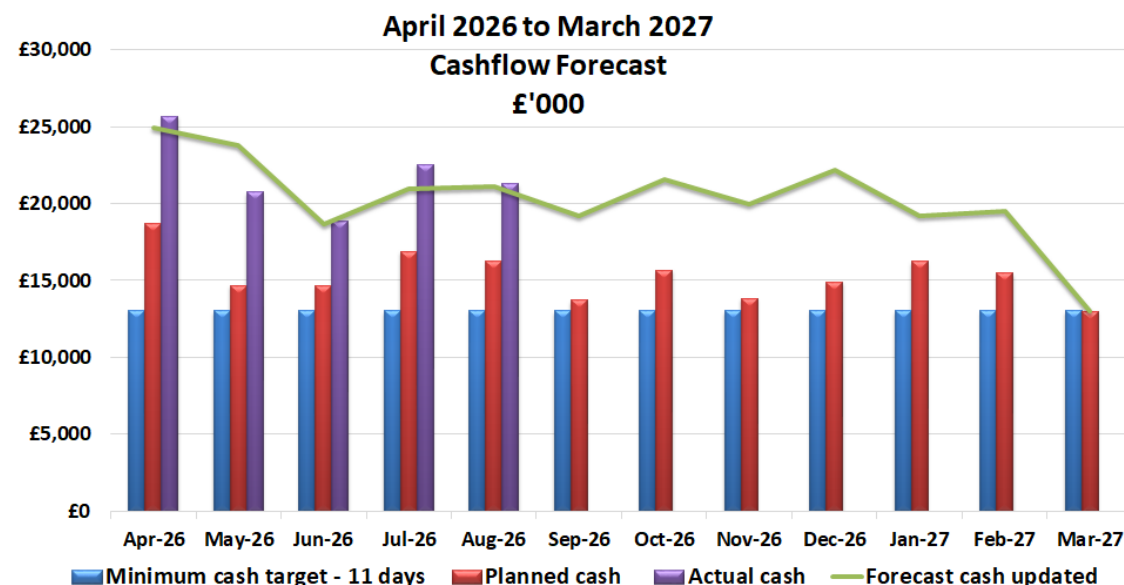
Net current assets / (liabilities) show net liabilities of £17.4m.

Taxpayers' Equity

August's deficit of £1.99m is reflected within retained earnings.

The Public dividend capital balance is £113m at the end of August. 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 August is £21.3m; an increase of £348k since the start of the year and an additional £5m compared to August's planned cash of £16.3m. This delivers 18 operating cash days - 4 days above the planned level of 14 days for Month 5. 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	21,075	19,192	21,587	19,956	22,180	19,220	19,530	13,000
Actual cash	25,664	20,760	18,856	22,531	21,289							

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	18	16	18	17	19	16	17	11
Actual cash days	22	18	16	19	18							

Receivables

Current receivables (debtors) total £11.8m, an increase of £4.6m since the start of the year. The increase mainly relates to accruals and prepayments.

Receivables	Current Month August 2026					
	NHS	Non	Emp's	Total	% Total	% Sales Ledger
	£'000	£'000	£'000	£'000		
Sales Ledger						
30 days or less	1,280	1,822	4	3,106	24.62%	63.0%
31 - 60 days	794	264	7	1,065	8.44%	21.6%
61 - 90 days	358	128	4	490	3.88%	9.9%
Over 90 days	52	10	206	268	2.12%	5.4%
	2,484	2,224	221	4,929	39.07%	100.0%
Non sales ledger	2,903	3,963	0	6,866	54.42%	
Total receivables current	5,387	6,187	221	11,795	93.49%	
Total receivables non current		821		821	6.51%	
Total	5,387	7,008	221	12,616	100.00%	0.0%

Debt greater than 90 days stands at £268k; this is a decrease of £11k 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 5 is 2.12% (last month: 2.07%). The monthly % has increased this month despite the 90 day debt value reducing - this is due to the overall total debt value reducing this month.

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

Payables

The current payables position in month 5 is £35.1m – an increase of £8.2m since the start of the year. Other liabilities of £6.1m relate to deferred income carried over from 2025/26, the majority of which relates to Provider Collaborative income.

APPENDIX G Risk adjusted forecast outturn

The table below shows a range of risk adjusted forecasts under best, likely and worst case assumptions.

The improvement in the directorate overspend rates has in turn led to an improvement in the operational / directorate year end forecast (from a £5m overspend in M3 down to £3.9m). However, the level of pay award funding to be allocated within the system is assumed to result in a £0.9m shortfall for LPT. Accordingly, the range of risk adjusted year end forecast has remained largely unchanged since month 3.

The best case forecast shows an I&E break-even (delivering our plan target), but does assume a level of directorate recovery still to be confirmed. The likely case – even assuming a level of further recovery – shows a deficit of £2.7m.

DIRECTORATES	VARIANCE		
	BEST CASE £000	LIKELY FOT £000	WORST CASE £000
DMH	(2,871)	(3,430)	(3,967)
CHS	(1,200)	(1,600)	(2,600)
FYPC	300	200	0
LD	(100)	(200)	(300)
ESTS	0	(154)	(754)
ENABLING	1,416	1,226	500
HOSTED	150	50	(200)
TOTAL DIRECTORATE FOT VARIANCE:	(2,305)	(3,908)	(7,321)

CORPORATE / NOT ALLOCATED	BEST CASE £000	LIKELY FOT £000	WORST CASE £000
<u>Delivery against original plan gap mitigations / contingencies</u>			
£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
<u>Other mitigations identified to date</u>			
Interest receivable gain over budget:	250	100	(50)
Directory recovery actions to be confirmed (target):	1,293	1,000	0
--			
Sub-total after further mitigations target:	2,305	2,100	450
<u>Other Corporate/Trust wide pressures</u>			
Pay award funding shortfall (assuming funded at CUF):	0	(911)	(911)
Nursing band 5 job evaluation (TBC):	0	0	(1,000)
TOTAL CORPORATE PRESSURES / MITIGATIONS:	2,305	1,189	(1,461)
TOTAL TRUST	0	(2,719)	(8,782)

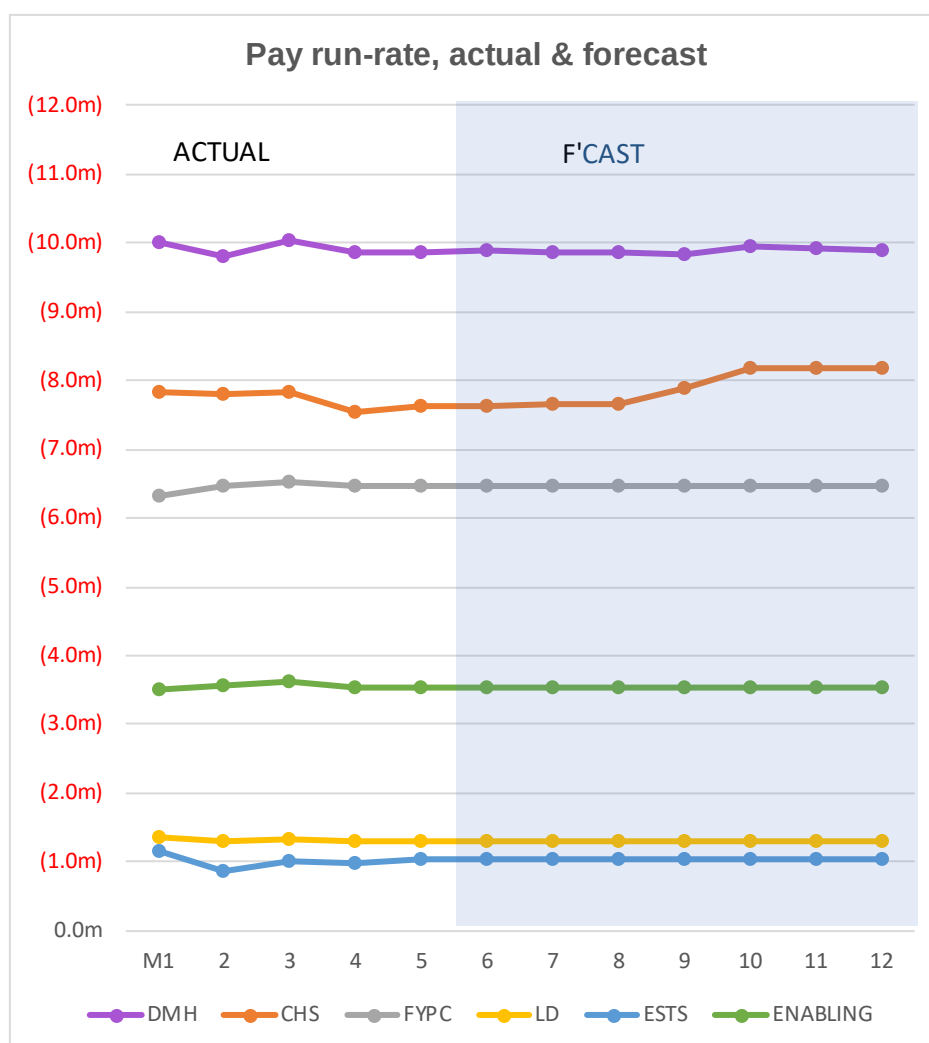
**In a best case scenario, any available transformation funding would likely be utilised to provide for future year costs subject to satisfying accounting requirements for financial provisions*

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).

Most directorates' costs appear relatively static in the likely forecast. This suggests that further cost improvement is required to meet the expectations of this year's financial plan and to also ensure that run-rates have reduced as we roll forward into the 27/28 financial year. Note that costs within CHS increase in the later months of the year on the assumption that Gracedieu Ward will again be opened to support winter pressures, along with some safer staffing recruitment.



Governance Table

For Board and Board Committees:	Trust Board meeting, 29 th September 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:	21 st September 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:	☐ Technology ☐ Healthy communities ☐ Responsive ☐ Including everyone ☐ Valuing our people ☒ Efficient 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



Public Trust Board – 29th September 2026

Integrated Performance Report: August 2026 (Month 5)

Purpose of the Report

To provide the Trust Board with an overview of Trust performance against an agreed set of KPI's for August 2026 (M5 of 2026/27).

Analysis of the Issue

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

Proposal

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

- The Delayed Transfers of Care/Clinically Ready for Discharge (DToC/CRFD) exception page has been temporarily removed pending the availability of Community Health Services (CHS) DToC data. This is expected to be reinstated in the next reporting cycle.
- A data quality issue has been identified relating to the locally reported metric 'number of children and young people with mental health waits over 104 weeks (help-based clock stop)', resulting to under-reporting in previous months, leading to reported figures for August increasing compared to July. We expect the downward trajectory to be re-established from September onwards and for the year end target of zero to be achieved and we remain above our planned position.
- The NHS Oversight Framework (NoF) section has been reinstated, presenting the Trust's current position alongside NHS Oversight Framework Q1 2026/27 scores.
- Flu vaccination performance data will be incorporated from November 2026, with reporting included within both the NHS Oversight Framework and Workforce Dashboard.

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 **assurance** from the previous month are as follows:

- From no assurance to consistently failing the target
 - o Dynamic Psychotherapy - Treatment waits - No of waiters
- From consistently failing the target to no assurance
 - o Sickness Absence

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

- From *common cause* to *special cause concerning higher values*
 - o No. of Category 2 pressure ulcers developed or deteriorated in LPT care
 - o Sickness Absence Costs
- From *special cause concerning higher values* to *common cause*
 - o The number of patient safety incidents reported within the Trust during the reporting period
 - o Total number of Restrictive Practices
 - o All Neurodevelopment (inc. CAMHS, SALT, PAEDS) - Treatment waits - 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:

- o 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:	18.09.2026
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:	☐ Technology ☒ Healthy communities ☒ Responsive ☒ Including everyone ☒ Valuing our people ☒ Efficient 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



Leicestershire Partnership
NHS Trust

Integrated Board Performance Report

August 2026 (Month 5)

Our group strategy



T Technology



H Healthy Communities



R Responsive



I Including everyone



V Valuing our people

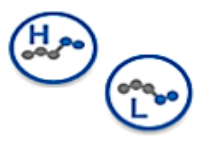


E Efficient and effective

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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 52Wks / TSPPD 52 wks / Medical_Neuro 52 wks / Stroke & Neuro / Speech Therapy / Community Paediatrics Treatment 52 Wks / Children's Physiotherapy 52 wks Safe staffing - Day
	Common Cause 	Gatekeeping MRSA Infection Rate / Clostridium difficile infection rate Staff with a Completed Annual Appraisal / % staff clinical supervision	Sickness Absence	Waiting Times: ADHD / Children's Audiology / CMHT 52 Wks / MHSOP Memory Clinic 52 Wks / All Neurodevelopment 52 Wks / CAMHS - Treatment waits
	Special Cause - Concern 			Waiting Times: Memory Clinic / Community Paediatrics / ADHD 52 weeks / Community Paediatrics 52 wks assessment

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%	Jul-26	80.5%	77.3%		
Memory Clinic (18 week local RTT) - Incomplete pathway	>=92%	Jul-26	45.3%	45.9%		
ADHD (18 week local RTT) - Incomplete pathway	>=92%	Jul-26	4.1%	4.8%		
CINSS (6 weeks) - Incomplete pathway	>=95%	Jul-26	58.2%	54.2%		
Speech Therapy - Voice, Respiratory and Dysfluency - Routine (6 weeks) - Incomplete pathway	>=95%	Jul-26	44.6%	34.2%		
Community Paediatrics (18 weeks) - Incomplete pathway	>=92%	Jul-26	7.6%	7.8%		
Childrens Audiology (6 week wait for diagnostic procedures) - Incomplete pathway	>=99%	Jul-26	29.1%	32.9%		

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

Workforce						
Vacancy Rate	<=10%	Aug-26	9.8%	9.9%		

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	Aug-26	0	0		
Cognitive Behavioural Therapy	0	Aug-26	15	17		
Dynamic Psychotherapy	0	Aug-26	0	0		
Therapy Service for People with Personality Disorder	0	Aug-26	0	0		
Medical/Neuropsychology	0	Aug-26	47	44		
ADHD (18 week local RTT) - assessment waits	0	Jul-26	8181	8053		
MHSOP Memory Clinics (18 week local RTT) - assessment waits	0	Jul-26	35	29		
Community Paediatrics - assessment waits	0	Jul-26	7899	7795		
Community Paediatrics Treatment (excl ND)	0	Aug-26	0	5		
All Neurodevelopment (inc CAMHS, SALT, PAEDS)	0	Aug-26	1369	1570		
CAMHS - Treatment waits (excl ND)	0	Aug-26	76	88		
Children's Physiotherapy	0	Aug-26	0	0		

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	Aug-26	0	0		
Clostridium difficile infection rate	<=12	Aug-26	0	0		

Quality & Safety Dashboard						
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%	Aug-26	100.0%	100.0%		

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%	Aug-26	6.8%	6.6%		
Core Mandatory Training Compliance for substantive staff	>=85%	Aug-26	98.6%	98.7%		
Staff with a Completed Annual Appraisal	>=80%	Aug-26	94.9%	95.9%		
% of staff from a BME background	>=22.5%	Aug-26	34.3%	34.1%		
% of staff who have undertaken clinical supervision within the last 3 months	>=85%	Nov-25	94.2%	94.4%		

