Leicestershire Partnership NHS Trust

Public Meeting of the Trust Board

24 November 2026 commencing at 9.30am

This meeting will take place via Microsoft Teams

Agenda

Standing Items

Time	No.	Item	Paper	Purpose	Lead
9.30am	1.	Apologies for absence: – Josie Spencer NED Welcome to meeting	Verbal	Briefing	Group Chair
9.35am	2.	Service Presentation: Families Young People & Children - Care Navigation Team	Verbal	Discussion	Executive Director of FYPCLDA
10.15am	3.	Questions from the Public	Verbal	Discussion	Group Chair
10.20am	4. 5. • Declarations of interest in respect of items on the agenda 6. • Declarations of interest report	Declaration of Interests	Verbal A	Discussion Briefing	Group Chair Group Chair
10.25am	7.	Minutes of the previous public meeting held 29 September 2026	B	**Decision**	Group Chair
10.30am	8.	Matters Arising (action log)	C	**Decision**	Group Chair
10.35am	9.	Trust Board Workplan	D	Briefing	Group Chair
10.40am	10.	Chair's Report	E	Discussion	Group Chair
10.45am	11.	Chief Executive's Report	F	Discussion	Group Chief Executive
10.50am	12.	Managing Director's Report	G	Discussion	Managing Director
10.55am	13.	Environmental Analysis	Verbal	Discussion	Chair/Group Chief Executive/Managing Director
11.05am	14.	**Break**			

Governance and Assurance

Time	No.	Item	Paper	Purpose	Lead
11.15	15.	Group Board Assurance Framework	H	Discussion	Director of Governance & Risk
11.25	16.	Joint Nomination and Remuneration Committee Terms of Reference	I	**Decision**	Chief People Officer

Quality, Safety and Compliance

Time	No.	Item	Paper	Purpose	Lead
11.35	17.	Quality and Safety Committee AAA Highlight Report: 20 October 2026	J	Discussion	NED (OBO Chair), Quality and Safety Committee
11.40	18.	Safe Staffing Monthly Report	K	Discussion	Group Chief Nurse
11.45	19.	Patient Safety and Learning Assurance Report	L	Discussion	Group Chief Nurse

Finance and Performance

Time	No.	Item	Paper	Purpose	Lead
11.55	20.	Finance and Performance Committee AAA Highlight Report: 20 August 2026 (deferred from last meeting), and 29 October 2026	M1 M2	Discussion	Chair, Finance and Performance Committee
12.00	21.	Finance Report: Month 7	N	Discussion	Chief Finance Officer
12.05	22.	Integrated Performance Report: Month 7	O	Discussion	Managing Director
12.10	23.	EPRR Core Standards Approval	P	**Decision**	Managing Director
12.15	24.	Charitable Funds Committee AAA Highlight Report: 23 September 2026	Q	Discussion	Chair, Charitable Funds Committee

Any Other Business

Time	No.	Item	Paper	Purpose	Lead
12.20pm	25.	Review of risk – any further risks as a result of board discussion?	Verbal	Discussion	Group Chair
12.25	26.	Any Other Business	Verbal	Discussion	Group Chair

	27.	Items not received in line with the workplan: None • Were items and timings appropriate? • What else should have been on the agenda? • Do we need to amend the risk register? • Are there any items to be disseminated across the Trust? • Were the papers clear, concise and aided decision-making? • Were decisions made with due regard to equality?	Verbal	Discussion	Group Chair
12.30pm	28.	**Close and date of next public meeting:** 26 January 2027 at 9.30am	Verbal		Group Chair
	29.	**Information Pack** • Board Assurance Framework • Minutes of the Group Trust Board Meeting held 29 September 2026	Information Pack		Not presented, for information only

Leicestershire Partnership NHS Trust

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Public Trust Board – 24 November 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 - Daughter – Teacher in Northampton	7062	30.09.26
Loyalty interests – son's partner is a police office 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

Current Declarations:	Declaration Reference	Date Interest Arose
Loyalty interests – Member of Midlands region CEO representative for national health working group	4104	01.04.23
Outside Employment – NHFT – Joint CEO	4068	14.11.23
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 – Nationwide Building Society Chair of Board	7058	22.09.26
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

Current Declarations:	Declaration Reference:	Date Interest Arose:
Outside Employment – ExtraCare Retail Limited (Director)	6810	01.01.26
Outside Employment – The ExtraCare Charitable Trust (Director)	6809	01.01.26

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

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

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

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

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

Current Declarations:	Declaration Reference:	Date Interest Arose:
Outside Employment - 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 Interests - Husband is a volunteer at Stewart House	7067	14.10.26
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 24 November 2026
Paper sponsored by:	Kate Dyer, Director of Governance and Risk
Paper authored by:	Kay Rippin Deputy Trust Secretary
Date submitted:	16 November 2026
Name and date of other committee / forum at which this report / issue was considered:	Not applicable
Level of assurance gained if considered elsewhere	☐Assured ☐ Partially assured ☐ Not assured
Date of next report:	July 2026
THRIVE strategic alignment:	☐ **T**echnology ☐ **H**ealthy communities ☐ **R**esponsive ☐ **I**ncluding everyone ☐ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	Not applicable
Is the decision required consistent with LPT's risk appetite:	Yes
False or Misleading Information (FOMI) considerations:	Considered
Positive confirmation that the content does not risk the safety of patients or the public:	Yes
Equality considerations:	Considered

B
Unconfirmed

Leicestershire Partnership NHS Trust

LPT Trust Board

Minutes of the Public Trust Board meeting held 29 September 2026 at 9.30am via Microsoft Teams

Present:
Josie Spencer, Non-Executive Director/Deputy Chair (Chairing)
Melanie Hall, Non-Executive Director/Interim Senior Independent Director
Hetal Parmar, 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:
Tanya Hibbert, Executive Director of Mental Health
Sarah Willis, Group Chief People Officer
David Williams, Group Executive Director of Strategy and Partnerships
Anne Rackham, Group Chief Delivery and Integration Officer (joined meeting at 11:30)
Kate Dyer, Director of Governance and Risk
Chris Skelton, Associate Non-Executive Director
Kamy Basra, Associate Director of Communications and Culture
Abbie Woodhouse, Head of Service, CHS (deputising on behalf of Sam Leak)
Colin Cross, Deputy Director FYPCLDA (deputising on behalf of Sam Leak)
Dr Jon Crossley, Consultant Clinical Psychologist, Systemic Family Psychotherapist and Associate Director of Psychological Professions (in attendance for item 2)
Dr Kelly Fenton, Consultant Clinical Psychologist and Lead of Enhanced Rehabilitation and Recovery Pathway (in attendance for item 2)
Dr Bandana Datta, Clinical Psychologist and Lead of Post-incident Pathway for Staff Support (in attendance for item 2)

TB/26-7/047	**Apologies for Absence** Apologies for absence were received from Faisal Hussain (Chair) Sam Leak and Paul Sheldon. Anne Rackham joined the meeting from 11:30am. Colin Cross and Abbie Woodhouse, deputising for Sam Leak, were welcomed to the meeting. Also welcomed were Dr Jon Crossley, Dr Kelly Fenton and Dr Bandana Datta who were in attendance to deliver the service presentation.
TB/26-7/048	**Service Presentation: Psychological Professions (Medical Directorate)** Bhanu Chadalavada introduced the service presentation which would focus psychological professions. The team presenting included Dr Jon Crossley (Consultant Clinical Psychologist, Systemic Family Psychotherapist and Associate Director of Psychological Professions), Dr Kelly Fenton (Consultant Clinical Psychologist and Lead of Enhanced Rehabilitation and Recovery Pathway) and Dr Bandana Datta (Clinical Psychologist and Lead of Post-incident Pathway for Staff Support).

Outlined on Community Enhanced Rehabilitation Team Presentation (CERT)

- The presenters highlighted the work of the Community Enhanced Rehabilitation Team (CERT) as an example of a high-functioning team culture. Benefits reported included:
- High staff retention.
- Low sickness absence.
- Reduced burnout.
- Improved patient outcomes.
- Fewer hospital readmissions.
- The team demonstrated how psychological approaches can improve both staff experience and quality of care.

Post-Incident Pathway for Staff Support Team Presentation (PIPS)

- A significant part of the presentation focused on the Post-Incident Pathway for Staff Support (PIPS), launched in 2024 to support staff following traumatic workplace incidents. Discussion covered:
- Structured support after difficult events.
- Psychological debriefing and recovery.
- Improved confidence returning to work.
- Reduced risk of long-term psychological harm.
- Positive feedback from staff who had used the service.
- Board members welcomed the initiative and its impact.

Board members asked several questions and made observations including:

- How lessons from successful teams could be spread across the Trust.
- Whether there was enough psychological support capacity to meet future demand.
- The relationship between staff wellbeing, retention and patient safety.
- How the Trust could further embed compassionate leadership and psychological safety within teams.
- Staff wellbeing is directly linked to patient care quality.
- Psychological support should be viewed as a strategic investment rather than simply a wellbeing initiative.
- Creating psychologically safe teams can improve recruitment, retention and staff experience.
- The work demonstrated a clear connection between organisational culture and clinical outcomes.

Angela Hillery thanked the presenters for an informative presentation and welcomed the opportunity to better understand the breadth of the Psychological Professions. Angela Hillery acknowledged the significant contribution of psychological professions to patient care and the positive examples of practice shared with the Board.