Trust Headlines

Overall CQC rating (provision of high-quality care) = 2

CQC Well Led rating = 2

Q1 Overall NOF Rating = 2

Operational Performance - Waiting Times	Operational Performance - Over 52 week waits (access / treatment)	Quality & Safety	Workforce	NHS Oversight - Operational Planning	NOF
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, trajectories added to the report support visibility of delivery. All trajectories have now been added and are fixed for the full year with variance addressed in individual exception reports. Improvement in performance remains variable across the services. The trend for positive change in Adult Neighbourhood Mental Health teams continues, however increased referral numbers in recent months is making this exceptionally challenging. 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 and has no waits over 52 weeks. 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 all have a deteriorating position with demand continuing to outstrip capacity, actions are in place to improve productivity and deliver transformation. 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 with a focus on ensuring all waits are appropriately categorised and reported; as part of this work a paper was taken to EMB in September identifying that CAMHS treatment waits had been incorrectly recorded and require recategorising as follow-up waits. This will reduce reported numbers waiting alongside ensuring robust mechanisms are in place to monitor the timing of follow-ups with clear routes for escalation where these become a concern. Psychological therapies continue to make exceptional 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 and this month delivered as zero over 52 week position as did Dynamic Psychotherapy (DPS). Cognitive Behavioural Therapy (CBT) continue to balance assessment and treatment activity to reduce numbers of over 52 week waiters. A reduction was also seen in the number of children waiting for treatment for ND disorders although numbers waiting for assessment continue to grow. Numbers waiting over 52 weeks continue to increase in Medical Psychology, Memory Services and Adult ADHD. Overall numbers waiting over 52 weeks, and the longest wait within this, continue to increase due in the main to numbers waiting in services relating to adults and children with neurodevelopmental disorders. Achieving sustainable change in these services require a system-wide transformation programmes which are under development with system partners in ICB, education, VCSE and primary care. In the interim internal transformation activities are in place to maximise opportunities to deliver improvements to the LPT element of the wider offer.	The report demonstrates a fifth consecutive month of 100% compliance with gatekeeping standards on mental health inpatient wards. August saw an overall reduction in the number of patient safety incidents, however there was an increase in the number and % of these resulting in severe harm or death. More detail on these incidents including any themes are contained within the Safety Assurance Report provided to Trust Board on a bi-monthly basis. Performance against the 72 hour follow-up standard continues to be above target and continues on an upward trajectory (this data is extracted from the national mental health core data pack and is reported in arrears). The number of complaints increased slightly in month whilst concerns and compliments decreased in the month, these changes are all within the expected tolerance. The numbers of wards not meeting safer staffing standards remains above the target of zero with 1 ward non-compliant for night shifts (down from 2 last month) however no wards breached this standard for day shifts (down from 1 last month). Numbers of seclusions increased slightly from 15 to 17, however the number of restrictive practices continued the reduction seen last month falling from 280 to 208. One restraint (prone) were reported in month. Numbers of pressure ulcers developed in LPT care decreased across all categories however the number of repeat falls increased from 38 to 58. The 'clock' for annual health checks restarts on 1 April each year and compliance, whilst appearing low, is improving and 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. The costs associated with sickness absence fell in month despite the higher levels of sickness reported.	Delivery against MH length of stay (3 month rolling average) was below trajectory for adult and PICU beds, increasing again in August with a 3 month rolling average of 60 days against a target of 51.5. Performance for beds for older people improved this month with a 3 month rolling average of 86.9 compared to 93.4 in July, however this remains above the target of compared to 86.8 in June, against a target of 77.5. There were no inappropriate out of area placements or bed days in August, this is in line with our target of zero. Compliance with the target for adults to wait no more than 18 weeks for community services remained high at 99.2% compared to 98.8% in July. Although the plan for the % of children waiting 18 weeks or less was exceeded, % compliance with the 18 week target remains low at 22.4% but has improved from the 22.1% compliance in July. 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 has increased this month following the identification of a data quality issue with historic data. We continue to expect to meet our year end target and remain above plan. 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 below expected levels for community contacts for adults and children and this is being investigated.	The NoF dashboard has been reinstated and contains an up to date position for all indicators using local and national data aligned to the relevant metric alongside the Trust's domain rankings for published NoF data for Q1. The Trust is demonstrating strong performance against the range of NoF metrics with the exception of over 52 week waits for community services which negatively impacts on our Access to Services score. An updated NoF dashboard will be included in the IPR each month, using local and national data to demonstrate performance on published metrics alongside the current NoF scoring for each domain; the latter will change quarterly as updated NoF scores are made public.

NHS Oversight Framework 2026-27

Domain	Source	Reporting Frequency	Indicator	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	Q1 Published Score
Access to services	Trust	Monthly	% of community wait list, where patients are waiting less than 18-weeks	Aug-26	57.6%	55.9%		3.04
	Trust	Monthly	% of community wait list, where patients are waiting more than 52-weeks	Aug-26	35.3%	36.7%		
	Trust	Monthly	% discharged from CMH with 2+ contacts & a paired outcome score (Adults)	Aug-26	6.1%	5.6%		
	Trust	Monthly	% discharged from CMH with 2+ contacts & a paired outcome score (CYP)	Aug-26	46.4%	48.0%		
	National	Monthly	% of CYP waiting 104+ weeks for a 'Help-Based Clock Stop'	Jun-26	23.0%	22.0%		
Experience of care	Trust	Monthly	% of intermediate care beds occupied by patients with 'no criteria to reside'	Aug-26	23.4%	28.9%		2.13
	Trust	Monthly (in arrears) (3-month average)	Mean length of stay for adult acute and PICU inpatients (at point of discharge)	Aug-26	60.0	54.6		
	Trust	Monthly (in arrears) (3-month average)	Mean length of stay for older adult acute inpatients (at point of discharge)	Aug-26	85.7	93.6		
	National	Annual Survey	CQC community mental health survey satisfaction rate	2025/26	2	2		
	National	Annual Survey	NHS Staff Survey – Advocacy Rate	2025/26	7.07			
Effectiveness of care and population health	Trust	Monthly	% of patients discharged from MH inpatients, who are re-admitted within 14-days	Aug-26	2.5%	3.1%		1.54
	National	Quarterly (rolling 12 months)	% of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	Mar-26	15.6%			
	Trust	Monthly	% of adult acute/ rehab discharged who have a follow-up appt within 72-hours	Aug-26	89.8%	91.5%		
Patient safety	Trust	Monthly	% Urgent MH crisis referrals to receive 1st face-to-face contact within 24-hours	Aug-26	87.0%	74.4%		1.29
	National	Annual	NHS Staff Survey – Raising Concerns sub-score	2025/26	6.93	6.96		
Finance and productivity and innovation	Trust	Annual Plan	Planned surplus or deficit	2025/26	£313k	n/a		1.55
	Trust	Monthly (Year to date)	Variance to Plan (Year-to-date)	Aug-26	£0	£0		
	Trust	Monthly	Combined Finance Score	Aug-26	1	1		
	National	Annual Plan	Relative Cost Difference (National Cost Collection Index)	2024/25	95.1%			
	National	Monthly	Data Quality Maturity Index	Aug-26	92.8			
People	Trust	Monthly (in arrears) (Rolling twelve months)	Sickness Absence Rate	Jul-26	5.5%	5.7%		1.91
	Trust	Monthly	Temporary staffing cost	Aug-26	£295,746.84	£500,034.28		
	Trust	Monthly	% of frontline Healthcare Worker Flu Vaccine administered by the NHS	Aug-26				
	National	Annual	NHS Staff Survey – Engagement Theme score	2025/26	7.12	7.20		
	National	Annual	NHS Staff Standards Score (predicted)	2025/26	7.97			
	National	Annual	National Education & Training Survey – Satisfaction rate	2025/26	80.7%			

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	<=51.5	Aug-26	60.0	54.8				
	TRUST	Monthly (3 month rolling)	Average Length of Stay in Older Adult Acute MH Beds	<=77.5	Aug-26	86.9	93.4				
	TRUST	Monthly	Active inappropriate adult acute mental health out of areas placements (OAPs)	0	Aug-26	0	0				
	TRUST	Monthly	Percentage of people on waiting lists per system who are waiting 18 weeks or less - Adult Community Services	Plan=97%	Aug-26	99.2%	98.8%				
	TRUST	Monthly	Percentage of people on waiting lists per system who are waiting 18 weeks or less - CYP Services	Plan=19%	Aug-26	22.4%	22.1%				
	TRUST	Monthly	Community Services waiting list over 52 weeks	Target =0 Plan=7672	Aug-26	7857	7926				
	TRUST	Monthly	Attended Community Care Contacts - CHS	Plan=90998	Aug-26	81463	88594				
	TRUST	Monthly	Attended Community Care Contacts - FYPC	Plan=10326	Aug-26	8352	9420				
	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=300	Aug-26	247	206				
	TRUST	Monthly	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	Target = 0% Plan=88%	Aug-26	66.7%	66.6%				
	TRUST	Monthly	Reliance on specialist inpatient care for adults with a learning disability and/or autism	23	Aug-26	30	29				
	TRUST	Monthly	Reliance on specialist inpatient care for children with a learning disability and/or autism	3	Aug-26	4	4				

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		Aug-26	23.4%	28.9%				
	TRUST	Monthly	Out of Area Placement - Inappropriate Bed Days	0	Aug-26	0	0				
	TRUST	Monthly	Occupancy Rate - Adult Acute & PICU MH Beds (excluding leave)	<=85%	Aug-26	92.2%	91.6%				
	TRUST	Monthly	Occupancy Rate - Older Adult Acute MH Beds (excluding leave)	<=85%	Aug-26	84.5%	86.4%				
	TRUST	Monthly	Occupancy Rate - Community Beds (excluding leave)	>=93%	Aug-26	92.6%	92.9%				
	TRUST	Monthly	Delayed Transfers of Care - Trust	<=3.5%	Aug-26						
	TRUST	Monthly	Clinically Ready for Discharge (CRFD) - DMH	<=3.5%	Aug-26	10.4%	12.7%				
	TRUST	Monthly	Delayed Transfers of Care (DTOC) - CHS	<=3.5%	Aug-26						
	TRUST	Monthly	Admissions to adult facilities of patients under 18 years old	0	Aug-26	0	0				

Quality & Safety Dashboard

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Quality Account	TRUST	Monthly	The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period	>=95%	Aug-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		Aug-26	0.0%	0.0%				
	TRUST	Monthly	The percentage of inpatients discharged with a subsequent inpatient admission within 30 days - 16+ years		Aug-26	8.8%	5.1%				
	TRUST	Monthly	The number of patient safety incidents reported within the Trust during the reporting period		Aug-26	1796	2032				
	TRUST	Monthly	The rate of patient safety incidents reported within the Trust during the reporting period		Aug-26	68.8%	68.5%				
	TRUST	Monthly	The number of such patient safety incidents that resulted in severe harm or death		Aug-26	11	8				
	TRUST	Monthly	The percentage of such patient safety incidents that resulted in severe harm or death		Aug-26	0.6%	0.4%				
	MHSDS	Monthly (a quarter in arrears)	72 hour follow Up after discharge (Aligned with national published data)	>=80%	Jun-26	95.0%	91.0%				
Quality & Safety	TRUST	Monthly	No. of Complaints		Aug-26	38	30				
	TRUST	Monthly	No. of Concerns		Aug-26	41	55				
	TRUST	Monthly	No. of Compliments		Aug-26	206	238				
	TRUST	Monthly	Safer staffing - No. of wards not meeting >80% fill rate for RNs - Day	0	Aug-26	0	1				
	TRUST	Monthly	Safer staffing - No. of wards not meeting >80% fill rate for RNs - Night	0	Aug-26	1	2				
	TRUST	Monthly	Care Hours per patient day		Aug-26	10.5	10.8				
	TRUST	Monthly	No. of Long term Segregations		Aug-26	0	0				

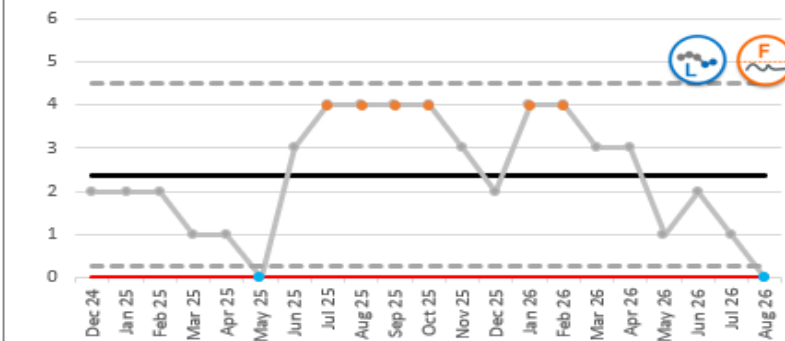
Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
	TRUST	Monthly	No. of episodes of seclusions		Aug-26	17	15				
	TRUST	Monthly	No. of episodes of prone (supported) restraint		Aug-26	1	2				
	TRUST	Monthly	No. of episodes of prone (unsupported) restraint		Aug-26	0	0				
	TRUST	Monthly	Total number of Restrictive Practices		Aug-26	232	280				
	TRUST	Monthly (In Arrears)	No. of Category 2 pressure ulcers developed or deteriorated in LPT care		Jul-26	142	145				
	TRUST	Monthly (In Arrears)	No. of Category 3 pressure ulcers developed or deteriorated in LPT care		Jul-26	15	22				
	TRUST	Monthly (In Arrears)	No. of Category 4 pressure ulcers developed or deteriorated in LPT care		Jul-26	13	14				
	TRUST	Monthly (In Arrears)	No. of repeat falls		Jul-26	58	34				
	TRUST	Monthly	No. of Medication Errors		Aug-26	73	94				
	TRUST	Monthly	LD Annual Health Checks completed - YTD		Aug-26	29.3%	20.9%				
	MHRA	Monthly	National Patient Safety Alerts not completed by deadline		Aug-26	1	1				
	TRUST	Monthly	MRSA Infections	0	Aug-26	0	0				
	TRUST	Monthly	Clostridium difficile infections	Annual <=12	Aug-26	0	0				
	UHL	Monthly (In Arrears)	E.coli bloodstream infections		Jul-26	0	0				
	GOV	Monthly (YTD)	Percentage of people aged 65 and over who received a flu vaccination		Aug-26						

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

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

Mean	Lower Process Limit	Upper Process Limit
2	0	5

Safe staffing - No. of wards not meeting >80% fill rate for RN Day shifts:



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
FYPCLDA 1 The Grange & The Gillivers - LD Short Breaks The amalgamation of the short break homes into a single reporting line enables a more accurate picture of staffing levels in the day.			

Achievements

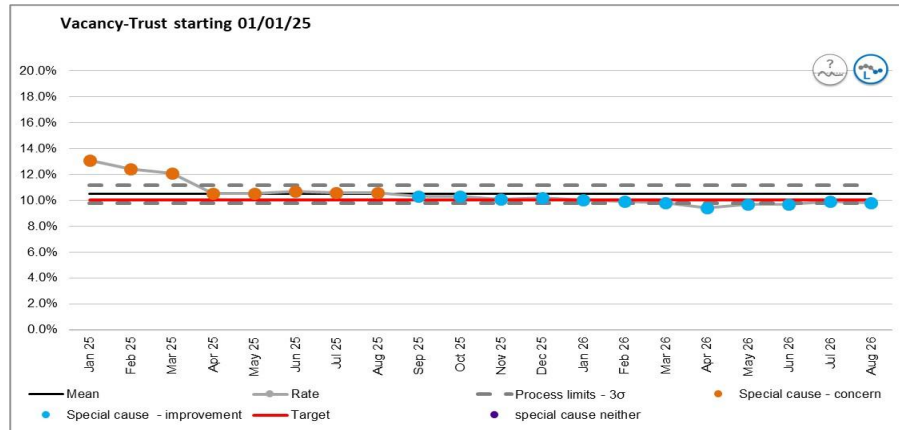
Workforce Dashboard

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%	Aug-26	6.8%	6.6%				
	TRUST	Monthly	Vacancy Rate	<=10%	Aug-26	9.8%	9.9%				
	TRUST	Monthly (In Arrears)	Sickness Absence	<=5.0%	Jul-26	6.1%	5.8%				
	TRUST	Monthly (In Arrears)	Sickness Absence Costs		Jul-26	£1,373,524	£1,271,184				
	TRUST	Monthly (In Arrears)	Sickness Absence - YTD	<=5.0%	Jul-26	5.5%	5.7%				
	TRUST	Monthly	Core Mandatory Training Compliance for substantive staff	>=85%	Aug-26	98.6%	98.7%				
	TRUST	Monthly	Staff with a Completed Annual Appraisal	>=80%	Aug-26	94.9%	95.9%				
	TRUST	Monthly	% of staff from a BME background	>=22.5%	Aug-26	34.3%	34.1%				
	TRUST	Monthly	Staff flu vaccination rate (frontline healthcare workers)		Aug-26						
	TRUST	Monthly	% of staff who have undertaken clinical supervision within the last 3 months	>=85%	Aug-26	93.5%	93.4%				

EXCEPTION REPORT - Vacancy Rate

	Target	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
TRUST	<=10%	10.3%	10.3%	10.1%	10.2%	10.0%	9.9%	9.8%	9.4%	9.7%	9.7%	9.9%	9.8%
DMH		13.1%	13.2%	13.3%	12.7%	12.8%	12.4%	12.4%	12.2%	12.1%	12.0%	12.4%	11.6%
CHS		9.9%	9.3%	8.5%	8.9%	8.4%	8.2%	7.9%	8.2%	8.2%	8.3%	8.8%	8.7%
FYPCLDA		9.3%	9.1%	9.3%	9.7%	9.5%	9.8%	9.5%	9.2%	10.8%	10.7%	10.6%	11.2%

Mean	Lower Process Limit	Upper Process Limit
10.5%	10.0%	11.0%



Analytical Commentary

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

Operational Commentary

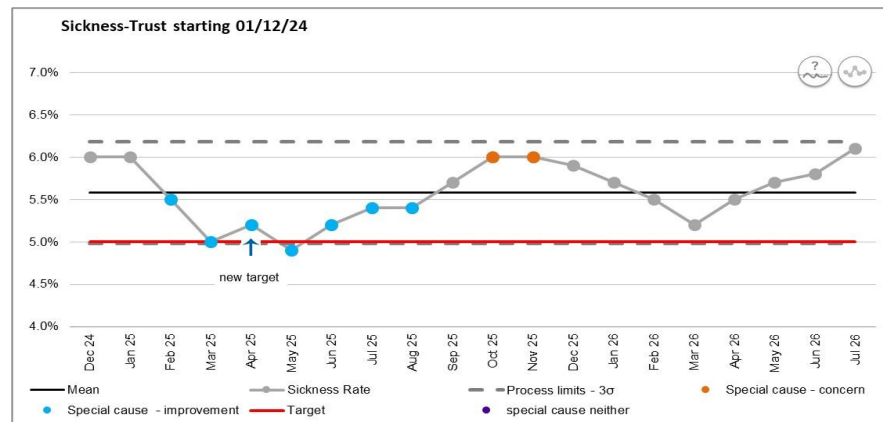
Actions	Timescales	Consequences	RAG
Workforce plan in place. This includes plans to recruit substantively to some vacancies in order to reduce the need to fill vacant post with bank or agency staff.	Mar-27	By the end of 26/27, we plan for a vacancy rate of 8.5%. This is based on an assumption there will 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	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
TRUST	<=5.0%	5.4%	5.7%	6.0%	6.0%	5.9%	5.7%	5.5%	5.2%	5.5%	5.7%	5.8%	6.1%
DMH		6.1%	6.7%	7.1%	7.3%	6.8%	6.6%	6.1%	5.8%	6.2%	6.5%	7.0%	7.2%
CHS		6.3%	6.7%	6.5%	6.3%	6.0%	6.0%	6.2%	5.4%	5.8%	6.3%	6.5%	6.8%
FYPCLDA		5.1%	5.0%	5.5%	5.9%	6.3%	5.6%	5.4%	5.4%	5.9%	5.7%	5.1%	5.2%

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



Analytical Commentary

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

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.	Complete
Implement actions arising from the 360 assurance audit into sickness absence.	Jul-27	Actions include enhanced support to managers and changes to processes to enable improved compliance with the Attendance Management and Wellbeing Policy.	
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

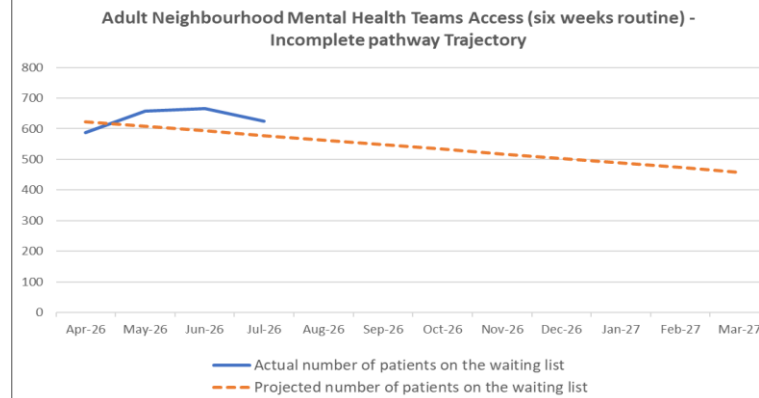
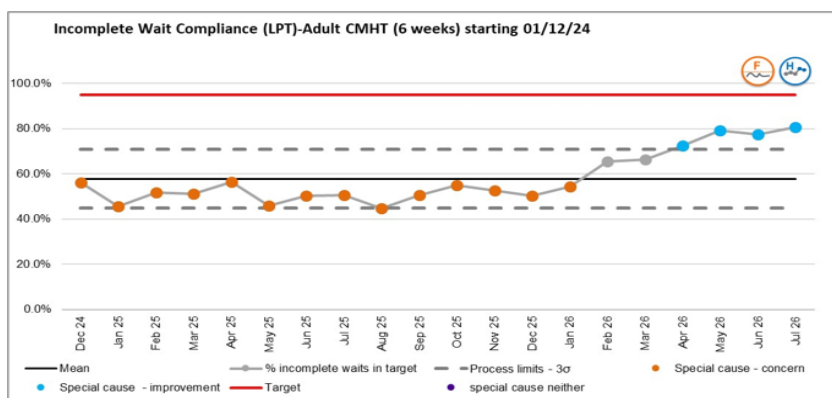
Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Finance	TRUST	Monthly	Variance to Plan - I&E (£000)	>=0	Aug-26	£0	£0				
	TRUST	Monthly	Variance to Plan – efficiency (£000)	>=0	Aug-26	£0	£0				
	TRUST	Monthly	Variance to Plan – capital spend (£000)	£0	Aug-26	£475k	£317k				
	TRUST	Monthly	Variance to Plan – agency spend (£000) - YTD	>=0	Aug-26	£131k	£-60k				
	TRUST	Monthly	Agency Spend % of Total Pay - YTD	<=1.87%	Aug-26	0.96%	1.6%				
	TRUST	Monthly	Agency annual expenditure cap – FOT performance	<=6,749,000	Aug-26	£4,721,000	£4,939,000				
	TRUST	Monthly	Bank annual expenditure cap – FOT performance	<=20,361,000	Aug-26	£20,361,000	£20,361,000				

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%	Jul-26	80.5%	77.3%				
	TRUST	Monthly (In Arrears)	Memory Clinic (18 week Local RTT) - Incomplete pathway	>=92%	Jul-26	45.3%	45.9%				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - Incomplete pathway	>=92%	Jul-26	4.1%	4.8%				
	TRUST	Monthly (In Arrears)	Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral - complete pathway	>=60%	Jul-26	61.3%	58.8%				
Operational Performance - 52 Week Waits	TRUST	Monthly (In Arrears)	Adult Psychiatry - Neighbourhood Mental Health Teams - Assessments waits over 52 weeks - No of waiters	0	Jul-26	0	2				
	TRUST	Monthly (In Arrears)	Adult Psychiatry - Neighbourhood Mental Health Teams - Assessments waits over 52 weeks - Longest waiter (weeks)		Jul-26	44	209				
	TRUST	Monthly	Adult Psychiatry – Neighbourhood Mental Health Teams – Treatment waits - No of Waiters	0	Aug-26	0	0				
	TRUST	Monthly	Adult Psychiatry – Neighbourhood Mental Health Teams – Treatment waits - Longest Waiter		Aug-26	14	15				
	TRUST	Monthly	Cognitive Behavioural Therapy - Treatment waits - No of waiters	0	Aug-26	15	17				
	TRUST	Monthly	Cognitive Behavioural Therapy- Treatment waits - Longest waiter (weeks)		Aug-26	69	85				
	TRUST	Monthly	Dynamic Psychotherapy - Treatment waits - No of waiters	0	Aug-26	0	0				
	TRUST	Monthly	Dynamic Psychotherapy - Treatment waits - Longest waiter (weeks)		Aug-26	45	47				
	TRUST	Monthly	Therapy Service for People with Personality Disorder - Treatment waits - No of waiters	0	Aug-26	0	0				
	TRUST	Monthly	Therapy Service for People with Personality Disorder - Treatment waits - Longest waiter (weeks)		Aug-26	35	23				
	TRUST	Monthly	Medical/Neuropsychology - Treatment waits - No of Waiters	0	Aug-26	47	44				
	TRUST	Monthly	Medical/Neuropsychology- Treatment waits - Longest Waiter		Aug-26	124	119				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	Jul-26	8181	8053				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - assessment waits over 52 weeks - Longest waiter (weeks)		Jul-26	270	265				
	TRUST	Monthly (In Arrears)	MHSOP Memory Clinics (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	Jul-26	35	29				
	TRUST	Monthly (In Arrears)	MHSOP Memory Clinics (18 week local RTT) - assessment waits over 52 weeks -Longest waiter (weeks)		Jul-26	88	83				

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

DMH	Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Mean	Lower Process Limit	Upper Process Limit
	>=95%	44.6%	50.5%	54.9%	52.5%	50.4%	54.4%	65.5%	66.2%	72.5%	79.3%	77.3%	80.5%	57.8%	45.0%	71.0%
No of Referrals		344	439	539	474	476	520	598	659	511	531	595	650			



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

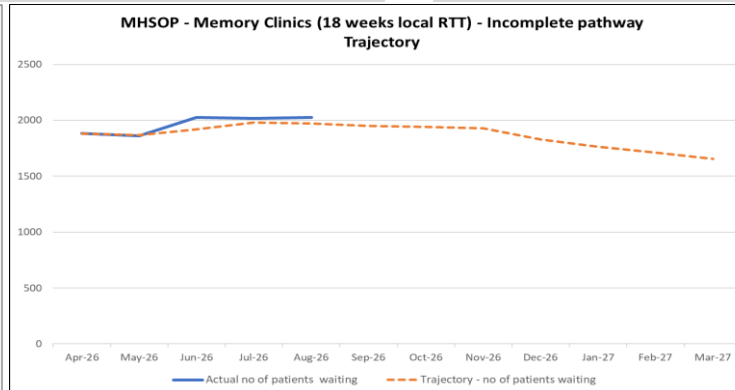
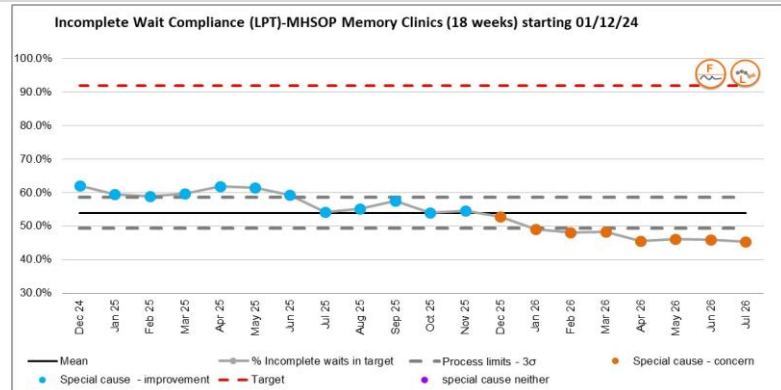
Actions	Timescales	Consequences	RAG
Substantive recruitment to Consultant posts with recruitment plan in place. 3 substantive Consultants recruited to date.	Oct-26	Increase capacity and reduce waiting times.	
Additional actions to increase capacity and improve flow include: - Dedicated medic and B7 nurse time to further support caseload reviews in North-West Leicestershire enabling appropriate patients to be booked into discharge clinics in October 2026. - Additional nurse clinics in City East, City West and North West Leicestershire to support medic capacity and caseload management. - Band 7 Non-Medical Prescriber facilitating annual reviews for stable depot patients in city teams will increase medic capacity. - Senior clinical and operational leads reviewing all workstreams to support delivery of phased plan for 26/27 - Review of caseloads will identify patients open to multiple team members and ensure this occurs only where remains appropriate.	Dec-26	Improve flow through the Neighbourhood Mental Health Teams. Sustained reduction in waiting times. Ensure patients seen for follow up as planned. Impact of actions monitored at weekly Community Waiting Times Meetings.	

Achievements

% compliance shows an improving trend with significant improvement seen in last two quarters

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

DMH	Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Mean	Lower Process Limit	Upper Process Limit
	>=95%	55.1%	57.6%	54.0%	54.6%	52.9%	49.1%	48.1%	48.3%	45.6%	46.1%	45.9%	45.3%	54.0%	49.0%	59.0%
No of Referrals		203	279	267	224	230	234	227	267	184	184	265	277			



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

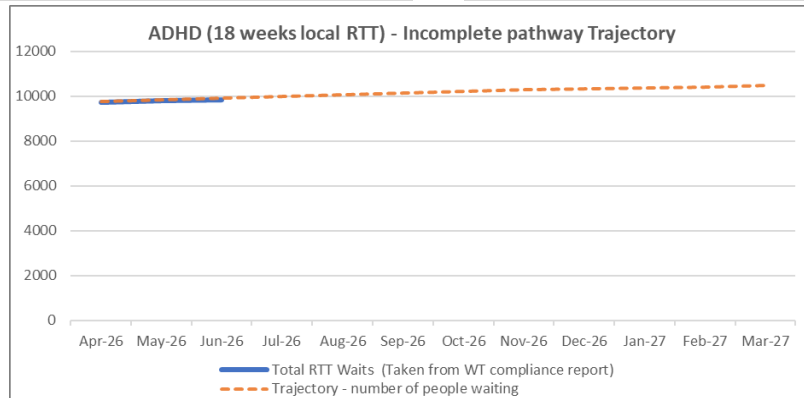
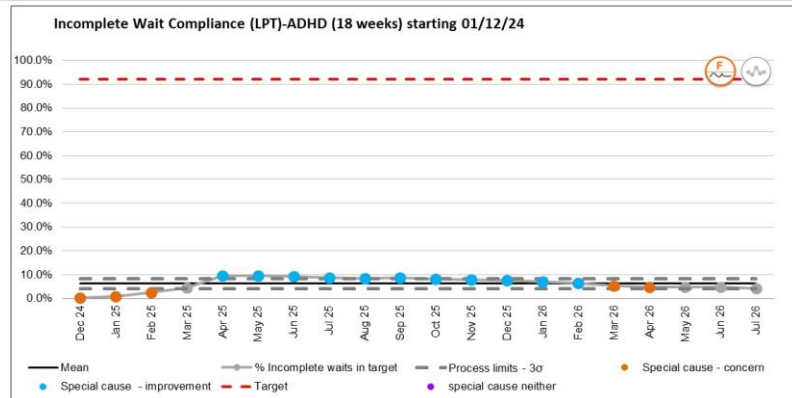
Actions	Timescales	Consequences	RAG
One Stop Clinic and Advanced Pathway reviewed to assess impact; outcome supports continuation Workforce review to be carried out to ensure appropriate capacity and skill mix in the service.	Sep-26	Increase efficiency, flow and patient experience. Reduction in waiting times. Assessment, diagnosis and treatment within one clinic will improve patient experience.	
Gaps in medical capacity is limiting delivery of One Stop Clinics, Lead Consultant and Clinical Director identifying options to address.			
Service capacity reduced by equivalent of 1.00 wt.e medic and mitigated through 0.4 w.t.e. GP with Special Interest and 0.4 wt locum cover. Lead consultant working with the Clinical Director to substantively resolve capacity gap. Additional capacity commenced August 2026 enabling Saturday clinics to increase assessment capacity.	Sep-26	Increase capacity enabling waiting times / number of over 52 waits to be reduced.	
Expansion of One Stop and Advanced Pathway will increase capacity from c28 appointments per week to c40 appointments per week from September 2026 (dependent on consultant/medical availability) and will move to c52 appointments per week when fully operational.			
Capacity compromised due to insufficient medic input and sickness in nursing team. Business Team supporting with demand and capacity exercise to maximise available resources. Plan to repurpose some medic funding to recruit B7 NMP for 12 months to increase the Advanced Pathway capacity.	Nov-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	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Mean	Lower Process Limit	Upper Process Limit
	>=95%	8.4%	8.8%	8.2%	7.8%	7.6%	7.1%	6.6%	5.4%	4.7%	4.9%	4.8%	4.1%	6.2%	4.0%	8.0%
No of Referrals		239	299	251	257	222	197	216	221	53	55	82	30			



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.