Angela Hillery asked about psychological safety, particularly during periods of organisational change, and how the Trust could support teams both in the short term and across the wider group

Jon Crossley said there is a balance between the top-down requirements the NHS expects organisations to deliver and the bottom-up views of staff and

	teams. Jon Crossley emphasised that leaders need to create environments where staff feel able to share ideas, work through uncertainty, and contribute to solutions. Jon Crossley also highlighted the importance of preparing staff moving into leadership roles to manage multiple perspectives and maintain psychological safety within teams. It was confirmed that there is work to do in developing leaders' skills to hold different viewpoints, encourage innovation, and create opportunities for staff to speak up and contribute ideas safely. Bandana Datta added that psychological safety is fundamentally a "felt experience" rather than something that can only be measured. She explained that if people experience safe, supportive environments, they understand what psychological safety looks and feels like, making it easier to achieve across teams Sharon Murphy shared a real-life example from the Finance Team following the sudden unexpected death of a colleague. Sharon Murphy said: • The team accessed the PIPS (Post-Incident Pathway for Staff Support) service. • The support provided was invaluable, both immediately after the event and on an ongoing basis. • As both an individual and a leader, she felt grateful to have that support available during a time when the team felt lost. • Sharon Murphy said the service made a significant difference to the team and thanked both the Trust and the Psychological Professions team for providing it. Tim Harrison asked how scalable is it in relation to increased demands in future years. Jon Crossley responded that demand had grown beyond the original intention of team debriefs and that there was now a significant need for individual support, particularly relating to: • Coroners' inquests • Tribunals • Other highly stressful professional processes Jon Crossley explained that the team was: • Working closely with the LPT Legal Team and colleagues. • Trying to identify periods when support demand is likely to rise. • Protecting time and resources to offer support. • Considering how to make the service sustainable given the growing demand. Bandana Datta agreed that requests for support around coroners' inquests were increasing. Bandana Datta explained that: • A qualitative service evaluation was being undertaken across the Trust. • The team was studying staff experiences of coroners' inquests. • They were linking with a university researcher who had completed research on mental health staff experiences of coroners.

- They were working with Nila Patel and the Legal Team to develop a longer-term support model.
- Some staff, especially medical colleagues, may not currently come forward for support, so unmet need may be greater than reported.

Tanya Hibbert made a supportive comment about the value of the service and the impact it has on staff. She highlighted that:

- The presentation demonstrated the significant contribution that psychological support services make across the Trust.
- The work was helping staff manage the emotional impact of difficult situations and supporting staff wellbeing.
- The service provided benefits not only for individual staff members but also for teams and the wider organisation.
- Tanya Hibbert welcomed the evidence presented and thanked the team for their work.

The presenters thanked Tanya Hibbert for her comments and agreed that continued investment in staff psychological wellbeing was important for both staff experience and patient care.

Melanie Hall questioned whether there may be more demand than is currently visible, with some staff not accessing support even when they would benefit from it.

Melanie Hall suggested exploring what the true level of demand should be for an organisation of LPT's size and the types of incidents staff experience.

Melanie Hall highlighted that psychological support could potentially be used more widely, including after:

  - Difficult grievances
  - Team disputes
  - Other challenging workplace situations, not just major incidents or traumatic events.

Melanie Hall strongly endorsed reflective practice, describing it as a key way to help reduce stress and anxiety and suggesting it should become more embedded in both everyday work and Trust-wide support arrangements.

Jon Crossley agreed with her observations and confirmed that it is difficult to know the true level of demand because the Trust is still developing a culture where staff feel able to seek psychological support. Increasing awareness and demonstrating the value of support are important. Using champions, as suggested earlier by Tanya Hibbert, could help encourage uptake. The Trust is learning from national networks, research, and pilot projects to understand what support staff need and what works best.

Hetal Parmar commented and thanked the presenters for an excellent and thought-provoking presentation noting the breadth of psychological support being provided across the Trust and the positive difference it was making to staff.

Hetal Parmar also highlighted the importance of creating environments where staff feel safe to speak up, learn, and reflect following difficult experiences, commenting that the work aligned closely with the Trust's ambitions around staff

	wellbeing, inclusion, learning culture and psychological safety. Hetal Parmar expressed support for continuing to develop and embed these approaches across services Jon Crossley responded and thanked Hetal Parmar for her comments and agreed that psychological safety and reflective practice are essential components of a healthy organisational culture. The importance of making support accessible and normalising conversations about wellbeing and staff experience was reiterated. Bhanu Chadalavada highlighted that the benefits extend beyond the individual member of staff and have a wider organisational impact. Bhanu Chadalavada referred to benefits such as: • Improved staff wellbeing and resilience. • Better staff retention and reduced impact of workplace stress. • More effective and supported teams. • A positive effect on organisational culture and staff experience. • Better outcomes for patients through a healthier and more supported workforce. Josie Spencer stated that the value of the service goes beyond the immediate support provided to individuals. Josie Spencer highlighted the wider benefits around prevention, staff retention, wellbeing, and organisational culture, many of which are difficult to measure but are nevertheless important. Bandana Datta responded and agreed that measuring the full impact of psychological support services can be challenging because many benefits are preventative and long term. They acknowledged that supporting staff wellbeing has wider organisational benefits, including staff retention, engagement and quality of care. Kamy Basra commented on the chat PIPPS is widely communicated via our HWB offer and Team Time Out materials confirming the great initiative that will continue to be promoted to leaders and staff. The Board thanked Jon Crossley for his presentation.
TB/26-7/049	**Questions from the Public (verbal)** There were no public questions received.
TB/26-7/050	**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/26-7/051	**Minutes of the previous public meeting held 28 July 2026 (Paper B)** The minutes were approved as an accurate record of proceedings. **Resolved:** The Board approved the minutes of the previous public meeting held 28 July 2026.
TB/26-7/052	**Matters Arising (Paper C)**

	There were no outstanding actions.
TB/26-7/053	**Trust Board Workplan 2026/27 (Paper D)** The Trust Board Workplan was presented for information. No questions or queries were received.
TB/26-7/054	**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: • The Chair advised that the report had been written by Faisal Hussain, who was unable to attend the meeting. • The Chair stated that if there were any questions, they would be recorded and Faisal Hussain would respond when he returned. • The Chair then asked whether there were any questions on the report. **Resolved:** The Board received this report for information.
TB/26-7/055	**Managing Director's Report (Paper F)** Jean Knight presented this report which provided an update on current local developments since the last Board meeting. **Key points highlighted by Jean Knight:** • The Annual General Meeting was held on 8 September with over 100 people attending online. • The Agnes Unit achieved a Good CQC rating, with positive feedback about the compassion and care provided by staff. • Two unannounced CQC inspections took place at the Beacon Unit and the Acute Inpatient/PICU services, with outcomes awaited. • Leicestershire Partnership NHS Trust achieved Segment 2 in the National Oversight Framework and was ranked 12th out of 58 mental health trusts. • The Celebrating Excellence Awards received over 270 nominations. • October was highlighted as Speak Up Month, with roadshows planned across 35 sites .Josie Spencer praised the report and highlighted: • The positive CQC result for the Agnes Unit. • The Trust's improved national ranking. • Interest in attending the Celebrating Excellence Awards. • Specifically drew attention to the research on preventable and avoidable deaths in people with learning disabilities, saying it looked like a very important piece of work and that she would like to see future updates through Quality & Safety Committee or the Board Jean Knight responded and agreed that the learning disabilities mortality research was a fundamental piece of work and stated that there are still too many deaths, particularly from conditions such as respiratory illnesses, and that services must do better. The Board welcomed the opportunity to connect the findings of that research with wider improvement work

	Melanie Hall commended the report, noting the Trust's strong focus on listening to patients, families, communities, and partners through initiatives such as service visits, Friends and Family Test feedback, research, and co-production. The Board received and noted the Managing Director's Report, with positive comments about the Trust's achievements and engagement work. **Resolved**: The Board received this report for information.

TB/26-7/056	**Environmental Analysis (verbal)**
	Angela Hillery provided a verbal update which included
	
	• The Board was reminded of the findings and recommendations from the Thirlwall Inquiry. Board members were encouraged to read the report and reflect on:
	  ○ What would be different within their own organisation.
	  ○ How they would know if similar issues could occur locally.
	• It was agreed that further consideration of the Inquiry would take place during a future Group Board development session.
	• Angela Hillery reported on a recent meeting with Healthwatch partners, including discussion of work undertaken by the Trust's charitable activities and ongoing engagement with local communities
	• An update was provided on the Mental Health Collaborative Forum, attended by 26 people. Positive developments highlighted included:
	  ○ Strong partnership working.
	  ○ Increased involvement of the voluntary and community sector.
	  ○ Co-production as a common theme across projects.
	  ○ Progress towards developing 24/7 mental health centres within neighbourhoods.
	  ○ An upcoming partnership away day for collaborative working.
	• The importance of the seasonal flu vaccination programme was emphasised, with Board members and staff encouraged to have their vaccinations to help reduce harm to patients and colleagues.
	
	The update was noted by the Board.

TB/26-7/057	**Audit and Risk Committee AAA Report: 11 September 2026 (Paper G)** Hetal Parmar presented this report which included the Annual Effectiveness Review and Terms of Reference and drew attention to the following key points: • The committee received Moderate Assurance from an internal audit on absence management. The findings were considered helpful and actions were already being progressed. • The Counter Fraud, Bribery and Corruption Report was reviewed. The Trust rated itself Amber for training completion, although bespoke training was available to staff. • The Audit and Risk Committee Annual Effectiveness Review was presented, highlighting achievements, challenges and future priorities. A key focus was ensuring ARC work links more directly to patient and people outcomes.