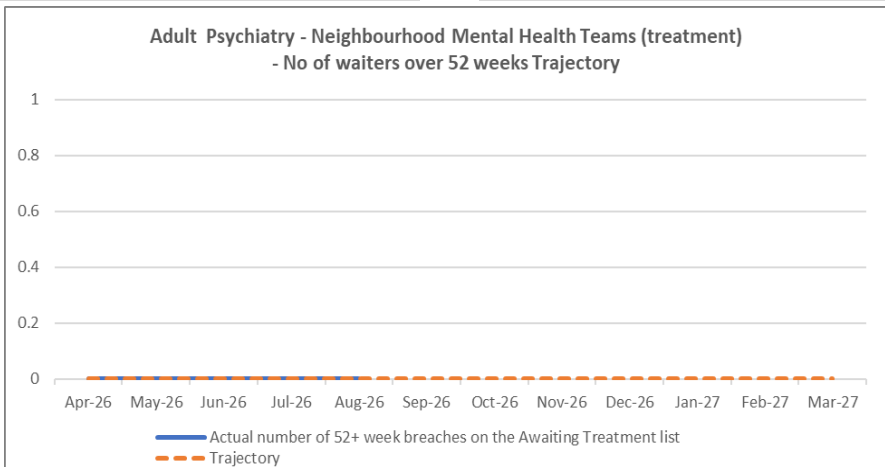
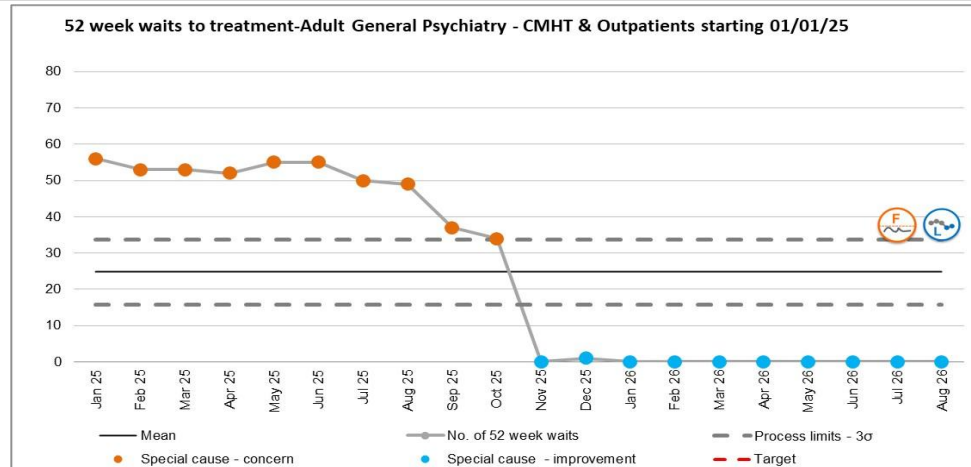
Operational Commentary

Actions	Timescales	Consequences	RAG
System-wide transformation of ADHD pathway will to improve access and reduce waiting times. Will focus on piloting AI Scribe to support improved efficiency across the pathway enabling increased availability of clinical appointments. Working with ICB and HEIM to assess opportunities for pathway remodelling using local learning / learning other Trusts nationally	Dec-26	Improved access and reduction numbers waiting in excess of 52 weeks. Improved service productivity. Improved patient experience. Improved staff experience.	Green
Improved recording and reporting of waiting times and pathways. Consider recommendations in the NHS ADHD National Improvement Plan, working with SystmOne, Integrated Information and Business Teams to progress. Workshop with service leads, LHS, Business Team and Integrated Information Team to review SystmOne configuration and reporting; actions are being progressed. SystmOne optimisation to ensure information effectively tracks patient journey.	Dec-26	Waiting times data consistent across all reports and systems.	Green
New provider (COGS AI) commissioned for pre/post diagnostic support.	Complete	Psychological and psychoeducation support provided to patients whilst waiting.	Blue

Achievements

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

DMH	Target	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Mean	Lower Process Limit	Upper Process Limit
	0	37	34	0	1	0	0	0	0	0	0	0	0	24.8	15.8	33.7



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

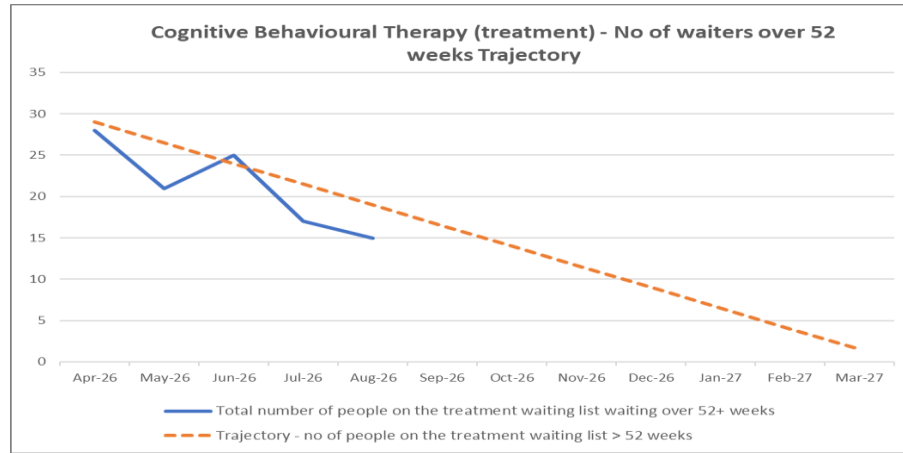
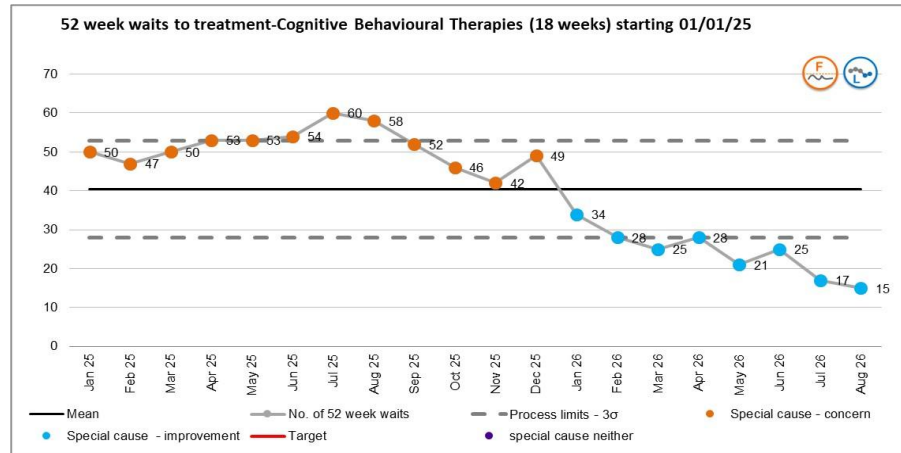
Actions	Timescales	Consequences	RAG
Sustaining this position will be supported by the actions identified in the exception report for NMHT 6 week waits	N/A		

Achievements

Work to review waiting lists, clinical activity and data recording, treatment waits in excess of 52 weeks is expected to belminate trestment waits with ZERO aits reported since Dec 2025.

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

DMH	Target	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Mean	Lower Process Limit	Upper Process Limit
	0	52	46	42	49	34	28	25	28	21	25	17	15	40.4	27.9	52.8



Analytical Commentary

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

Operational Commentary

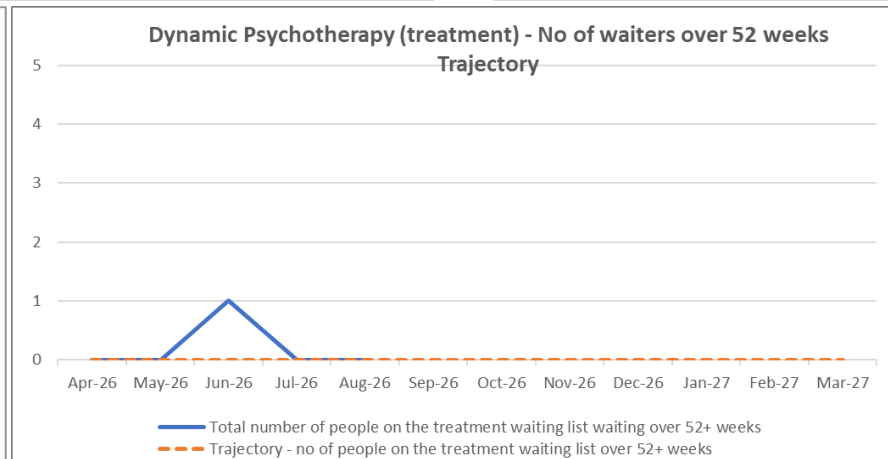
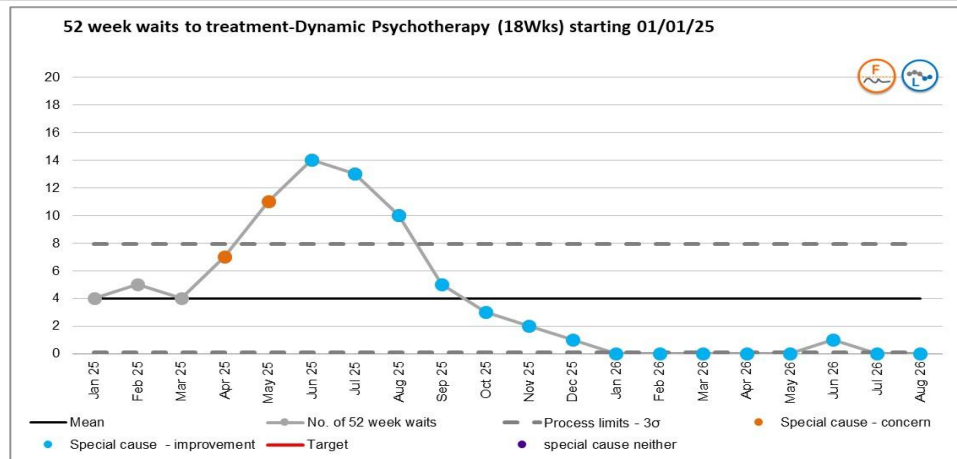
Actions	Timescales	Consequences	RAG
Neighbourhood Mental Health Teams (NMHTs) now positioned as the access point ("front door") for all Cognitive Behavioural Therapy (CBT) referrals. This shift will streamline referral management, improve consistency, and strengthen integration across services. However, several operational pressures are impacting on implementation timelines and overall service flow. 95% of the new work coming into the service is now via the new referral pathways allowing the team to support the daily huddles more easily.	Nov-26	High referral volumes from primary care limiting NMHT capacity to absorb the additional referrals currently sent directly to CBT and risks delaying full implementation of new referral pathway. Service leads working with NMHTs to resolve.	
Expansion of regular, scheduled group CBT delivery, supported by a 12-month rolling programme.	Dec-26	A refreshed rolling programme in place for 2026/27, signalling a long-term commitment to group-based delivery as a core productivity driver. This approach is expected to increase throughput, reduce waiting times, and establish predictable treatment cycles, but is dependant 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	Enhanced productivity whilst also focusing on 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	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Mean	Lower Process Limit	Upper Process Limit
	0	5	3	2	1	0	0	0	0	0	1	0	0	4.0	0.8	7.9



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.

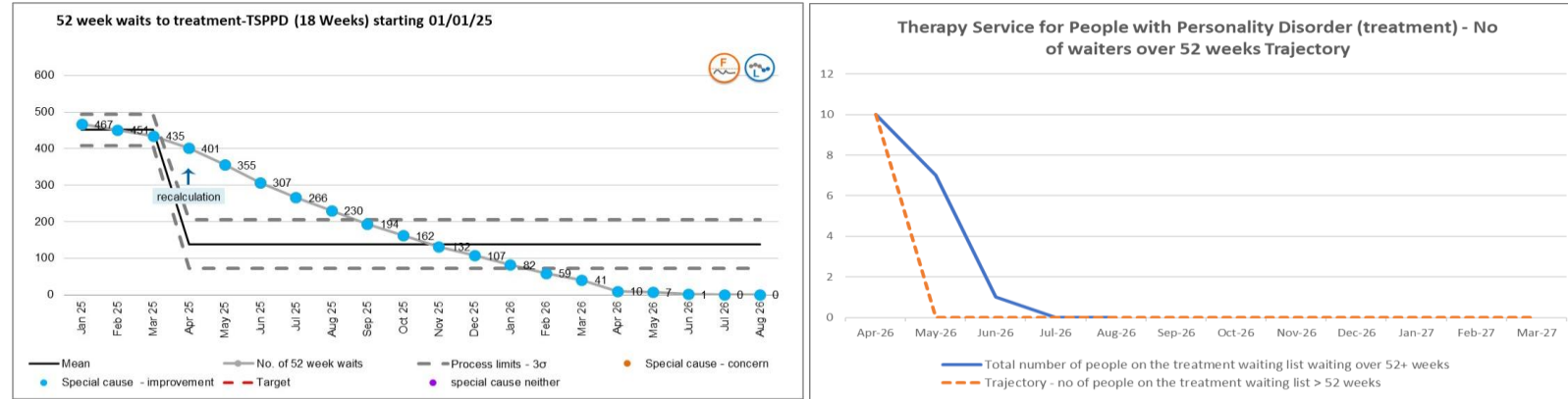
Operational Commentary

Actions	Timescales	Consequences	RAG
All referrals to DPS will go through the Neighbourhood Mental Health Teams, with adjustments to the new front door process enabling referrals to be picked up following discussion in the consultor meeting/daily huddle. Work in progress to close other routes of referral enabling a streamlined process; approach signed off at CRG on 28/07/26.	Sep-26	Joined-up approach will improve flow, ensure patients are seen by the most appropriate service and reduce repeat assessments.	