	• The Governance and Risk Report highlighted the breadth of governance and risk management work across the Trust and its importance in supporting patient care and organisational culture. • The Emergency Preparedness, Resilience and Response (EPRR) report confirmed the Trust believed it was fully compliant and that an NHS England challenge exercise would be undertaken. • A notable success was the signing off of the annual accounts with a completely clean external auditors' report, which was highlighted as a significant achievement. Melanie Hall asked whether the internal audit report on sickness absence management had been shared with the People and Culture Committee (PCC) and whether there was clear ownership for following up the actions arising from the audit. Hetal Parmar responded and confirmed that the sickness absence audit report had been shared with Tim and relevant colleagues. Some actions would need to be overseen through the appropriate Level 1 committees, including the People and Culture Committee. And one key action related to improved reporting on adherence to policy. Tim Harrison commented and confirmed that sickness absence management was already being picked up through the joint People and Culture Committee. He stated it would continue to be monitored and owned through that route. When the Board moved to the Audit & Risk Committee Annual Effectiveness Review, Hetal Parmar reminded members that the Board not only needed to note the report but also formally agree the assurance regarding the committee's effectiveness. The Board subsequently agreed it was assured about the effectiveness of the Committee. **Resolved:** The Board received this report for information and assurance.
TB/26-7/058	**Trust Board Annual Effectiveness Review 2025-26 and Terms of Reference (Paper H)** Kate Dyer presented the Trust Board Annual Effectiveness Review 2025-26 and Terms of Reference. Kate Dyer reported that Board member attendance throughout 2025-26 had been good and all meetings had remained quorate. The annual review assessed the effectiveness of the Board against the requirements of the Code of Governance. Feedback from Board members highlighted the importance of continuing to place patients at the centre of Board discussions, maintaining oversight of the Trust's strategic ambitions, and further improving the quality and effectiveness of Board papers. The review also noted strong alignment amongst Board members regarding the Board's strengths, priorities and areas for future development. Melanie Hall said the effectiveness review process was healthy, transparent and important because it allowed reflection on both achievements and areas for development. Kate Dyer responded that there was strong consistency in Board members' feedback, indicating alignment among members regarding achievements, challenges and future priorities.

	Resolved: The Board confirmed assurance regarding the effectiveness of the Trust Board and Approved the updated Terms of Reference for 2026-27.
TB/26-7/059	**Joint Nominations and Remuneration Committee Terms of Reference (Paper I)** Kate Dyer presented the Joint Nominations and Remuneration Committee Terms of Reference. The report outlined proposed amendments to the Terms of Reference to ensure they remained aligned with current governance arrangements and the developing Group structure. Board members considered the proposed changes, and no significant concerns were raised. The revisions were intended to clarify the committee's responsibilities, membership and reporting arrangements. The Board subsequently approved the updated Terms of Reference. Hetal Parmar commented that under membership it says two non-executive directors from both trusts and asked if that meant four members in total (two from each trust), or does it mean two members overall with representation from both trusts. Kate Dyer clarified Two from each trust, so four in total. Melanie Hall also raised a related point about the wording around the Chair or Joint Chair and whether the drafting could be made clearer. Kate Dyer agreed that the wording should be tightened up to make the membership arrangements clearer while still approving the Terms of Reference. **Resolved:** The Board approved the updated Joint Nominations and Remuneration Committee Terms of Reference.

TB/26-7/060	**Quality and Safety Committee AAA Report: 18 August 2026 (Paper J)**
	Josie Spencer presented this report and highlighted the following key points:
	
	The Board received the Quality and Safety Committee AAA Report: 18 August 2026. The report provided assurance from the committee regarding quality and safety matters considered at its August meeting, including patient safety, quality performance, governance arrangements and key risks. The Board noted the assurances provided by the committee and the actions in place to address identified concerns and support continuous improvement.
	
	Key points included:
	
	• There were no new alerts for the Board.
	• The existing alert regarding neurodevelopmental waiting times and pathways remained in place.
	• Concerns were noted regarding the cessation of non-recurrent ADHD funding and the impact on waiting lists.
	• Positive assurance was received regarding:
	  ○ Equality Impact Assessments linked to Cost Improvement Programmes.
	  ○ Improved complaints performance, with 92% of complaints closed within timescales and 99% acknowledged within three days.
	  ○ The success of the one-stop memory service, where 88% of people received a diagnosis on the same day.

	Chris Skelton asked whether there was any national development or "light at the end of the tunnel" regarding ADHD waiting lists, noting that the situation appeared to be worsening across NHS trusts. Josie Spencer acknowledged the significance of the issue, noting that it had been discussed extensively by the Quality and Safety Committee due to concerns about the impact of funding changes. Josie Spencer advised that discussions were ongoing with commissioners and system partners regarding future service models and invited colleagues to provide further detail on developments Tanya Hibbert explained that commissioners had established a joint approach across Leicester, Leicestershire, Rutland and Northamptonshire. New ADHD service models being developed in the Northwest were showing promise. The proposed future model would treat ADHD more as a long-term condition, with greater involvement from primary care. This would require investment and commissioning changes, but work was progressing positively through the ICB governance processes. Bhanu Chadalavada, advised that future pathways would prioritise people based on need and complexity, including those requiring medication and those who may benefit from alternative interventions. Angela Hillery reported that the issue had also been discussed at the Mental Health Collaborative and that a Midlands and East improvement network was being developed to share best practice across trusts. Hetal Parmar welcomed the progress made by the memory service and asked whether future ADHD prioritisation would take account of vulnerability, particularly for homeless individuals and children requiring early support. Colin Cross and Bhanu Chadalavada confirmed that prioritisation would be needs-based and would consider vulnerability and co-morbidity factors. **Resolved:** The Board received this report for information and assurance.
TB/26-7/061	**Safe Staffing Monthly Report (Paper K)** Linda Chibuzor presented this report which provided a full overview of nursing safe staffing during the month of May 2026. The report provided an update on safe staffing levels across the Trust, including workforce metrics, fill rates and staffing pressures. The Board noted the assurance provided regarding the monitoring of staffing levels and the actions being undertaken to support safe and effective care delivery. Key points included: • Overall assurance that safe staffing levels continued to be maintained across the Trust through established monitoring and governance processes. • Staffing fill rates remained under close review, with particular attention given to areas experiencing workforce pressures. • Ongoing recruitment and retention initiatives were helping to reduce reliance on temporary staffing in some services. • Any staffing risks identified through the reporting process were being escalated and managed through the appropriate governance routes.

	Melanie Hall questioned the variation in staffing levels and the use of temporary staffing across services. Melanie Hall sought assurance that areas experiencing workforce pressures were being appropriately risk assessed, and that patient safety was not being compromised where vacancies existed. Linda Chibuzor responded and explained that safe staffing reviews were undertaken regularly. Services with staffing pressures were subject to enhanced oversight. Temporary staffing was deployed where required to maintain safe care and any significant staffing risks were escalated through the Trust's governance processes. Hetal Parmar queried whether the increase in bank and agency staffing use in some areas represented a short-term issue or indicated a more sustained workforce challenge, and sought assurance that staffing pressures were being managed appropriately. Linda Chibuzor advised that staffing pressures were being closely monitored through the Trust's safe staffing processes, and that recruitment activity was ongoing. She explained that temporary staffing continued to be used where necessary to maintain safe services while permanent recruitment and retention actions progressed. Angela Hillery asked about the sustainability of staffing arrangements and the Trust's ability to maintain safe staffing levels in the context of ongoing workforce shortages. Angela Hillery sought assurance that there was sufficient oversight of areas experiencing recruitment difficulties and that risks were being effectively managed. Linda Chibuzor confirmed that staffing levels and associated risks were closely monitored through established governance arrangements, supported by ongoing recruitment and retention initiatives. The Board received assurance and noted the report. **Resolved:** The Board received this report for information and assurance.
TB/26-7/062	**Patient Safety and Learning Assurance Report (Paper L)** Linda Chibuzor presented this report which provided assurance of the efficiency 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: • Patient safety performance and learning from incidents across the Trust. • Themes, trends and areas requiring continued oversight to improve patient safety outcomes. • How learning from incidents, investigations and safety reviews was being embedded within services. • Assurance regarding the Trust's patient safety governance arrangements and improvement activity.

	Hetal Parmar asked whether there was any benchmarking data to compare LPT's patient safety incident rates (moderate harm, low harm, etc.) with similar trusts and whether LPT was an outlier. Linda Chibuzor responded Benchmark information is available through regional and national patient safety networks. LPT is not considered an outlier confirming that comparisons have limitations because different organisations classify incidents differently, particularly near misses. Melanie Hall asked whether the summer heatwaves may have influenced patient safety incidents, behaviours, or physical health issues, and whether this was reflected in the report. Linda Chibuzor responded the trust believes weather conditions may have had an impact and is reviewing the data. Further analysis is being carried out to understand any correlation. Extensive measures were taken during hot weather, including hydration support, environmental adaptations and patient safety actions. A fuller review would be reported later. Bhanu Chadalavada added National discussions are taking place about heat impacts on healthcare services. LPT monitored risks such as dehydration, medication absorption and photosensitivity. No evidence had been seen at that stage of increased medication toxicity related to the heatwave Tim Harrison commented positively that the patient safety data appeared stable and consistent, which provided assurance compared with previous years when variation was greater Josie Spencer raised concerns about wards experiencing repeated self-harm incidents (specifically mentioning Walter Mead and Beaumont wards) and asked what support was being provided to staff working in these stressful environments Bhanu Chadalavada responded that: Self-harm incidents are reviewed through the Self-Harm and Suicide Prevention Group. Emerging patterns trigger work with ward teams; support strategies are developed with wards. Staff can access the Post Incident Pathway Support (PIPS) service where needed. Linda Chibuzor explained staff support arrangements: • Immediate team debriefs occur after incidents. • Senior nursing leaders and executives provide direct support. • Professional Nurse Advocates (PNAs) offer restorative supervision. • Psychological support is available from trust psychologists. • Staff can access ongoing individual support where required. Tanya Hibbert added that regular reflective practice sessions are built into ward programmes as routine support, this helps staff process difficult experiences even when there has not been a major incident. These sessions complement PIPS and other wellbeing support **Resolved:** The Board received this report for information and assurance.
TB/26-7/063	**Emergency Preparedness, Resilience and Response (EPRR) Annual Report (Paper M)**

	Anne Rackham presented the Emergency Preparedness, Resilience and Response (EPRR) Annual Report and gave Key points from the report:
	• LPT submitted its Core Standards application and expected to achieve full compliance, with further validation from NHS England still to take place.
	• Significant focus during the year was on:
	  ○ Training for managers and directors on call.
	  ○ Business continuity planning.
	  ○ Site-specific resilience planning.
	  ○ Emergency exercises and testing arrangements.
	• The trust has expanded planning for multi-team community sites, helping preparedness for incidents such as:
	  ○ Fire
	  ○ Lockdowns
	  ○ Cyber incidents
	  ○ Building-related emergencies
	• Following the summer heatwaves, the trust plans to undertake a summer debrief across the group to identify lessons learned for future planning.
	
	Anne Rackham advised that the Executive Management Board had recently considered the report and supported the assurance provided regarding the Trust's emergency preparedness, resilience and response arrangements.
	
	Melanie Hall Provided very positive feedback and highlighted:
	• The report demonstrated a strong commitment to preparedness.
	• Emergency plans are valuable, but regular exercises and testing are what create "muscle memory" when an actual incident occurs.
	
	Resolved: The Board received this report for information and awareness

TB/26-7/064	**LLR LeDeR Annual Report 2025-26 (Paper N)**
	
	David Williams presented the LLR LeDeR Annual Report 2025-26, outlining activity undertaken during the year and the learning identified through reviews of the deaths of people with learning disabilities and autistic people across Leicester, Leicestershire and Rutland. The report highlighted key themes, learning and improvement actions, together with arrangements for sharing learning across the system. The Board noted the report and received assurance regarding the governance and oversight of the LeDeR programme and the actions being taken to improve outcomes and reduce health inequalities.
	
	LPT is the lead provider for the LeDeR programme, bringing together system partners to review the lives and deaths of people with learning disabilities and autism and identify learning across the system. Key points included:
	  ○ Mental Capacity Act understanding and application.
	  ○ Improving access to screening and immunisations.
	  ○ Earlier diagnosis of physical health conditions.
	  ○ Making reasonable adjustments for people with learning disabilities and autism.
	David Williams asked the Board to:
	  ○ Receive assurance on the report.
	  ○ Endorse the findings and recommendations.
	  ○ Support implementation of priority areas.

	○ Continue oversight of progress. Angela Hillery Highlighted the repeated theme around the Mental Capacity Act (MCA). And asked for assurance that the Trust continues to challenge itself on whether staff are translating MCA knowledge into everyday practice, not just understanding the legislation. Sharon Murphy reflected on a recent visit to the Primary Care Liaison Nursing Team. Sharon Murphy praised the work to ensure people are included on the Learning Disability Register, noting the report showed 100% of reviewed cases in 2025/26 were on the LD register, which she described as a testament to the team's advocacy and hard work David Williams responded and explained that being on the LD register not only supports annual health checks but also ensures people can be identified for LeDeR reviews after death, stating that individuals not recorded on the register can be missed in learning-from-deaths processes. Josie Spencer commented that annual health checks and register development have helped identify people who may previously have had little or no contact with secondary care services. Linked this work directly to reducing health inequalities. Chris Skelton asked about the safeguarding ratings table on page 219 and queried whether safeguarding referrals should be considered where ratings are 2 or lower, rather than only where both scores are at the lowest level. It was agreed that the wording appeared to require correction and confirmed it should likely refer to 2 or lower. Melanie Hall praised the report and highlighted the extensive partnership working behind the outcomes and commented that the report demonstrates why system-wide collaboration is essential to improving outcomes for people with learning disabilities and autism Hetal Parmar reflected on a recent visit to the Integrated Community Specialist Palliative Care Team. Observed that LeDeR learning has practical implications for how services prioritise and support people with learning disabilities and autism, commenting on the positive impact the work has on service-user care
TB/26-7/065	Finance Report – Month 5 (Paper O) Melanie Hall summarised key points from the recent Finance and Performance Committee • The committee had one advisory concern relating to financial pressures, reflecting the ongoing challenges in delivering savings while managing operational pressures. • A detailed review of the Director of Mental Health value programme showed good progress in delivering efficiencies, but some of these gains were being offset by pressures such as private bed usage. • The committee undertook a deep dive into Board Assurance Framework Risk 12, concerning the unstable external environment, and received significant assurance on how the risk was being managed.

	• They reviewed the draft Digital Plan and received assurance regarding both the quality of the plan and the resources identified for the Green Plan
	
	Sharon Murphy highlighted the following key points:
	
	• The Trust delivered its planned year-to-date financial position at Month 5, with a deficit of £1.9 million, which was in line with plan.
	• The operational overspend was £1.8 million, an increase of £132,000 from Month 4, but the rate of overspending was continuing to reduce, which she described as a positive sign.
	• On Cost Improvement Programmes (CIPs):
	  ○ There was an operational under-delivery of £905,000.
	  ○ This was being offset by over-delivery in corporate schemes.
	  ○ Executive teams were reviewing additional mitigations to close the gap.
	• The Trust had seen positive movement in reducing overspend run rates and forecast overspends had reduced by around £1 million compared with Month 4.
	• However, there remained uncertainty around funding for the 2026/27 pay award from the ICB, and a prudent assumption had been included in the forecast because funding might not fully cover Trust costs.
	• To achieve the planned break-even position by year end, the Trust still needed approximately £3 million of further cost reductions over the remaining seven months of the financial year.
	• Agency spending and cash performance were both delivering better than plan, which was positive.
	• On capital spending:
	  ○ Year-to-date spend was £3.3 million.
	  ○ This was £4.4 million below plan, largely due to delays in approval and receipt of nationally funded schemes.
	  ○ This was a national issue affecting multiple providers, not just LPT.
	
	Looking ahead, Sharon Murphy said work on the Medium-Term Financial Plan was progressing well, with early identification of savings plans intended to put the Trust in a stronger position from 1 April 2027.
	
	One particularly notable comment was that although financial performance was improving, the Trust still needed to maintain reductions in spending and deliver additional savings to remain on track for break-even by year-end.
	
	The Board noted the Month 5 financial position, discussed the key risks and mitigating actions, and received assurance regarding delivery of the Trust's financial plan.
	
	Resolved: The Board received this report for information and assurance.

TB/26-7/066	**Integrated Performance Report – Month 5 (Paper P)** Sharon Murphy presented the report noting:

	• The Trust has maintained its Segment 2 rating under the National Oversight Framework. • The performance dashboard now includes the published Quarter 1 scores. • There are now 26 performance metrics, more than double the number used last year, making the continued Segment 2 rating particularly positive. • Performance trajectories for all measures are now included and are being monitored through Trust governance processes. • The Directorate of Mental Health length of stay was slightly above target at Month 5 due to increased demand and complexity during the summer months. • 52-week waiting times continue to improve, with many services now showing zero patients waiting over 52 weeks. • There has been exceptional progress in psychological therapy services, supported by pathway redesign and balancing assessment and treatment capacity. • Performance was reviewed in detail at the Accountability Framework meeting, and there was nothing further to escalate to the Board Josie Spencer also noted Improvements in areas such as audiology waiting times. Ongoing concern regarding staff sickness absence was noted, which remained flagged and would likely be discussed further through the People and Culture Committee and Group Board discussions. Angela Hillery highlighted concerns about the number of patients who are clinically ready for discharge within mental health services. She noted that although performance is improving, the numbers remain significant. The issue requires partnership working with other agencies. The Board should continue focusing on the impact on patients waiting for beds and on system-wide risks. Tanya Hibbert responded that: • There is established governance around clinically ready for discharge patients. • Work with partner organisations is ongoing every day. • Positive feedback had previously been received from partners and inspectors regarding discharge processes. • The issue remains an ongoing challenge and could be explored further through the Quality and Safety Committee. **Resolved:** The Board received and approved this report.
TB/26-7/067	**Group Board Assurance Framework (BAF) (Paper Q)** This item / paper / report was received for information. Kate Dyer explained the Group BAF is presented to each individual Trust Board, where a Group Board meeting takes place on the same day, the detailed discussion is held at the Group Board meeting rather than the Trust Board meeting. **Resolved:** The Board received this report for information.
TB/26-7/068	**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/26-7/069	**Any Other Urgent Business**
TB/26-7/070	**Papers/updates not received in line with the work plan** • Finance and Performance Committee AAA Highlight Report: 20 August 2026 – *deferred to November 2026.*
	Close - date of next public meeting: Tuesday, 24 November 2026 at 9.30am