Achievements

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

DMH	Target	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Mean	Lower Process Limit	Upper Process Limit
	0	194	162	132	107	82	59	41	10	7	1	0	0	138.5	71.8	205.1



Analytical Commentary

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

Operational Commentary

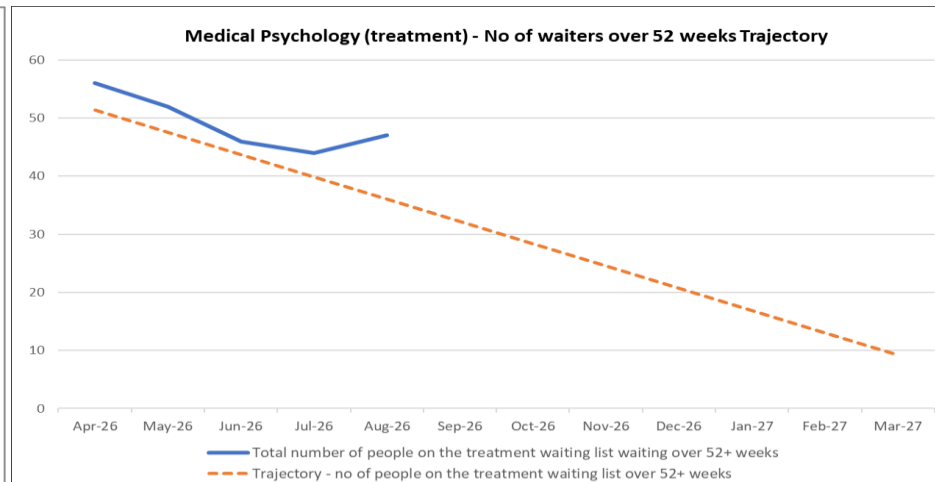
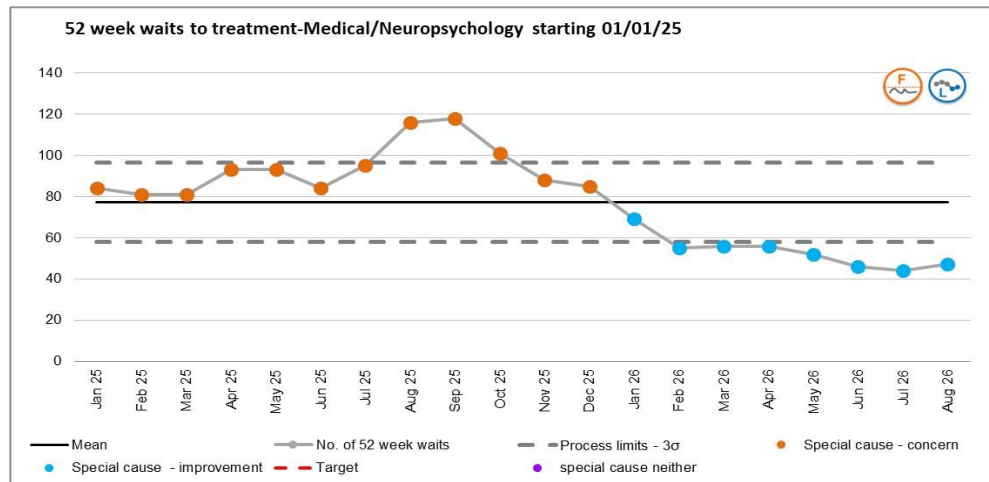
Actions	Timescales	Consequences	RAG
Development of training support to voluntary and community services to enhance the primary care offer (small scale) alongside foundational training in Trauma Informed Care. Training to commence in City East and City West in September 2026 with training dates for other neighbourhood areas to be agreed for 2027.	Dec-27	Support to VCSE/primary care to reduce 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. Operational plans reviewed / discussed in weekly 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 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.	
New Neighbourhood Team clinical model to be tailored to meet the needs personality difficulties. Part of IN2 and reporting through Transformation Project Structure.	Oct-26	Model in place for working with people with moderate personality difficulties within Neighbourhood Teams.	
Establish the 'Personality Disorder Hub'. Model in development through weekly TSPPD transformation meeting and organisational development sessions. CPD and workshops for TSPPD workforce to begin September 2026. Comms and engagement for urgent care and inpatient services to be arranged.	Jan-27	Improve service offer, increase efficiency, and reduce waits.	

Achievements

Significant and sustained reduction in numbers waiting over 52 weeks over the last 12 months. At end of August 2026 no patients were waiting over 52 weeks, down from 230 in August 2025.

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

DMH	Target	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Mean	Lower Process Limit	Upper Process Limit
	0	118	101	88	85	69	55	56	56	52	46	44	47	77.2	58.0	96.4



Analytical Commentary

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

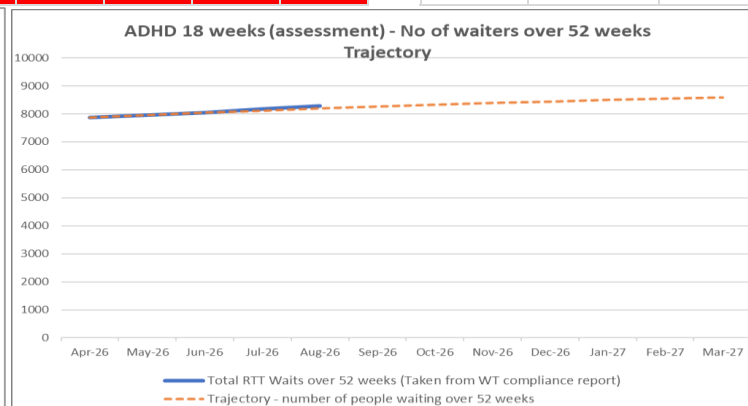
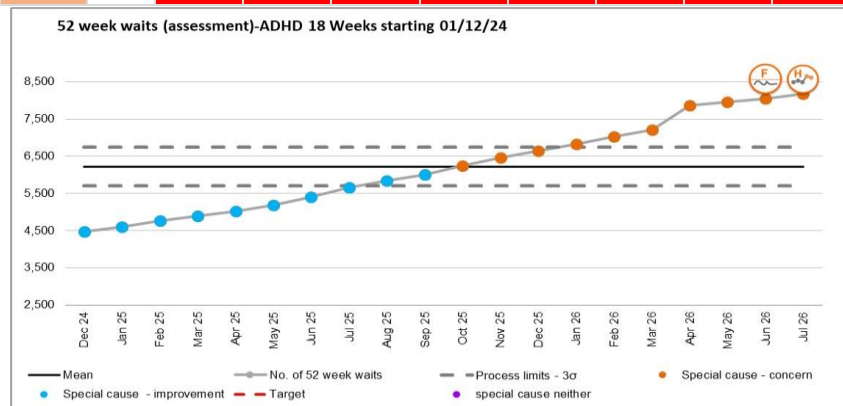
Operational Commentary

Actions	Timescales	Consequences	RAG
Group only offer for pain referral introduced and exploring options for additional groups .	Complete	Increase capacity and reduce waiting times for treatment.	Blue
Caps to sessions for pain and general medical service to maximise throughput	Complete	Improve flow through the service.	Blue
Assessment weeks running when referrals increase.	Complete	Increase capacity to assess patients during periods of increasing demand.	Blue
Waiting list review pilot for General Medical treatment list.	Complete	Enable wait times to be reduced.	Blue
Exploring new opportunities to reduce waits to treatment recognising the challenge in the context of the number of referrals and staffing capacity.	Dec-26	New models of delivery will support reduced waiting times.	Green
Maintain oversight of increasing referrals for cancer with associated risk of increased waits.	Dec-26	Maintain oversight of demand and escalate as required.	Green

Achievements

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

DMH	Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Mean	Lower Process Limit	Upper Process Limit
	0	5833	6006	6250	6464	6639	6830	7023	7211	7860	7951	8053	8181	6214.7	5694.7	6734.6



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.

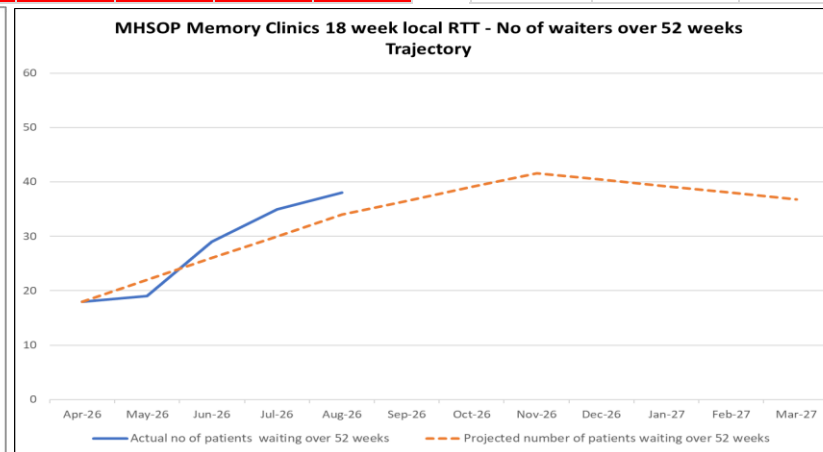
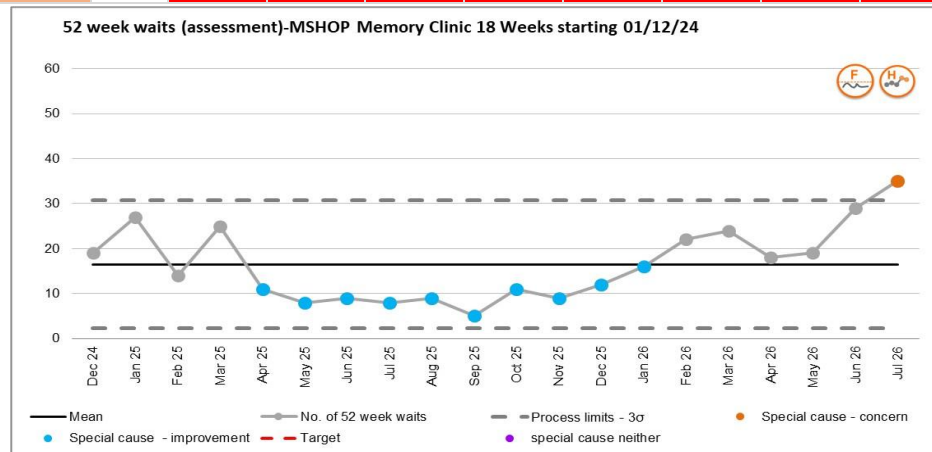
Operational Commentary

Actions	Timescales	Consequences	RAG
System-wide transformation of ADHD pathway will to improve access and reduce waiting times. Will focus on piloting AI Scribe to support improved efficiency across the pathway enabling increased availability of clinical appointments. Working with ICB and HEIM to assess opportunities for pathway remodelling using local learning / learning other Trusts nationally	Dec-26	Improved access and reduction numbers waiting in excess of 52 weeks. Improved service productivity. Improved patient experience. Improved staff experience.	Green
Improved recording and reporting of waiting times and pathways. Consider recommendations in the NHS ADHD National Improvement Plan, working with SystmOne, Integrated Information and Business Teams to progress. Workshop with service leads, LHS, Business Team and Integrated Information Team to review SystmOne configuration and reporting; actions are being progressed. SystmOne optimisation to ensure information effectively tracks patient journey.	Dec-26	Waiting times data consistent across all reports and systems.	Green
New provider (COGS AI) commissioned for pre/post diagnostic support.	Complete	Psychological and psychoeducation support provided to patients whilst waiting.	Blue

Achievements

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

DMH	Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Mean	Lower Process Limit	Upper Process Limit
	0	9	5	11	9	12	16	22	24	18	19	29	35	16.5	2.2	30.8



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
One Stop Clinic and Advanced Pathway reviewed to assess impact; outcome supports continuation Workforce review to be carried out to ensure appropriate 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 will improve patient experience.	RAG
Gaps in medical capacity is limiting delivery of One Stop Clinics, Lead Consultant and Clinical Director identifying options to address. Service capacity reduced by equivalent of 1.00 wt.e medic and mitigated through 0.4 w.t.e. GP with Special Interest and 0.4 wt locum cover. Lead consultant working with the Clinical Director to substantively resolve capacity gap. Additional capacity commenced August 2026 enabling Saturday clinics to increase assessment capacity.	Sep-26	Increase capacity enabling waiting times / number of over 52 waits to be reduced.	RAG
Capacity compromised due to insufficient medic input and sickness in nursing team. Business Team supporting with demand and capacity exercise to maximise available resources. Plan to repurpose some medic funding to recruit B7 NMP for 12 months to increase the Advanced Pathway capacity.	Nov-26	Increase capacity enabling waiting times / number of over 52 waits to be reduced.	RAG

Achievements

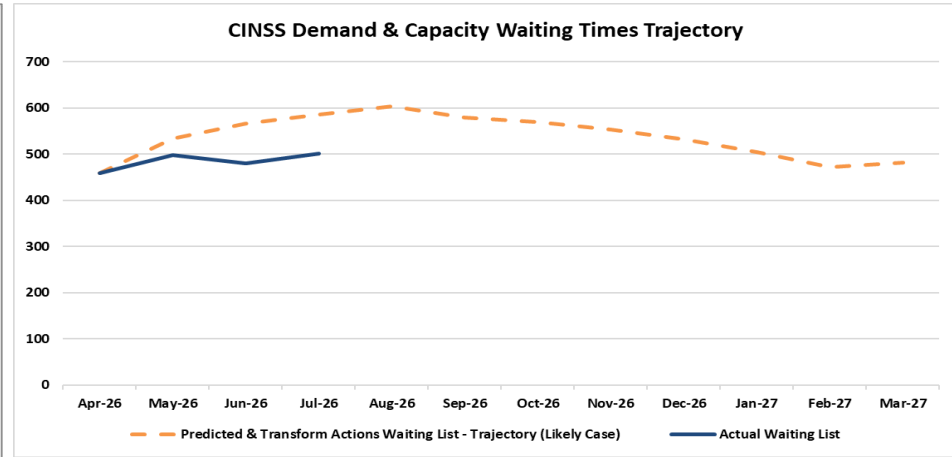
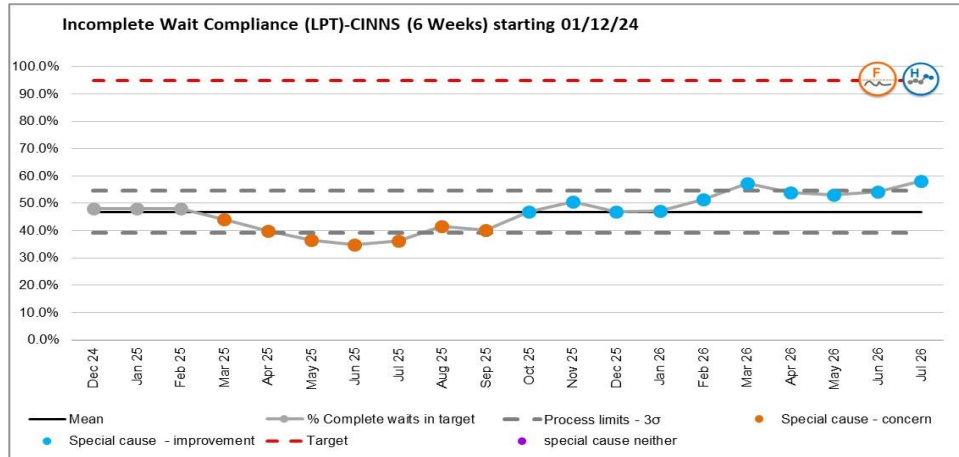
One Stop Clinics and Advanced Dementia Pathway have enabled new approaches to be implemented which offer significant benefit to patients and carers in terms of waiting time and patient experience.

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%	Jul-26	58.2%	54.2%				
	TRUST	Monthly (In Arrears)	Speech Therapy - Voice, Respiratory and Dysfluency - Routine (6 weeks) - Incomplete Pathway	>=95%	Jul-26	44.6%	34.2%				

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

CHS	Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Mean	Lower Process Limit	Upper Process Limit
	>=95%	41.5%	40.2%	46.9%	50.6%	46.9%	47.3%	51.4%	57.4%	54.0%	53.0%	54.2%	58.2%	46.9%	39.0%	55.0%
No of Referrals		205	165	188	178	180	174	169	212	181	178	203	222			



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

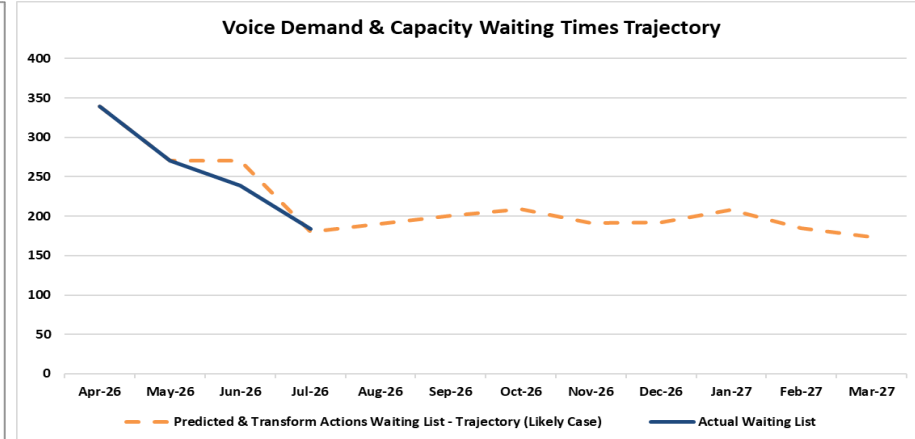
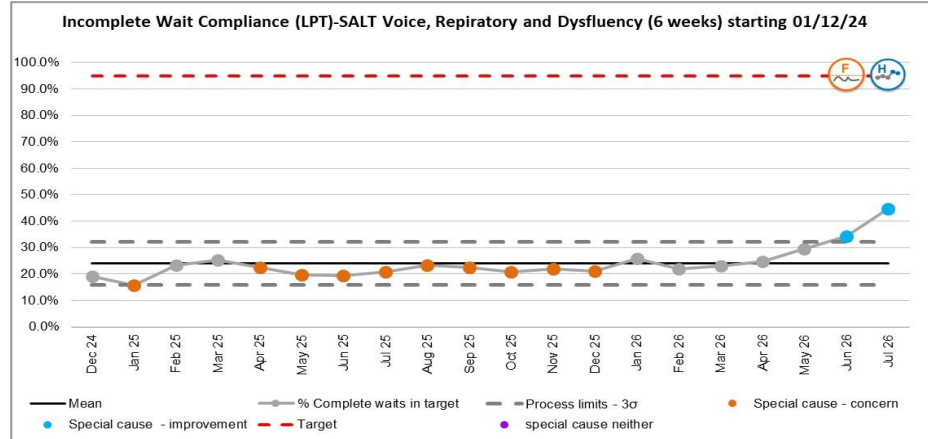
Actions	Timescales	Consequences	RAG
Energy Management Group to be rolled out	Oct-26	Increase capacity and throughput of patients; reduce numbers waiting	
Student workforce allocation reviewed and standardised across the Trust.	Nov-26	Releasing Time to Care	
Dictation software options being explored - awaiting trustwide progress and funding	TBC	Releasing Time to Care	
SystemOne holistic templates to be reviewed	Nov-26	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	Complete	Reduce waiting list; reduce longest waiters	

Achievements

95th percentile waiting list has decreased to 14 weeks. All patients waiting over 15 weeks have an appointment booked in the next 6 weeks. 99.2% 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	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Mean	Lower Process Limit	Upper Process Limit
	>=95%	23.2%	22.5%	20.7%	21.9%	21.2%	25.9%	22.0%	23.1%	24.6%	29.6%	34.2%	44.6%	23.0%	15.0%	31.0%
No of Referrals		81	81	72	56	74	88	45	63	69	57	74	70			



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
Recruitment to voice therapist vacancy	Nov-26	Increase clinical capacity; reduce waiting list.	
Individual job planning	Complete	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	Complete	Reduce cancellations; increase capacity; reduce waiting list	
Set up next cohort of group patients	Complete	Reduce waiting list; reduce longest waiters	
Weekly monitoring of new patient appointments & prospective bookings	Complete	Reduce waiting list; reduce longest waiters	

Achievements

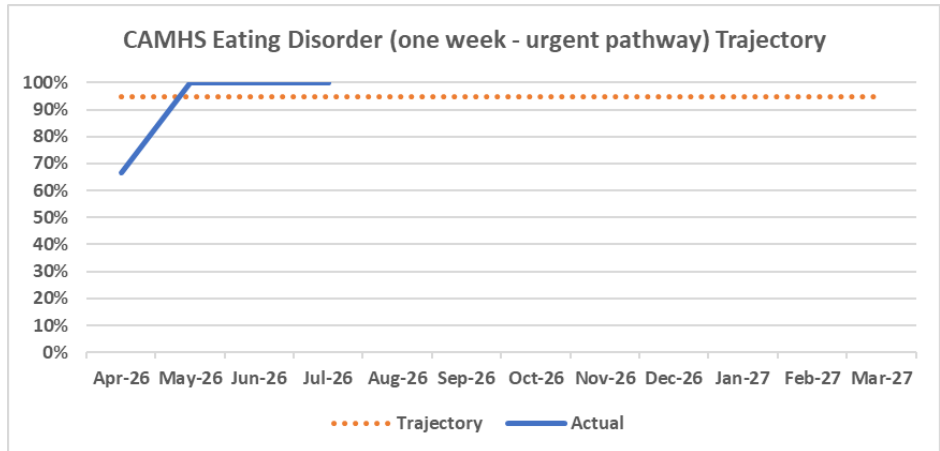
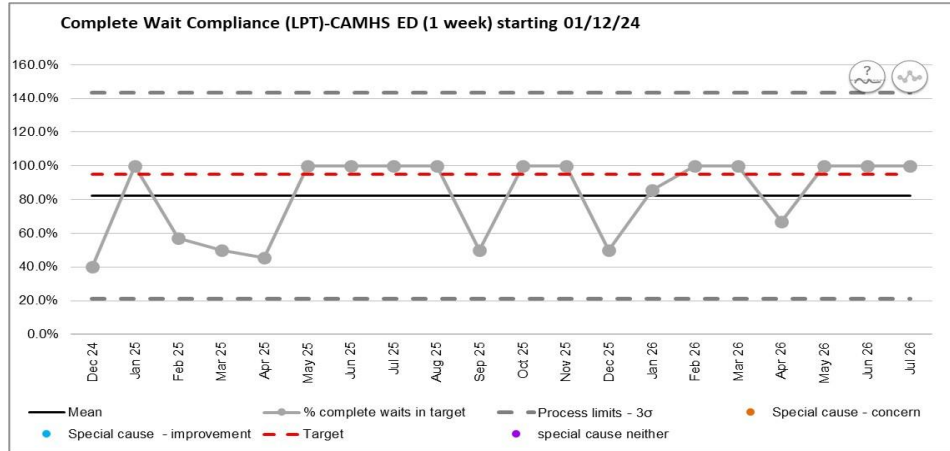
Significant reduction in numbers waiting. Improvement in waiting times compliance. Over-achieving on likely case waiting list trajectory, with 95th percentile wait decreasing to 25 weeks.

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%	Jul-26	100.0%	100.0%				
	TRUST	Monthly (In Arrears)	CAMHS Eating Disorder (four weeks) - Complete pathway	>=95%	Jul-26	100.0%	100.0%				
	TRUST	Monthly (In Arrears)	Community Paediatrics (18 weeks) - Incomplete pathway	>=92%	Jul-26	7.6%	7.8%				
	TRUST	Monthly (In Arrears)	Childrens Audiology (6 week wait for diagnostic procedures) - Incomplete pathway	>=99%	Jul-26	29.1%	32.9%				
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)		Aug-26	31.4%	42.4%				
	TRUST	Monthly	(5-18yrs) Percent of RHAs sent to LA in month within 12 months of previous assessment (City/County/Rutland)		Aug-26	94.4%	91.9%				
	TRUST	Monthly	(0-4yrs) Percent of RHAs sent to LA in month within 6 months of previous assessment (City/County/Rutland)		Aug-26	81.8%	100.0%				
Operational Performance - 52 Week Waits	TRUST	Monthly (In Arrears)	Community Paediatrics - assessment waits over 52 weeks - No of waiters	0	Jul-26	7899	7795				
	TRUST	Monthly (In Arrears)	Community Paediatrics - assessment waits over 52 weeks - Longest waiter (weeks)		Jul-26	238	233				
	TRUST	Monthly	Community Paediatrics Treatment (excl ND) - No of waiters	0	Aug-26	0	5				
	TRUST	Monthly	Community Paediatrics Treatment (excl ND) - Longest waiter		Aug-26	49	87				
	TRUST	Monthly	All Neurodevelopment (inc CAMHS, SALT, PAEDS) - Treatment waits - No of waiters	0	Aug-26	1369	1570				
	TRUST	Monthly	All Neurodevelopment (inc CAMHS, SALT, PAEDS) - Treatment waits - Longest waiter (weeks)		Aug-26	241	233				
	TRUST	Monthly	CAMHS - Treatment waits (excl ND) - No of waiters	0	Aug-26	76	88				
	TRUST	Monthly	CAMHS - Treatment waits (excl ND) - Longest waiter (weeks)		Aug-26	78	75				
	TRUST	Monthly	All LD - Treatment waits - No of waiters	0	Aug-26	0	2				
	TRUST	Monthly	All LD - Treatment waits - Longest waiter (weeks)		Aug-26	50	54				
	TRUST	Monthly	Children's Physiotherapy - No of waiters	0	Aug-26	0	0				
	TRUST	Monthly	Children's Physiotherapy - Longest waiter		Aug-26	40	40				
	TRUST	Monthly	Audiology - No of waiters	0	Aug-26	0	0				
	TRUST	Monthly	Audiology - Longest waiter		Aug-26	44	42				
	TRUST	Monthly	Adult Eating Disorders Community - Treatment waits - No of waiters	0	Aug-26	0	2				
	TRUST	Monthly	Adult Eating Disorders Community - Treatment waits - Longest waiter (weeks)		Aug-26	44	56				

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

FYPCLDA	Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Mean	Lower Process Limit	Upper Process Limit
	>=95%	100.0%	50.0%	100.0%	100.0%	50.0%	85.7%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	82.3%	21.0%	143.0%
No of Referrals		3	4	5	1	3	10	4	1	3	1	1	6			



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

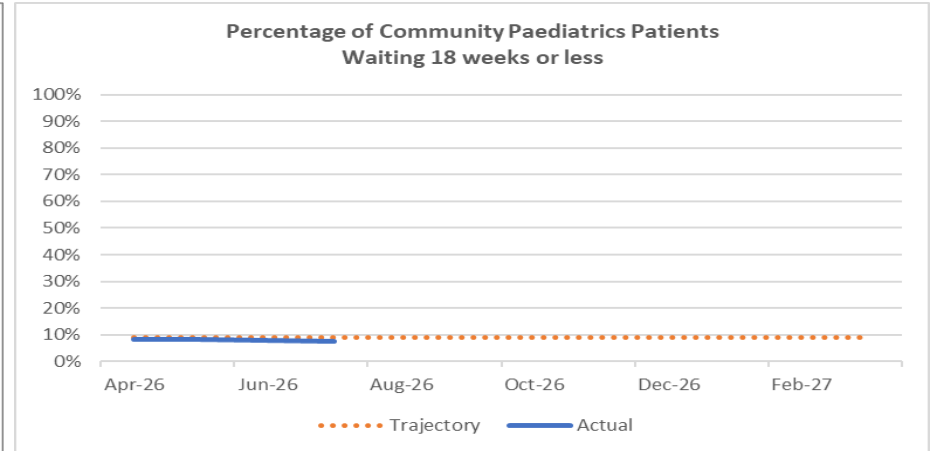
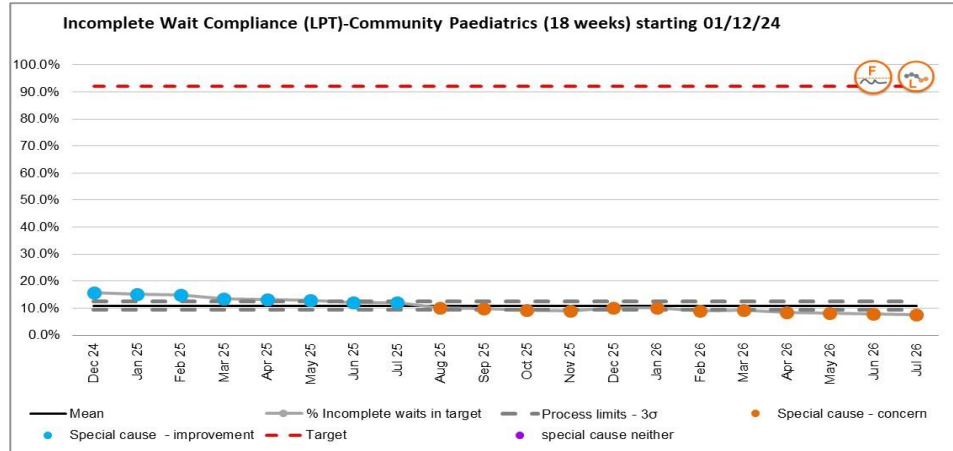
Actions	Timescales	Consequences	RAG
Daily service led PTL's with monthly oversight PTL supported by the Business Team.	TBC	Early intervention where children at risk of breaching target so improving adherence to KPI	

Achievements

Target achieved for 8 out of last 12 months.

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

FYPCLDA	Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Mean	Lower Process Limit	Upper Process Limit
	>=92%	10.2%	9.8%	9.3%	9.0%	10.1%	10.0%	9.1%	9.4%	8.3%	8.1%	7.8%	7.6%	10.9%	9.0%	12.0%
No of Referrals		137	215	295	226	278	299	377	446	176	191	205	220			



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.

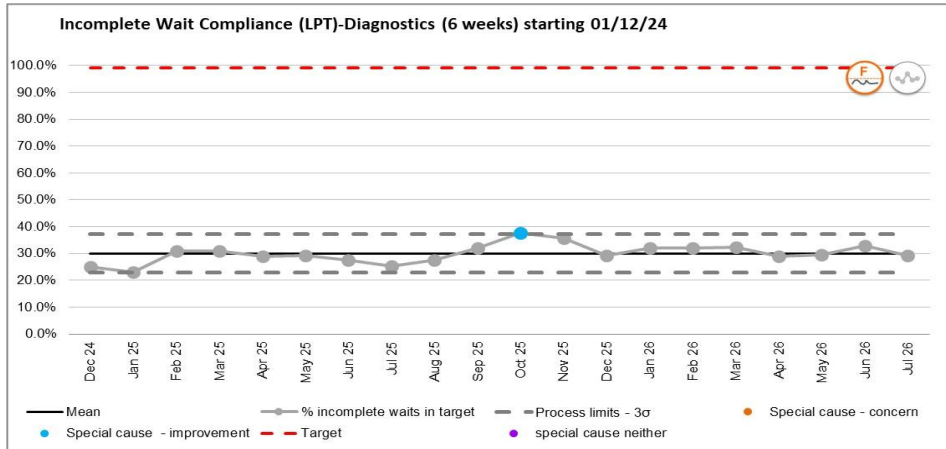
Operational Commentary

Actions	Timescales	Consequences	RAG
Pathway review- workshop with NHFT	Jun-26	Shared learning and opportunities for improvement	
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 oversight 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 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	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Mean	Lower Process Limit	Upper Process Limit
	>=99%	27.5%	32.0%	37.6%	35.7%	29.2%	32.0%	32.0%	32.4%	28.8%	29.4%	32.9%	29.1%	30.0%	23.0%	37.0%
No of Referrals		201	246	271	205	166	238	255	292	243	179	249	194			



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 above the process limits.

Operational Commentary

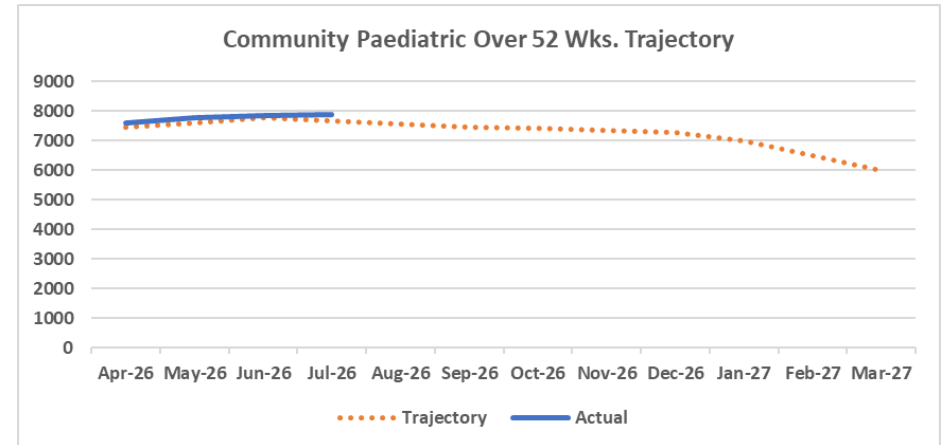
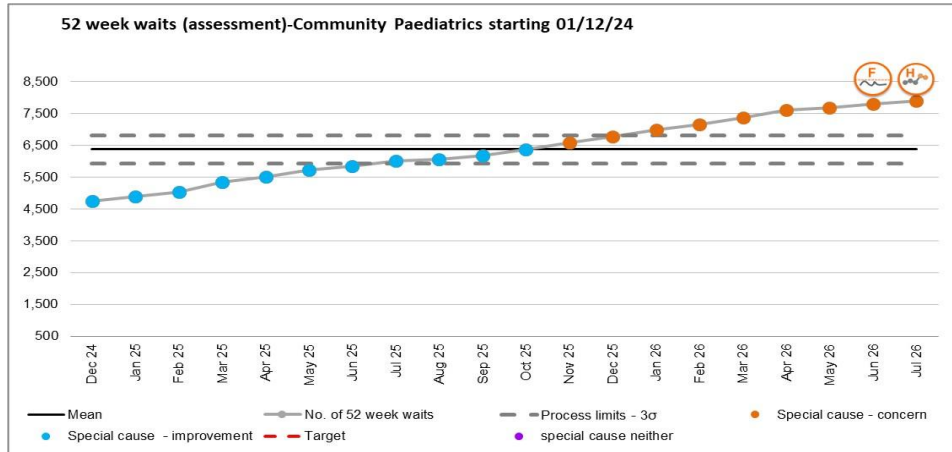
Actions	Timescales	Consequences	RAG
Regular oversight PTL, led by DMT, dedicated to review of patients with long waits.	Feb-27	Deliver agreed trajectory for 6 week KPI and early identification of potential breaches, enabling earlier intervention.	
Onboarding of upgraded soundproofed estate	Sep-26	Increased 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	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Mean	Lower Process Limit	Upper Process Limit
	0	6067	6182	6380	6585	6782	7003	7154	7385	7604	7684	7795	7899	6382.3	5940.04	6824.56



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.