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NHS
Leicestershire Partnership
NHS Trust

Public Trust Board 24 November 2026

Matters arising from the Public Trust Board meeting held 29 September 2026

Action sheet

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

T H R I V E

NHS
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NHS Trust

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LPT Trust Board Workplan 2026/27 v9

		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

T H R I V E

		26- May-26	24-June-26	28-July-26	29-Sep-26	24-Nov-26	26-Jan-27	30-Mar-27
Item/Theme		DMH	EGM	FYPCLDA	Enabling / Medical	CHS	DMH	FYPCLDA
Managing Director's Report	Every meeting	X		X	X	X	X	X
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 *(to be appended to AAA Highlight Report)*	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 *(Annual Reports to be appended following the June QSC)*	Every meeting Chair, QSC	X *(21.04.26)*		X	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
				(19.05.26 & 16.06.26)				
Safe Staffing Monthly Report	Every meeting Group Chief Nurse	X		X	X	X	X	X
Patient Safety and Learning Assurance Report	Every meeting Group Chief Nurse	X		X	X	X	X	X
Freedom to Speak Up Annual Report *(FTSU Guardian to attend to present)*	Annual Managing Dir			X				
Emergency Preparedness, Resilience and Response (EPRR) Annual Report	Annual Managing Dir			~~X~~ 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							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
	Group Exec Dir. Strat & Part							
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		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
	Group Chief People Officer							

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Public Trust Board [24th November 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 October – November 2026. Activities relating to formal Committees of the Board are reported through custom reports.

Analysis of the Issue

Chair/NED Appraisals, Recruitment and Succession Planning

NED appraisals have now been shared with NHSE in line with regulatory reporting requirements and I will shortly begin mid-year reviews with the team.

We have recently undertaken a NED recruitment campaign, however on this occasion we were not in a position to make an appointment to the vacancy. We will now consider the next steps required to progress the recruitment.

Joint Board Development Workshop

On 27 October 2026, Board colleagues from both Trusts came together for a Joint Board Development Workshop, facilitated by Deloitte. The workshop formed part of NHS England's Board Development Programme, a 12-month programme designed to strengthen collective Board leadership, governance and the ability to lead organisational transformation.

The day explored the role and purpose of the Board, their role in transformation, and in leading change. It also provided an opportunity for us to consider the most critical adaptive challenges and how we approach those. This reflects the wider programme's emphasis on supporting Boards to shape strategic direction and organisational culture, with a focus on quality at the centre of leadership.

We look forward to undertaking two further sessions over the next year.

NHSE NED Best Practice Away Day

NHSE Midlands held an NED Best Practice Away Day, on 12th November 2026, which was a great opportunity for our NEDs to hear updates on integrated health organisations from our Group Trust, Northamptonshire Healthcare Foundation NHS Trust (NHFT) and their potential benefits, strengthening patient and staff voices in Board discussions, and opportunities for closer working with care homes and domiciliary care providers. The agenda also included approaches to frailty, urgent and emergency care and planned elective care, providing a focus for shared learning across the region.

Mental Health Chairs Network

October's Mental Health Chairs Network meetings covered discussions on the cross government mental health strategy and areas of priority of challenges. Discussions focused on prevention, early intervention, neighbourhood-based support and specialist services, alongside the opportunities and challenges associated with delivery, including workforce capacity, funding, commissioning, data quality and the role of digital services. Chairs emphasised the need for sustainable investment, robust evidence and strong partnership working to ensure the strategy delivers meaningful improvements in mental health outcomes.

Working with Partners and Stakeholders

I continue to meet regularly with Chairs across LNR, both individually and collectively. These sessions continue to prove invaluable for all partners, not least for focusing on the main challenges being faced by our NHS organisations in LNR and how we can collectively tackle these together as a system – including working with other stakeholders. They are also a clear forum for strengthening relationships with my Chair colleagues and using the forum as safe space for the purposes of learning and sharing exchange.

At the recent LNR health system Chairs and Chief Executives session we focused our discussions on urgent and emergency care and winter preparedness, drawing on input from the Urgent and Emergency Care Boards in both counties. We discussed system-wide actions, with a particular focus on discharge opportunities.

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

- NHSE Mental Health Regional Chairs Call
- East Midlands Alliance (EMA) Learning Event
- System Chair/CEO Meetings
- Joint NED Catch Up meetings
- East Midlands Alliance: Quality & Safety Committee Chairs

Public, Patient and Staff Engagement

The Deputy Chair, representing me, had the pleasure of attending our Celebrating Excellence Awards on 1 October 2026 at the Athena in Leicester. The event brought together staff, teams and volunteers, with awards presented across several nominations from patients, service users, carers, colleagues and members of the public. It provided an opportunity to celebrate the work taking place across all of our services and the contribution to our vision of building compassionate care and wellbeing for all. I would like to thank everyone involved in making the evening really special.

I was honoured to join supporters, community partners and staff to celebrate the 10th anniversary of Raising Health, our charity. The event highlighted the difference charitable support makes to our patients and services. In 2025/26, £598,000 supported 183 projects, directly benefiting an estimated 46,000 people across Leicester, Leicestershire and Rutland. Looking ahead, the charity's £1 million appeal aims to create dementia-friendly environments across our community hospitals and older adult mental health wards, supporting independence and improving patient experience. I would like to thank everyone whose generosity helps us enhance care beyond what NHS funding alone can provide.

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

- Supporting Freedom to Speak Up Roadshow
- Celebrating Excellence Awards
- AHP Conference
- Service visit: Adult Eating Disorder
- Service Visit Early Language Support for Everyone (ELSEC)
- Support Freedom To Speak Up Roadshows

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 November 2026
Paper sponsored by:	Faisal Hussain, Interim Group Chair
Paper authored by:	Sinead Ellis-Austin, Head of Chair/CEO Office
Date submitted:	16th November 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:	January 2026
THRIVE strategic alignment:	☒ **T**echnology ☒ **H**ealthy communities ☒ **R**esponsive ☒ **I**ncluding everyone ☒ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	N/A
Is the decision required consistent with LPT's risk appetite:	N/A

False or Misleading Information (FOMI) considerations:	None
Positive confirmation that the content does not risk the safety of patients or the public:	Yes
Equality considerations:	Incorporated in approach to recruitment and other activities.

Appendix 1

E

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Hetal Parmar	18/08/2026	DAISY Award	I
Hetal Parmar	27/08/2026	360 Internal Audit catch-up	I
Hetal Parmar	03/09/2026	HR meeting - Absence Meeting Audit findings	I
Hetal Parmar	08/09/2026	LPT Annual General Meeting	I
Hetal Parmar	10/09/2026	NHS Group Governance models	E
Hetal Parmar	17/09/2026	Service visit: Integrated Community Specialist Palliative Care service	I
Melanie Hall	02/10/2026	Freedom To Speak Up Roadshow	I
Faisal Hussain/Deputy Chair	06/10/2026	Chair/Deputy Chair Meeting	I
Faisal Hussain	06/10/2026	NHSE Regional Chair Meeting	E
NEDs	07/10/2026	LPT Board development session	I
Melanie Hall	11/10/2026	Freedom To Speak Up Roadshow	I
Melanie Hall	12/10/2026	Finance & Performance Committee agenda planning meeting	I
Josie Spencer/Melanie Hall	13/10/2026	Freedom To Speak Up Roadshow	I

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Melanie Hall	13/10/2026	Freedom To Speak Up Guardian catch up	I
Josie Spencer	14/10/2026	AHP Conference	I
Josie Spencer	14/10/2026	Mental Health Chairs Network Conference Call	E
Faisal Hussain	19/10/2026	Pre-meet ICB Chair regarding NHSE Regional Roadshow	E
NEDs/Chair	19/10/2026	Joint NED Catch Up	I
Faisal Hussain	21/10/2026	LPT Director of Governance & Risk	I
Faisal Hussain	23/10/2026	LPT NED Recruitment Shortlisting	I
Chris Skelton	23/10/2026	Freedom To Speak Up Roadshow	I
Faisal Hussain	26/10/2026	Group CEO	I
NEDs/Chair	27/10/2026	Group Board Development Workshop	I
Faisal Hussain	27/10/2026	Raising Health Anniversary Celebration	E
Faisal Hussain	28/10/2026	Mental Health Network Chairs Conference Call	E

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Faisal Hussain	28/10/2026	LNR ICB Chair	E
Faisal Hussain	28/10/2026	Joint Trust Board agenda setting meeting	I
Melanie Hall	28/10/2026	Finance & Performance Committee pre-meet with Chief Finance Officer	I
Melanie Hall	28/10/2026	Consultant Interview candidate meeting	I
Melanie Hall	28/10/2026	Freedom To Speak Up Roadshow	I
Faisal Hussain	30/10/2026	Freedom To Speak Up Roadshow	I
Chris Skelton	30/10/2026	NED session on Artificial Intelligence	E
Josie Spencer	03/11/2026	Service Visit Early Language Support for Everyone (ELSEC)	I
Chris Skelton	03/11/2026	NHS England Non Executive Director Induction	E
Faisal Hussain	04/11/2026	Joint Corporate Governance Catch Up	I
Faisal Hussain/Melanie Hall	04/11/2026	Joint Quarterly Freedom To Speak Up Guardian Meeting	I
Faisal Hussain	04/11/2026	NHSE Regional Chair Meeting	E

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Faisal Hussain	05/11/2026	LNR System Chairs & CEO Meeting	E
Josie Spencer	06/11/2026	LPT NED Recruitment stakeholder panel	I
Faisal Hussain	06/11/2026	Chair: Nottinghamshire Healthcare NHS Foundation Trust	E
Faisal Hussain	06/11/2026	LPT NED Recruitment Interviewing	I
Josie Spencer	10/11/2026	Quality Regulation Excellence Group	I
Faisal Hussain	10/11/2026	Chair: University Hospital of Northamptonshire	E
Faisal Hussain	10/11/2026	LNR System Chair meeting	E
Melanie Hall	10/11/2026	Freedom To Speak Up Guardian catch up	I
Josie Spencer	11/11/2026	East Midlands Alliance: Quality & Safety Committee Chairs	E
Faisal Hussain	11/11/2026	Mental Health Network Chairs Conference Call	E
NEDs*	12/11/2026	NHSE NED Best Practice Away Day	E
Melanie Hall*	13/11/2026	East Midlands Alliance Learning Event	E

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
NEDs/Chair*	16/11/2026	Joint NED Catch Up	I
Faisal Hussain/Josie Spencer*	17/11/2026	Chair/Deputy Chair Meeting	I
Faisal Hussain*	17/11/2026	Senior Independent Director Meeting	I
Josie Spencer*	19/11/2026	Consultant Interviews	I
Faisal Hussain*	19/11/2026	International men's day - blue light event	E
Faisal Hussain*	19/11/2026	Joint Corporate Governance Catch Up	I
Faisal Hussain*	19/11/2026	LPT Director of Governance & Risk	I
Faisal Hussain*	20/11/2026	Chair: NHS Hampshire & Isle of Wight ICB	E
Faisal Hussain*	23/11/2026	LNR ICB Chair	E
Faisal Hussain*	23/11/2026	Group CEO	I
Faisal Hussain*	25/11/2026	Mental Health Network Chairs Conference Call	E
Faisal Hussain*	25/11/2026	ICB: Hereford & Worcestershire ICB	E

Non-Executive Attendee(s)	Date	Event/Meeting	Internal/External to the Trust (I/E)
Tim Harrison/Melanie Hall*	25/11/2026	Joint People & Culture Committee agenda setting meeting	I
Tim Harrison*	25/11/2026	Suicide Prevention Webinar	E
Melanie Hall*	27/11/2026	Service visit: Adult Eating Disorder	I
Melanie Hall*	30/11/2026	Finance & Performance Committee agenda planning meeting	I
Josie Spencer	Various	Informal calls with potential LPT NED Candidates	I

*Planned at time of writing

Abbreviations:

AGM = Annual General Meeting

aNED = Associate Non-Executive Director

AHP = Allied Health Professionals

ARC = Audit and Risk Committee

CEO = Chief Executive Officer

CFC = Charitable Funds Committee

EMA = East Midlands Alliance

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

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Leicestershire Partnership NHS Trust

Public Trust Board [24th November 2026]

Chief Executive Officer Report

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

Analysis of the Issue

We continue to work with and support our Group Trust Northamptonshire Healthcare NHS Foundation Trust (NHFT) as they develop their business case as part of the next phase towards initial IHO contractual arrangements from April 2027.

East Midlands Mental Health and Learning Disability Alliance

The East Midlands Alliance held its annual learning event for member Boards on 13 November 2026 in Leicester. The programme included updates on delivery of the Alliance Plan for 2026/27, regional collaborative programmes and progress with the Patient and Carer Race Equality Framework. Presenters also shared updates on the East Midlands Gambling Harm support and Op Courage service. We also took the opportunity to share learning from the Advanced Foundation Trust (AFT) and Integrated Health Organisation (IHO) process. The event provided an opportunity for member Boards to develop shared priorities and inform the Alliance Plan for 2027/28.

At the most recent East Midlands Alliance Board meeting in September, we received updates on regional programmes, including progress with the Patient and Carer Race Equality Framework. Discussions covered health inequalities, digitisation of the Mental Health Act and opportunities for shared learning between partner Boards. We also reviewed delivery of the 2026/27 Annual Plan, collaborative governance arrangements and future service provision, alongside patient safety and workforce challenges.

Midlands and East Mental Health and Learning Disability Chief Executive Network Meeting

At the recent Midlands and East Mental Health and Learning Disability Chief Executive and Deputy Chief Executive Network meeting in September 2026, we received an update on the CQC's improvement programme. The developing Modern Service Framework for Severe Mental Illness was also presented, with a focus on timely access, integrated care, physical health and reducing inequalities. We received an update on the NHS Alliance's mental health communications and influencing campaign, which aims to support consistent, evidence-based messaging, share good practice and inform national policy development. The programme also included updates from national groups and the neurodevelopmental workshop, alongside consideration of future opportunities for benchmarking and shared learning.

The Midlands and East Mental Health CEO forum is developing a Learning and Improvement Network (LIN) approach to neurodevelopmental waits with NHSE. Regional leads have committed resources to support joint working across autism and ADHD services. A follow-up session has since taken place to share good practice, explore learning from innovation and help define the network's overall aim. The model will enable organisations to test different approaches and share learning from both successful and unsuccessful initiatives.

Midlands NHS Leadership Event

The Midlands NHS Leadership event on 20 October 2026 focused on transforming performance and delivering improved outcomes during the second part of the year. The programme included a regional update and sessions on frailty pathways, elective care transformation and integrated urgent and emergency care. A session delivered by LNR ICB and NHFT provided an update on the Integrated Health Organisation (IHO) journey.

Strengthening co-production across East Midlands Provider Collaboratives

The East Midlands Provider Collaboratives for Child and Adolescent Mental Health Services (CAMHS), Adult Eating Disorders and Perinatal services are expanding their Experts by Experience network to strengthen co-production across the region. People with experience of receiving care or supporting someone using specialist mental health services are invited to help shape service design, development and delivery. Flexible opportunities are available, with no previous co-production experience required and no commitment at the expression of interest stage. Partner organisations are encouraged to promote the opportunity to people they support, helping ensure services remain responsive to the needs and experiences of those who use them.

Further information can be found on the EMA website: Home | Alliance

Support for mental health, ADHD and autism

Following the publication of *The independent review into mental health conditions, ADHD and autism: final report* on 9 October 2026, the government has set out a move towards earlier, needs-led support for children, young people. The forthcoming mental health strategy will prioritise prevention and earlier, needs-led support in schools, colleges and communities without waiting for a clinical diagnosis. Timely diagnosis and treatment will remain available where clinically appropriate. Plans also include stronger regulation of ADHD and autism assessments and a review of advertising practices. The measures aim to prevent escalating distress and support participation in education, employment and community life.

Further information can be found here: Government pledges earlier support to tackle mental health crises - GOV.UK

Healthy Babies programme

The Healthy Babies programme will expand to every Best Start Family Hub in England, covering all local authorities and more than 1,000 hubs by 2028. Families will receive enhanced infant feeding and parental mental health support, help with parent–baby relationships, and access to health visiting and midwifery services. Based on Sure Start principles, the expansion supports neighbourhood health by bringing integrated health, early years and family support closer to home.

Further information: Support for families and babies rolled out to all family hubs - GOV.UK

Unauthorised access to patient records

The Information Commissioner's Office (ICO) has asked health service Chief Executives for personal assurance on arrangements to prevent, detect and respond to unauthorised access to patient records. The priorities are effective access controls, audit and monitoring, staff training, and prompt, consistent investigation and action. Following NHS England's correspondence to all Trusts in September, we have assessed Group compliance across both Trusts to provide assurance on the controls in place, with work continuing to embed further improvements.

Winter preparedness and urgent care investment

We welcome the announcement from the Government regarding funding of almost £140 million for 14 urgent care schemes across England, including new urgent treatment centres, same day emergency care services, ambulance fleets and emergency department upgrades. A further 25 new or expanded sites, announced in April, are expected to open for winter. The investment aims to increase capacity and ease pressure on emergency departments, forming part of almost £2 billion committed to urgent care capital projects up to 2030.

A £40 million programme will provide proactive GP support for up to 300,000 vulnerable patients this winter. Health checks, home assessments and medication reviews will support people with conditions including heart disease, frailty and chronic obstructive pulmonary disease. The programme aims to address needs early, helping patients remain well at home and reducing avoidable admissions. It complements wider winter preparations, including flu vaccinations, additional urgent care capacity and stronger social care partnerships.

Further information can be found here: £140 million boost to urgent care to ease winter pressures on NHS - GOV.UK

Further information can be found here: £40 million for GPs to keep vulnerable patients out of hospital this winter - GOV.UK

Keep Britain Working review update: a national growth opportunity

The September 2026 Keep Britain Working update outlines progress against the independent review's recommendations to reduce health-related economic inactivity. It prioritises earlier support to prevent avoidable job loss, rather than intervention only after people leave employment. The proposed Workplace Health System combines inclusive workplaces, improved workplace health provision and better use of health and inclusion data. Employers and local partnerships will play a key role in helping people remain in or return to work, supporting health outcomes and economic growth.

Further information: Keep Britain Working review update: a national growth opportunity, September 2026 - GOV.UK

National Care Service

The Prime Minister has set out plans for a National Care Service in the next Parliament, which include the proposal of free personal care for older people based on need rather than ability to pay. Introduction would be phased as funding, workforce and provider capacity increase. Funding would come from savings through State Pension Triple Lock changes from April 2030. The independent social care commission will recommend how and when the service should develop, reporting in summer 2027. The plans aim to improve social care access and reduce pressures on NHS emergency services and hospital discharge.