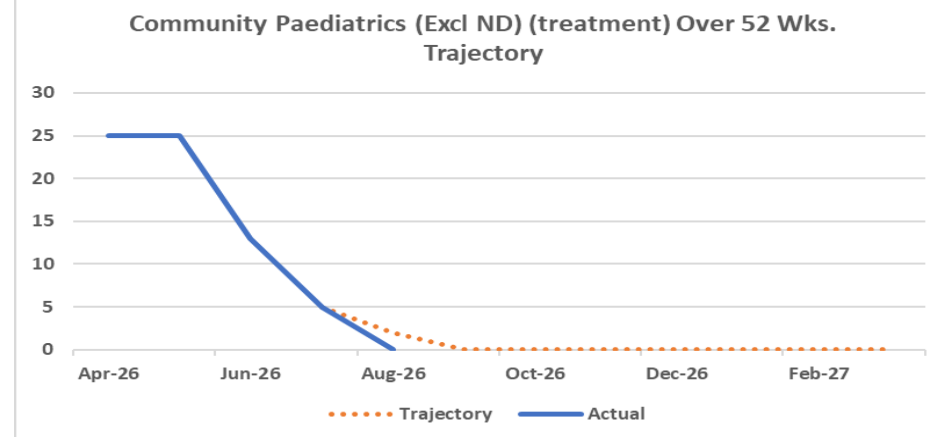
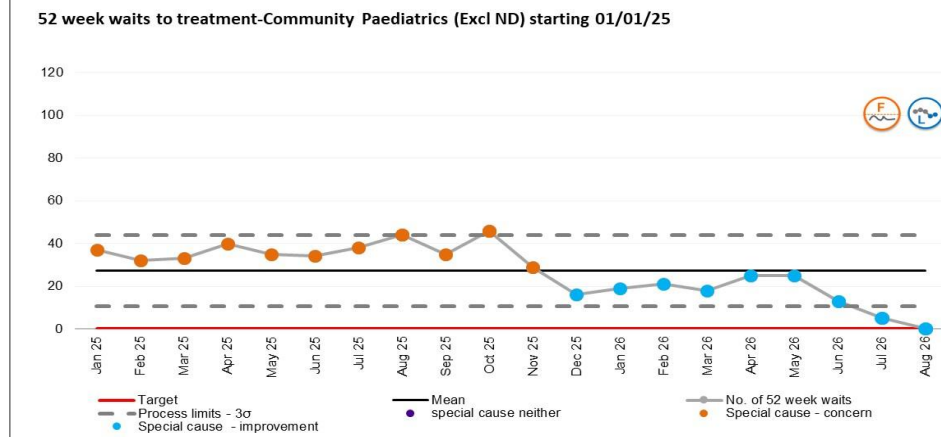
Operational Commentary

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	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Mean	Lower Process Limit	Upper Process Limit
	0	35	46	29	16	19	21	18	25	25	13	5	0	27.3	10.59	43.91



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

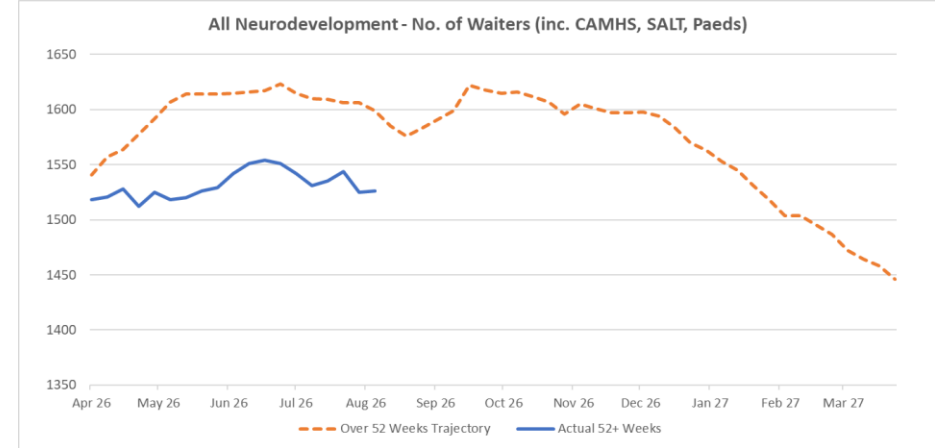
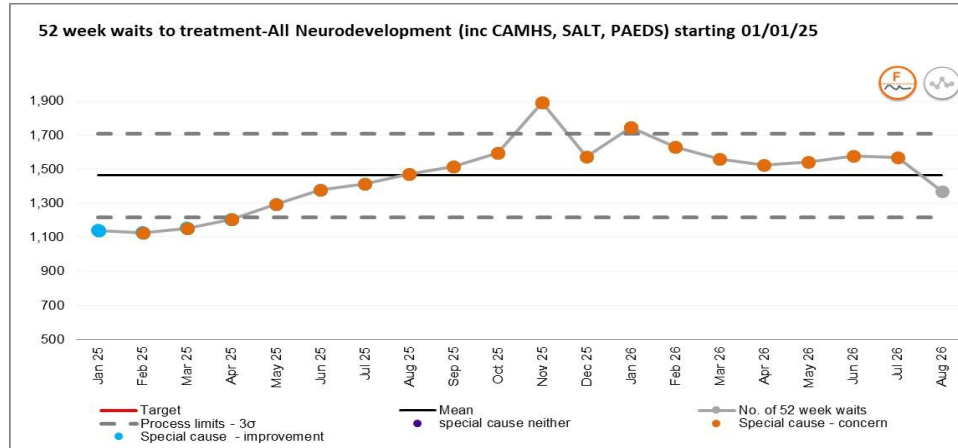
Actions	Timescales	Consequences	RAG
Review waiting list to ensure all patients correctly categorised by wait type.	Jul-26	Waits are correctly categorised ensuring patients appropriately supported. Reporting accurately reflects waits	
Completion of waiting list validation exercise to identify follow up and treatment waits.	Sep-26	Waiting list validated	
Establish an options appraisal for a single ND front door	Sep-26	Streamline service provision and minimise risk of delay for 'core' referrals	

Achievements

Zero 52 week waits at the end of August.

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

FYPCLDA	Target	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Mean	Lower Process Limit	Upper Process Limit
	0	1518	1597	1893	1575	1747	1632	1562	1523	1544	1578	1570	1369	1464.8	1219.1	1710.5



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

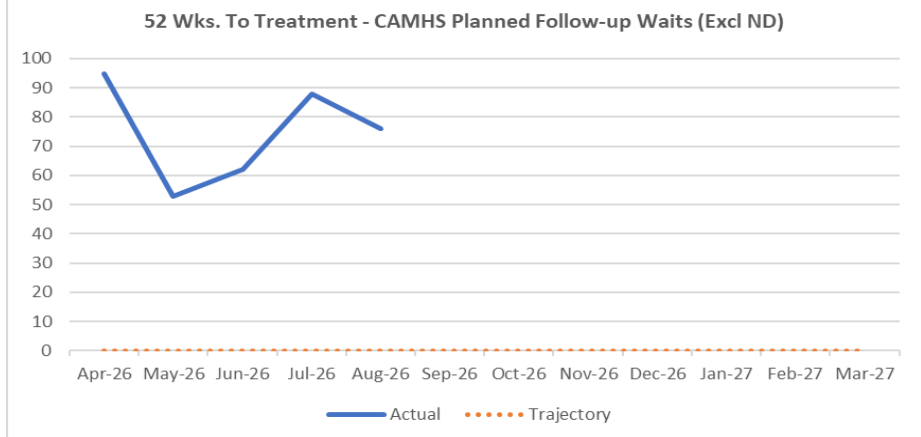
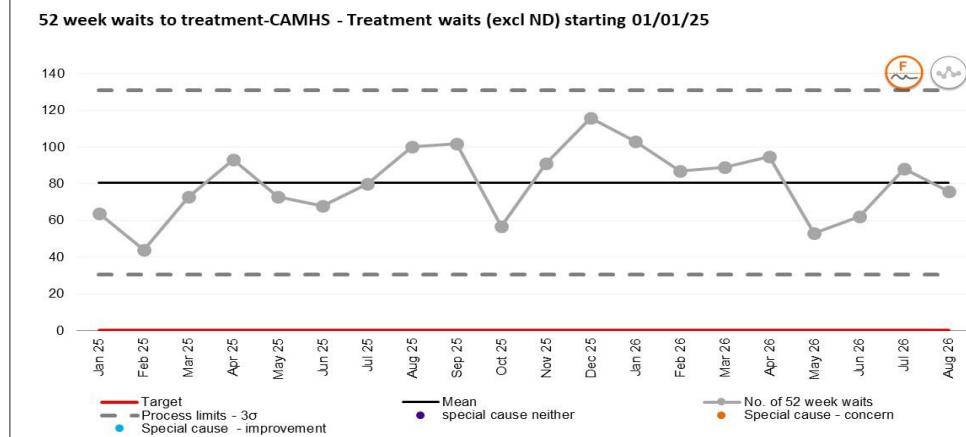
Actions	Timescales	Consequences	RAG
Recruitment and onboarding of non-medical prescriber for CAMHS	Sep-26	Increased capacity enabling increased throughput to enable waiting times to be reduced.	
Exploration of digital health contact - sign off EQIA	Jul-26	Support waiters and identify CYP who may no longer 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

The service is over-delivering on the trajectory for reducing over 52 week waits

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

FYPCLDA	Target	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Mean	Lower Process Limit	Upper Process Limit
	0	102	57	91	116	103	87	89	95	53	62	88	76	80.7	30.58	130.82



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

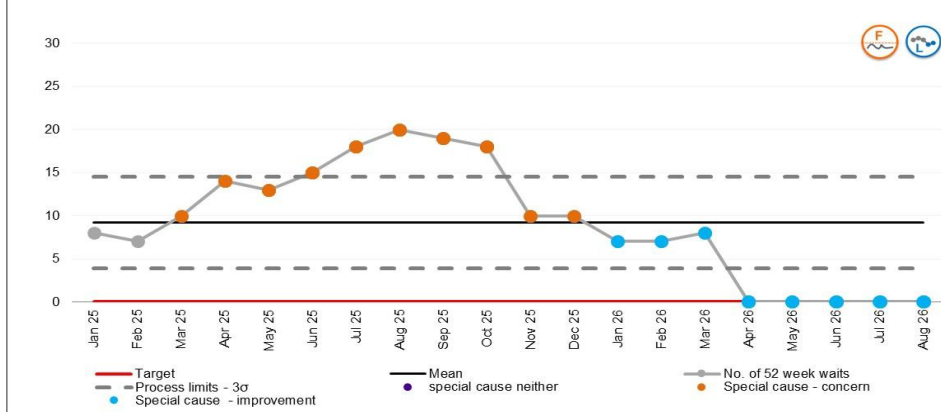
Actions	Timescales	Consequences	RAG
Deep dive into waiting lists to validate and confirm nature of wait- treatment or follow up.	Jun-26	Confirmation of wait types to ensure CYP on appropriate lists and these are reported through the appropriate governance route	Complete
CAMHS Clinical and Operational 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 Sept 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.	Complete

Achievements

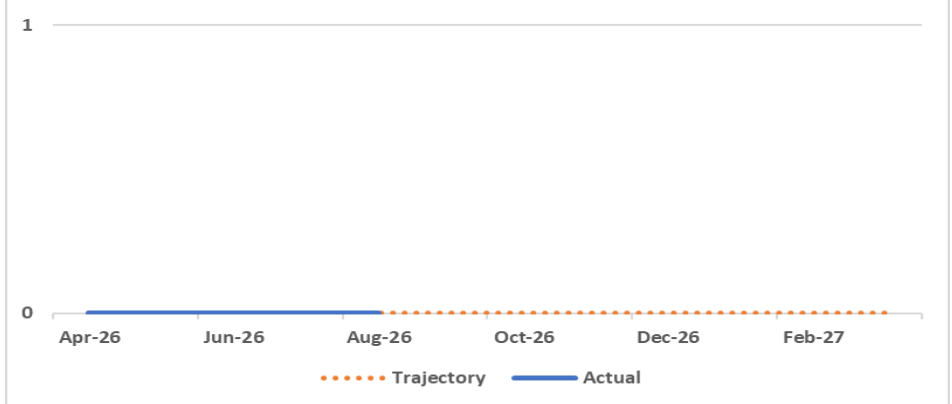
EXCEPTION REPORT - Children's Physiotherapy (treatment)- No of waiters over 52 weeks

FYPCLDA	Target	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Mean	Lower Process Limit	Upper Process Limit
	0	19	18	10	10	7	7	8	0	0	0	0	0	9.2	3.88	14.52

52 week waits to treatment-Children's Physiotherapy starting 01/01/25



Children's Physiotherapy Over 52 Wks. Trajectory



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	Maintain position of no over 52 week waits.	Complete

Achievements

Service has eliminating all over 52 week waits and has systems in place to sustain this position.

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.

Q

For information

Board Assurance Framework

September 2026



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

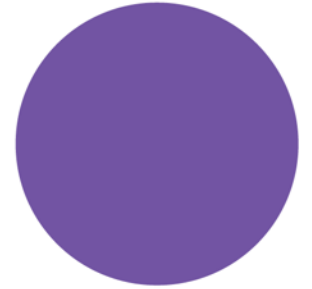
The format presents the controls, assurances, gaps and actions together. This means that we can provide assurance over whether existing controls are working. Where they are not, we can be clear about the action required to resolve this. We are also able to clearly identify where additional controls and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

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.

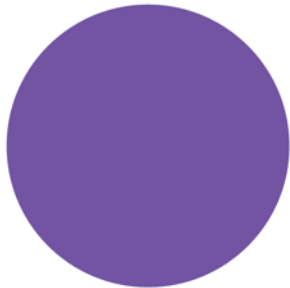
Scoring

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.				Current Risk Position: Impact 4 (major) / Likelihood 3 (possible) Heatmap position: Amber (Medium) Rationale: Increased threat, strong controls, gaps exist			
Date	1 April 2026 - initial score (I4/L3)	Last updated 25 August 2026				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		
Strategic Link	THRIVE: TECHNOLOGY	Exec lead(s) Group Chief Commissioning Officer (PS)						
Governance	Trust Information Management & Technology Groups LPT and NHFT Finance and Performance Committees, Group Strategic Executive Board, Group Trust Board LLR/NICB system cyber group							
Context	Access to electronic systems which are fit for purpose, digital transformation, cyber attack							
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 – DDAT Aug 26; GSEB Sept 26 • Adoption and deployment of strategic cyber security solutions SIEM and SOC – July 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	• 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 Options to improve clinical leadership in digital decision making identified					
			3rd Line: Clinical Focus and Engagement in decision making to be an essential element of its governance arrangements.					