Further information: Prime Minister Andy Burnham sets out plans for a new National Care Service - GOV.UK

Strategic Infrastructure Partnerships programme



The National Institute for Health and Care Research (NIHR) has launched its Strategic Infrastructure Partnerships programme which will bring together research expertise and resources to address complex health and care challenges and accelerate innovation adoption. Initial priorities are technologies supporting independent living at home and reducing demand on urgent, emergency and primary care. The programme supports the 10-Year Health Plan's shift from hospital to community care.

Further information: NIHR to fund major partnerships to tackle the nation's biggest health and care challenges | NIHR

Relevant External Meetings attended since last Trust Board meeting

October 2026	November 2026
Mental Health Supply Side Review Working Group	Webinar - External Inquiries Overload: How Should Boards Respond
CEO of The Royal Orthopaedic Hospital NHS Foundation Trust	CQC Trust well led reference group
Presented at NHSE Commissioning Away Day	Chief Experience Officer Northumbria Healthcare NHS Foundation Trust
LNR CEOs	LNR System Chairs and CEOs Meeting
NHFT & LPT Joint Medical Education Conference	CEO Midlands Partnership University NHS Foundation Trust
CEO UHN	*NHSE NED Best Practice Away Day
NHSE Deputy Director of Oversight Strategy	*East Midlands Alliance Learning Event
CEO Merseycare NHS Foundation Trust	*NHSE Freedom to Speak Up Exec Lead engagement session
Partner Member for Primary Medical Services at Northamptonshire ICB	*LNR ICB CEO
Care Group Director of Operations at Buckinghamshire Healthcare NHS Trust	*LLR ICB and NICB Boards Deloitte-led Development Session
Regional Strategic Review Meeting with NHSE	*HSJ Awards

East Midlands Alliance CEO Meeting	*LNR Health Partners' Executive Meeting
Mental Health Trusts CEOs with Regional Leads and SROs	*CEO Coventry and Warwickshire Partnership Trust
Regional Chair NHSE	Webinar - External Inquiries Overload: How Should Boards Respond
NHSE Director of Intensive Support	CQC Trust well led reference group
NHS CEO Advisory Group	Chief Experience Officer Northumbria Healthcare NHS Foundation Trust
CEO Greater Manchester Mental Health NHS Foundation Trust	LNR System Chairs and CEOs Meeting
	*CEO Coventry and Warwickshire Partnership Trust

Proposal

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

Decision Required

Briefing – no decision required

Governance Table

For Board and Board Committees:	Trust Board of Directors
Paper sponsored by:	Angela Hillery, Chief Executive Officer
Paper authored by:	Sinead Ellis-Austin, Head of CEO & Chair Office
Date submitted:	17th November 2026
Name and date of other committee / forum at which this report / issue was considered:	
Level of assurance gained if considered elsewhere	☐Assured ☐ Partially assured ☐ Not assured
Date of next report:	March 2027
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

Leicestershire Partnership NHS Trust

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Trust Board 24 November 2026

Managing Director's Report - Public

Purpose of the Report

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

Local developments and innovation

National Oversight Framework (NOF) – Q1 2026/27

The results for Q2 are not yet published. In Q1 the score for LPT was 1.99 which placed the Trust in segment 2 and ranked 12 out of 52 providers. The metrics for Q2 are expected to be published mid December 2026.

City Neighbourhood Mental Health Centre

Mental Health Collaborative approval has been secured for the proposed site at No.19 University Road. Venue scoping has been completed, and partnership discussions are progressing to support the next phase of development. Alongside site planning, work has continued with lived experience representatives, social care colleagues and estates teams to ensure the new centre is designed around the needs of local communities. This marks a significant step forward in bringing neighbourhood-based mental health support into the heart of Leicester.

School aged immunisation service launched flu vaccination campaign in schools

Our school aged immunisation service began its campaign to offer more than 160,000 children and young people a free flu vaccination in school to help to protect them against the virus this winter. The service will visit every primary, secondary and special school in Leicester, Leicestershire and Rutland (LLR), with vaccinations taking place from 7 September, right through to the end of term in December 2026. Parents and carers have been able to consent to one of two vaccines, including the flu nasal spray or the injectable flu vaccination. This is through the new MAVIS consent system, which sends information directly to them via text or email.

New guidance to help people with a learning disability stay healthy this winter

Health and care partners across Leicester, Leicestershire and Rutland (LLR) are launching a new winter wellbeing campaign to help people with a learning disability stay healthy and well through the colder months.

The campaign focuses on guidance around six simple actions:

1. Get your flu vaccine.
2. Eat well.
3. Attend your annual health check.
4. Wear layers and keep warm.
5. Take vitamin D.
6. Speak up if you are worried about your health.

As part of the guidance there's a new easy-to-understand animation, Top tips for self-care in winter: if you have a learning disability, which covers practical topics such as keeping warm, eating and drinking well, staying active, and knowing where to get help if needed. It also encourages people to attend their annual health check and have their flu vaccine when invited.

Co-produced with people with a learning disability and their families/carers, the animation uses clear language and accessible messages so people can make informed choices about their health and when and where to seek support.

CAMHS Crisis Team embed new pathway with EMAS

CAMHS Crisis Team have embedded a new pathway with EMAS to reduce unnecessary A&E attendances. Since the pathway went live at the end of April, EMAS have received referral for 43 children and young people presenting with Mental health difficulties. 32 of these were referred to the CAMHS Crisis team by EMAS. 25 were accepted referrals and EMAS effectively avoided taking them to A&E. There has been a 58% reduction in mental health cases conveyed to UHL A&E since the introduction of the pathway.

Outstanding LPT staff and volunteers celebrated at the Trust's annual awards

Some of our fantastic staff, teams and volunteers were recognised for their outstanding achievements at our Celebrating Excellence Awards on Thursday 1 October. Taking place at the Athena in Leicester, the sponsored event saw nominees and their nominators treated to a three-course meal and awards presentation, where we heard about the work and achievements of each nominee across 14 categories. Winners were presented with a special star trophy and runners up each received a certificate. A huge thank you to Tilbury Douglas and LPT's registered charity, Raising Health, for making the event possible. Read about all the winners on our website here: Outstanding NHS staff, teams and volunteers honoured at LPT awards ceremony - Leicestershire Partnership NHS Trust

Five years of the Better Mental Health for All Network

On Tuesday 6 October, around 150 delegates came together to celebrate five years of the Better Mental Health for All Network at the Big Shed in Leicester. The network is led by local voluntary sector partners, with support from LPT and local councils, working together on shared ambitions to improve mental health services across Leicester, Leicestershire and Rutland. (LLR). The event was chaired by Khudeja Amer-Sherif, CEO of Shama women's Centre in Leicester with LPT speakers including executive director of mental health, Tanya Hibbert, the mental health collaborative commissioning team lead, Justin Hammond, consultant psychologists Dr Claire Hemming and Dr Lara Harris and lead consultant for LPT's mental health crisis team, Dr Sherif Abdallah.

Mental Health Priorities

LPT continues to progress plans to achieve the seven mental health priorities which is monitored via Executive Management Board. Two areas in particular have been highlighted within this report, neighbourhood mental health centre and CAMHS crisis, that focus on both early intervention and 24/7 hubs. At present there are no concerns to highlight and key activities will continue to be included in this update.

Helping children and young people to open up about their mental health for Hello Yellow day

To ensure children, young people and teachers had resources to take part in Hello Yellow day, our mental health support teams in schools (MHSTs) created a range of age-appropriate PowerPoints and activities, which they sent to all schools in LLR. The annual, national event took place on Friday 9 October, marking 10 years of the campaign, designed to help start conversations about mental health. The information pack for schools contained tips on how to look after mental health and advice on how to access mental health support for children and young people.

Advice and support shared to mark Baby Loss Awareness Week

From Friday 9 October to Thursday 15 October, our maternal mental health service ran a social media campaign to remind people that support is available for those impacted by pregnancy or baby loss. Throughout the week, they shared videos of support, details of local events being put on by local charity partners, tips on how to support someone going through pregnancy or baby loss and details of where to go for help. The service's assistant psychologist, Saffron Barker, also appeared on BBC Radio Leicester to talk about the support available.

St Luke's Hospital garden given a makeover in honour of grandmother

A lasting tribute was created by a family in honour of their much-loved grandmother at the garden surrounding the End-of-Life suite at St Luke's Hospital. Jill Barnett, who died aged 92, spent her final days receiving compassionate palliative care in the Market Harborough hospital's End-of-Life suite following a stroke. Wanting to thank the staff for the kindness shown to Jill and her family, they asked for donations for the hospital, which were enhanced through matched funding from Raising Health.

At the end of September, Jill's family and friends joined a team of volunteers from insurance company, AXA, to complete the refurbishment. Together, they weeded and cleared the garden, restored and repainted a bench, refreshed planting beds and introduced a variety of flowers and plants, including daffodils, to provide colour, texture and seasonal interest throughout the year.

Health visitor celebrated ahead of retirement for hitting golden anniversary of NHS service

Margaret 'Peggy' Oates celebrated a half century NHS career, which she'd dedicated to improving outcomes for babies, children and young people, before hanging up her uniform for good at the end of October 2026. Peggy worked as a public health nurse for our Healthy Together health visiting service, based at Narborough Health Centre, during the latter part of her career. Families supported by her consistently provided positive feedback about her care, with a mother recently describing Peggy as "amazing, helpful and thorough".