BAF02	If we do not continue to evolve our partnerships and collaboratives, we will not reduce health inequalities and deliver improved outcomes for our communities.				Current Risk Position: Impact 4 (major) / Likelihood 2 (unlikely) Heatmap position: Green (Low) Rationale: Good system approach, further maturity anticipated		
Date	1 April 2026 - initial score (I4/L2)		Last updated 17 September 2026			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 3 rd line	
Strategic Link	THRIVE: HEALTHY COMMUNITIES		Exec lead(s) Group Director of Strategy and Partnerships (DW)				
Governance	LPT and NHFT Finance and Performance Committees, Group Strategic Executive Board, Group Trust Board						
Context	Healthy Communities are essential to the delivery of our system strategy, preventing ill-health and reducing demand on NHS services						
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 - Board DNA/WNB oversight		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 Environmental analysis and agenda items in Group SEB & EMB e.g. H&WB update; JCCCG 3A into Group SEB & ICB Meetings feedback.		Consistent feedback from system meetings	Board oversight of DNA/WNB metrics for Core20PLUS5 groups – Group Trust Board September 2026 - Group Director of Strategy	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. Transformation and QI committee oversight of PCREF delivery and impact 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	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, Report & comms to be issued Sept 2026 – complete	
			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)		
		Evidencing the impact of the Group social value charter		3rd Line ICB Health Inequalities Meetings			

BAF03	If we are unable to build a sustainable approach to the continual development our research, innovation and professional learning capability , our ability to attract the best people, operate on the leading edge of service delivery and exert influence within the sector will decline over time.				Current Risk Position: Impact 4 (major) / Likelihood 2 (unlikely) Heatmap position: Green (Low) Rationale: Progressing maturity		
Date	1 April 2026 - initial score (I4/L2)	Last updated 21 August 2026				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	
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						
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	• Assurance over uptake and PRES survey outcomes Medical Directors: annual data presented to respective QSCs with research submission – August 26 - complete • 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 – Oct 26 • to develop models for interprofessional learning across the Directorates – Medical Directors – Sept 2026 • LPT & NHFT build links with universities for both training & research –Medical Directors - Sept 26 • CMOs to provide quarterly updates on progress of work towards achieving University Hospital Status to GSEB – Medical Directors - July 2027		Oversight of research participant recruitment numbers to form part of reporting to QSCs Monthly group Research & Innovation Oversight Group – started May 26
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 Oct 26 (NHFT & LPT are at different stages of the process) – complete – Launch of The Big Pitch and progression of The Dragon’s Den to add innovation to the Joint Strategic Oversight Group as part of research, education & innovation.		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.				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	
Date	1 April 2026 - initial score (I5/L3)	Last updated 27 August 2026				
Strategic Link	THRIVE: RESPONSIVE	Exec lead(s) Group Chief Nurse (LC); Chief Medical Officer LPT (BC)				
Governance	Trust Access Groups, Waiting List Management, Patient Tracker 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					
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 - Wait List Management Meeting (NHFT) - Patient Tracking Lists - Data Quality forum meetings (NHFT/LPT)		- National strategy for neurodiversity demand - Local/national commissioning plans for addressing significant increases in demand (multiple services – e.g. ADHD/Autism, Dietetics, gender services)	1st Line: Directorate attendance at Access Group and AFM/TOMG WL trajectories and initiatives by service Operational risk profile AFM/EMB 2nd Line: - Access Group with AAA to AFM/TOMG/EMBs Waiting List Management and Patient Tracker Groups - 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	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 - Policy compliance with Access policy - Director of Governance – Oct 2026 - Ensure that focus on low & medium secure services in Northampton does not reduce transformation capacity elsewhere - March 2027 Group Director of Strategy & Partnerships & Chief Integration and Delivery Officer - Alignment of wait list management governance and oversight across the Group structure (including links to Data Quality, annual planning and transformation) – Group Chief Nurse April 27	Control gaps outside of Trusts’ remit to address.
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 and Report		- Data insight & reporting on harm whilst waiting	1st Line Directorate/Care Pathway attendance at Access Group and AFM/TOMG for escalation 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	Clarity over policy compliance measures and rates Comprehensive quality dashboard focusing on outcome measures, including those attributed to waiting	LPT Accountability and Empowerment Framework 2026-27 – including draft quality framework - for approval at EMB – Group Chief Nurse - Aug 2026 – complete	Quality dashboard delivery framework developed (3-year programme)

BAF05	If we do not continue to review and improve our systems and processes for patient safety , we may not be able to provide the best experience and clinical outcomes for our patients and their families.			Current Position: Impact 5 (catastrophic) / Likelihood 3 (possible) Heatmap position: Red (high) Rationale: Criticality and responsiveness		
Date	1 April 2026 - initial score (I5/L3)		Last updated 27 August 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			Target Position: Impact 5 (catastrophic) / likelihood 2 (unlikely) Target zone: Red (high) Rationale: Criticality remains, ongoing need for maturity		
Context				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.				Current Risk Position: Impact 4 (major) / Likelihood 2 (unlikely) Heatmap position: Green (Low) Rationale: Strong controls, unpredictability of external environment	
Date	1 April 2026 - initial score (I4/L2)		Last updated 9 September 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				Target Risk Position: Impact 4 (major) / likelihood 2 (unlikely) Target zone: Amber Rationale: Maintain controls, external threat remains	
Context	Maintain organisational resilience. External factors, social, environmental and economic impact				Control Summary: High Robust control framework	
					Assurance Summary: High strong assurance including 3 rd 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			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 EPRR Group – Dec 2026 • EPRR Core Standards submission (Aug 26) – Nov 2026	BCP reviews on track Final submission on tack for November 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.				Current Risk Position: Impact 4 (major) / Likelihood 3 (possible) Heatmap position: Amber (Medium) Rationale: Good staff survey, strong controls, some gaps remain	
Date	1 April 2026 - initial score (I4/L3)	Last updated 27 August 2026				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
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					
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			1 st Line : Staff Networks across LPT & NHFT; 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
			2 nd Line : Delivery of the Our Future Our way Programme of work & Together We THRIVE for LPT & NHFT – priorities agreed across Group; & leadership behaviours; Reasonable adjustment clinics & meetings established LPT & developing in NHFT; Leadership Development Conferences ; F2SU Guardians, NED F2SU role and reporting; Group programme reporting to SEB every month for oversight	Meeting reasonable adjustment requirements (NHFT)		
			3 rd Line : LPT Internal Audit Fit and Proper Persons Test significant assurance 2025; LPT & NHFT Health & Wellbeing internal audit rated significant assurance 2025			
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	1 st 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
			2 nd Line : Mental Health and Wellbeing Lead sharing work across the Group; 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 27 August 2026			Target Risk Position: Impact 5 / likelihood 3 (possible) Target zone: Red (High) Rationale: Criticality, long term issues Control Summary: Medium some gaps remain Assurance Summary: Medium some gaps remain	
Strategic Link	THRIVE: VALUING EVERYONE		Exec lead(s) Group Chief People Officer (SW)				
Governance	LPT and NHFT workforce development groups Joint People and Culture Committee, Group Strategic Executive Board, Group Trust Board						
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/GSEB; Agency reduction Group/ 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	
			2nd Line: • Group People and Culture Committee • System People and Culture Board • Workforce deep dives. • Jobtrain effectiveness Review (LPT)	• Delivery of the workforce and agency reduction plan • Delivery of the Workforce efficiency value programme		People plans developed	
			3rd Line: • Benchmarking against workforce metrics • Internal Audit • NHSE Workforce Scrutiny meetings - system				
Effect: High Agency / Bank Usage							
• Agency/Bank Reduction Plans • Start well, stay well, leave well action groups (NHFT) • 90-day onboarding LPT. • Jobtrain implemented (LPT) • Safe staffing Policy • Workforce dashboard monitoring through EMB • Dynamic Risk Assessment process (DRA) • Workforce Efficiency Panel (WEP) NHFT		Nurse vacancies	1st Line • EQIAs DRA and break glass criteria to stop deployment of Thornbury HCA • Workforce safeguards/guardian of safe working hours reports. • Monthly Unify reporting to DoH.		Delivery of the workforce and agency reduction plan Group Chief People Officer March 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	
			2nd Line Agency and bank reduction to Group People & Culture Committee through people dashboards	Delivery of the workforce and agency reduction plan / value programme			
			3rd Line • LLR People Programme Delivery Group • Internal Audit				

BAF09	If we are unable to maintain a sustainable infrastructure and therapeutic environment in line with service requirements, patient need and policy, we may be unable to deliver the desired patient outcomes and financial plan.			Current Risk Position: Impact 4 (major) / Likelihood 3 (possible) Heatmap position: Amber (Medium) Rationale: Strategic commitment with reliance on capital		
Date	1 April 2026 - initial score (I4/L3)	Last updated 25 August 2026			Target Risk Position: Impact 4 / likelihood 2 (unlikely) Target zone: Amber (Medium) Rationale: Standards are met and need maintaining	
Strategic Link	THRIVE: EFFICIENT AND EFFECTIVE	Exec lead(s) Group Chief Commissioning Officer (PS)				
Governance	LPT and NFHT estates groups LPT and NHFT Finance and Performance Committees, Group Strategic Executive Board, Group Trust Board			Control Summary: Medium some gaps remain		
Context	Therapeutic, patient experience, fit for purpose, meet standards, agile working, sustainable			Assurance Summary: Medium some gaps remain		
Key Controls		Control Gaps	Key Sources of Assurance	Assurance gaps	Key Actions	Progress
Cause: unable to maintain and improve our estate						
- Estates Strategy and Delivery Plan - Group Strategic Estates Plan - Accommodation & Space Policy - Estates Annual Plan 24-25 - Green Plan 2026 – 29 - Health and Safety Committee		- Lack of capital funding - Aging estate with limited options for improvement - Having adequate space for clinics and supervision and training	1st Line: Capital Prioritisation process Sustainability Programme Delivery Group	Project timelines for outstanding fire actions relating to Bradgate roof space	- Identify alternative sources of capital Engagement internal to prioritise estates safety Chief Finance Officer, August 26 - Estates Quality Summit complete – 11 actions ongoing – NHFT CFO - Dec 26	Scope of works agreed, contractors working on final design
		Lack of clarity around the cost of implementing the Green Plan	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 Target Risk Position: Impact 3 / likelihood 3 (possible) Target zone: Amber Rationale: Requires sufficient & sustained capital allocations Control Summary: High Assurance Summary: Medium some gaps remain		
Date	1 April 2026 - initial score (I5/L4)	Last updated 11 September 2026						
Strategic Link	THRIVE: EFFICIENT AND EFFECTIVE	Exec lead(s) LPT Chief Finance Officer (SM) NHFT Chief Finance Officer (PS)						
Governance	LPT and NHFT capital committees LPT Finance and Performance Committee, Group Strategic Executive Board, Trust Boards							
Context	Delivery within available capital resources. Estates, digital regulatory, constitutional and legal requirements.							
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		Policy compliance		• External audit of 26/27 accounts CFOs –June 2027 • Manage Trust’s capital plans, CFOs March 27	
			2nd Line: Accounting policies / SFIs and SORD [Audit and Risk Committee]					
			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 receipt of material capital bids		Investigate brokerage/ deferral options with NHSE. LPT CFO – Dec 26	Raised- in July PRM – ongoing
			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 capital strategy								
• National planning guidance		• None	• 1st Line: LLR Joint Capital Resource Use Plan 2026/27; LPT & NHFT medium term capital plans		Lack of national strategic capital funding for estate redevelopment (specifically LPT MH inpatients)		Investigate sources of strategic funding – CFOs – long term Medium term Bradgate Unit estates plan – (PS) – Dec 26	
			2nd line: ICS Capital committee reviews organisational delivery across cluster					
			3rd line:					

BAF11		Inadequate control, reporting and management of each Trust’s 2026/27 financial position could mean we are unable to deliver our financial plan resulting in a breach of our statutory duties and medium-term financial plan.				Current Risk Position: Impact 4 (major) / Likelihood 4 (likely) Heatmap position: Amber (Medium) Rationale: Target Risk Position: Impact 3 / likelihood 4 (likely) Target zone: Amber Rationale: Control Summary: Medium Assurance Summary: Medium		
Date	1 April 2026 - initial score (I5/L4)	Last updated 11 September 2026						
Strategic Link	THRIVE: EFFICIENT AND EFFECTIVE	Exec lead(s) LPT Chief Finance Officer (SM) NHFT Chief Finance Officer (PS)						
Governance	Performance and Finance and Performance Committees, Group Strategic Executive Board, Group Trust Board & Trust Boards							
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.							
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	1 st 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		- Continue reporting & organisational actions to reduce run rate – CFOs Mar 27 - External audit of 26/27 accounts - CFOs June 2027	
			2 nd Line: Accounting policies / SFIs and SORDs		Policy compliance			
			3 rd Line: External Audit 25/26 annual accounts unqualified opinions		26/27 annual accounts audit			
Cause: Inadequate reporting and management								
- Monthly Reports with exec level oversight - Value Programme to deliver local efficiencies		CIP programme	1 st Line: Directorate finance reports; bi-monthly service level run rate reviews; Cost Improvement Plans delivery review		Non recurrent CIP; In year overspends & funding gaps.		- Finalise year 2 & 3 CIP plans –CFOs August 26 - Submit NHSE weekly tracker weekly - CFOs August 2026	LPT – Complete - review at Trust Board 29/09/26
			2 nd Line:					Tracker formally ceased by NHSE 27 August
			3 rd Line: Annual Internal Audit programme					
Effect: Breach of Statutory Duty								
National guidance		None	1 st 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		External audit of 26/27 accounts - CFOs June 2027	
			2 nd Line					
			3 rd Line 2025/26 annual accounts and VFM conclusion		26/27 annual accounts audit			
Effect: Non achievement of medium-term financial plans								
Financial strategies & plans			1 st Line: Medium term financial plans presented to Group SEB		Outputs of deconstructing the block exercise & uncertainty around impact on future revenue receipts		- Work with commissioners to jointly understand outputs of exercise – CFOs Sept 26 - Submit completed exercise – CFOs – Sept 26	CFOs have met with ICB CFO to review high level outcomes, pre submission
			2 nd line: Financial controls & NHSE submissions					
			3 rd line: Internal Audit, financial controls & NHSE submissions					

BAF12	The NHS reforms and performance oversight framework may create an unstable environment with tighter restrictions, which may impact on the pace and delivery of service transformation across our communities.				Current Risk Position: Impact 4 (major) / Likelihood 4 (likely) Heatmap position: Amber (Medium) Rationale: Significant reform creating uncertainty	
Date	1 April 2026 - initial score (I4/L4)	Last updated 16 September 2026				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]
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					
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	1st Line: 2nd Line: Accountability Framework meetings and Executive Management Board LNR System Executive, and Priority Programme infrastructure 3rd Line: NOF segmentation and Provider Capability Ratings NHSE CEO Briefing forums		 System coordination of resource and programme management. Delays in publication of NOF and MTP guidance	- Lobby ICB for greater programme management of key system workstreams (SCS, Digital, etc). Group Chief Integration and Delivery Officer – Sept 26 - Governance redesign to strengthen the delivery of the accountability framework Director of Governance LPT - Oct 26	Discussions underway with ICB, conclusions unlikely until ICB restructure complete ICB programme leads identified for ADHD & OPIP Group NOF dashboard design underway
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) 2nd Line: Tactical (Power BI / QlikView) Dashboards and ward to board oversight of performance 3rd Line: Management Information System (MIS) and BI Data Warehouse 3rd Line: ViH programme reports for increased capacity		Ability to control methodology Reconciliation with national datasets Under-developed impact measures Configuration and management of data quality	- 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.
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) 2nd Line: Triple-A progress reports from Care Delivery Pathway and Directorate Leads 3rd Line:		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 TOMG Group Chief Integration and Delivery Officer - Aug 26 – complete - Combine reporting for Transformation, Quality Improvement & R&I (for clear oversight of capacity prioritisation). Group Chief Integration and Delivery Officer – Dec 26	Both actions are underway, being led via the Strategic Transformation Group. AFT Preparation ongoing