Raising Health charity anniversary

Supporters, funders, community partners, charity champions and frontline healthcare workers, came together to celebrate a decade of LPT's registered charity, Raising Health.

A special event, held at our County Hall headquarters, saw attendees reflect on ten years of charitable impact across our mental health, community health, family, young people, children and learning disability and autism services, whilst also hearing about the charity's ambitions for the future. Guests listened to powerful stories from patients, families and staff, showcasing how charitable funding has enhanced care, improved environments and created opportunities beyond what NHS funding alone can provide.

In 2025/26 alone, an estimated 46,000 people from communities across Leicester, Leicestershire and Rutland directly benefited from projects funded through Raising Health. A total of 183 projects have been supported through charitable funding, worth £598,000. Their annual impact report for 2025-26 showcases the real effect that charitable funds have on our services and communities can read this report here: https://www.raisinghealth.org.uk/downloads/raising-health-impact-report-2025-26.pdf

The charity was also a finalist in the Most Promising Pilot category at the Health Tech Awards 2026 for their work funding Flow Neuroscience transcranial direct current stimulation (tDCS) headsets for mental health crisis services (at LPT).

Men's health event

To mark International Men's Day 2026 on 19 November, colleagues from across blue light services came together for 'It's Time to Talk', a free event at the Leicester Tigers stadium with inspiring speakers, honest conversations, practical wellbeing support and a chance to connect with others.

Staff flu campaign

Colleagues across our Trust have been taking up the offer of getting their free flu vaccination to help protect themselves, their colleagues and our patients and service users. Drop-in flu clinics are available to all staff, bank staff and volunteers across our Trust. More than 1,000 staff were vaccinated in the first week of the vaccination campaign alone, with nearly twice as many staff vaccinated compared to the same period last year. So far, as of 9 November, our flu vaccine uptake level is at 36.9% (2,062 frontline healthcare workers vaccinated), which is already higher than this time last year.

Staff survey

Throughout late September, October and November we have been encouraging our workforce to complete the annual NHS Staff Survey. The findings of the anonymous survey help us to understand more about how staff are feeling, what is working and what requires more focus or improvement. We take the results very seriously and monitor actions in response to feedback at a Trust Board level, to ensure LPT is a positive and supportive workplace. This includes work carried out as part of the Our Future Our Way culture improvement programme, which recently produced new resources to support staff experiences of racism and discrimination and career development. Our response rates so far are above this time last year.

Cyber awareness campaign

During October, we took part in Cyber Awareness Month to encourage staff to stay secure online. We promote regular advice and tips through our internal Cyber Force campaign to build safer digital habits and help to keep our organisation protected from cyber-crime.

Fraud Awareness Week

As part of International Fraud Awareness Week, the Trust is promoting a programme of fraud awareness sessions for all staff delivered by 360 Assurance, the Trust's Counter Fraud provider. The sessions are designed to increase staff awareness of fraud, bribery and corruption, covering topics including the current fraud landscape, fraud risks, social engineering, departmental case studies, and reporting mechanisms. These sessions will support efforts to improve staff awareness and knowledge.

Allied Health Professionals (AHP) Day

On Wednesday 14 October, we celebrated AHPs Day to mark the fantastic work our allied health professionals across our Trust do every day. To mark the celebration around 250 AHPs from across Leicestershire, Northamptonshire and Rutland came together for an event focused on AHPs and neighbourhood health – with a focus on the 10-year plan, digital and AI innovation and evidence-based practice.

LPT team featured in national professional publication

The work of LPT's Adult mental health speech and language therapy team was featured in the Royal College of Speech and Language Therapists (RCSLT) Bulletin magazine. The article, Communicating with Huntington's Disease, written by Alice Newey, assistant psychologist and her colleagues, was about an audit the team ran to explore the effectiveness of augmentative and alternative communication (AAC) devices for people living with Huntington's disease. The findings have helped shape future approaches to communication support and highlighted the importance of tailoring interventions to individual needs.

New partner organisation to join the shared care record

DHU Healthcare has joined the LLR Care Record. The not-for-profit community interest company provides a range of services, including urgent and emergency care, primary care, out-of-hours services and NHS111, to a population of almost ten million people. The LLR Care Record, hosted by LPT, is joining up people's health and care records across the NHS and local authorities. It means information recorded about someone's health and care such as illnesses, medications and hospital admissions can be accessed by different people who are directly involved in their care.
Comms to provide

Equality and Human Rights Commission definition of biological sex guidance released

New guidance was issued in October by NHSE regarding single sex spaces in our premises that cover patients/service users and staff. LPT is currently working through the guidance to align our policies and practice and will be engaging with staff and key stakeholders on this. This is a complex process and will take time. In the meantime, LPT remains committed to providing safe, dignified, and respectful care for every patient and where all staff are treated with dignity, compassion and respect.

Latest LLR LeDeR report published

The **Learning from lives and deaths report for LLR** has been published. Since 2020, more than 500 local reviews have helped identify ways to improve care and reduce health inequalities for people with a learning disability and autistic people, who on average die younger than the wider population. The report highlights examples of excellent care and innovation, while setting out key areas for improvement. In response, our Trust's LeDeR team – working with the LDA Collaborative – has identified **'Top Ten Learning into Action Points'** for healthcare professionals to focus on to ensure our communities live good, happy lives.

Dementia support service provider change

The Memory Advice and Dementia Support Service for Leicester City and Leicestershire transferred from Age UK Leicestershire and Rutland to Alzheimer's Society on Thursday 1 October 2026. Both organisations worked closely together to ensure a smooth transition, with continuity of support for people living with dementia and their unpaid carers remaining the priority.

Forthcoming building works at our sites

Contractors have been on site at The Willows from Monday 26 October to carry out important refurbishment works. The refurbishment is expected to last until next April and while contractors are on site it will mean some noise and disruption as well as a reduced number of parking spaces.

Works also commenced at the Evington Centre on Monday 9 November which may also lead to noise, disruption and a reduced number of parking spaces.

Neurodevelopmental Pathways Transformation

Teams across LLR have been working together with an aim to transforming pathways for patients with an aim to shift from diagnosis led pathways to ones which are needs led to deliver earlier support, consistent access and specialist capacity focused where it adds most value. As these pathways involve many different partners across the health and social care footprint, these developments are collaborative and system based. It is anticipated that the adult pathway will be ready to progress to the approval stage by the end of December. For children and young people, work has begun to change the triage process and review the pathway. Colleagues are also linking in with the Getting It Right First Time (GIRFT) team who are reviewing several Trusts to support the development of an information pack for suggested improvements across the sector.

GIRFT improvement funding secured

LPT secured GIRFT improvement funding of approximately £220k to deliver around 550 additional neurodevelopmental medical screening assessments (test and learn pilot), reducing waits, improving patient flow, and supporting wider neurodevelopmental pathway transformation. Operationalisation currently being managed with clinics due to commence from November 2026.

The Childhood Lottery

The Childhood Lottery is a landmark report and dataset published in October 2026 by the Children's Commissioner for England, which analyses 162 metrics across 153 local authorities to map how heavily a child's postcode determines their life chances, health, education, and safety in England.

Key findings detail:

- Stark disparities
- Education gaps
- Mental Health & Support
- Youth spending
- Hardest places to grow up

Explore the full dataset and read the breakdown via the Children's Commissioner for England website.

Health and Wellbeing Boards

Leicestershire Health and Wellbeing Board – 17 September – LPT presented on Neighbourhood Health in Leicestershire. Other agenda items included Joint Health and Wellbeing Strategy progress updates on Dying Well and Living & Supported Well, LLR Adult SARC and Healthwatch Annual Report. Papers available via Leicestershire County Council website link

LLR Joint Health Scrutiny – 28 September - LPT not required to present, agenda included primary care access recovery plan, impact of Healthwatch closure and a briefing paper on leadership and governance arrangements for UHL and UHN. Papers available via Leicester City Council link.

Rutland County Council Health and Wellbeing Board – 29 September- LPT were not required to present, agenda included Safeguarding Children Partnership annual report, winter health plan, LLR ICS update and same day access and Rutland Memorial Hospital capital update. Papers available via Rutland County Council website link.

Leicester City Health and Wellbeing Board – 1 October - LPT provided an overview of Intermediate Care, including current provision, outcomes and patient and experiences, and highlighted key challenges and areas of focus. Papers available via Leicester City Council link.

Rutland County Council Health and Wellbeing Board – 3 November- agenda included Safeguarding Children Partnership annual report, winter health plan and LLR ICS update. Papers available via Rutland County Council website link.

Leicester City Public Health and Health Integration (PHHI) – 3 November - agenda included winter plan, health protection and vaccination in Leicester City. Papers available via Leicester City Council link.

Leicester County Health and Communities Overview Scrutiny Committee – 4 November - agenda included winter plan, all age continuing healthcare and healthy weight, food and nutrition. Papers available via Leicester County Council website link.

Staff Voice

The staff at LPT continue to be as important to the Trust as the patients they strive to deliver outstanding care. Their voices can be heard through the many avenues they are encouraged to speak up through, including, but not exhaustive to, the service visits the Board undertake, staff networks, valued star awards/celebrating excellence/thank you postcards, monthly supervisions (known as one to ones), appraisals, clinical supervisions, Freedom to Speak Up avenues, line management and Staffside/trade unions, Human Resources and our Trust policies.

In October a new Staffside page was launched on our intranet, bringing together information about trade union representation, partnership working, and the support available to staff across our Trust. The page also the role of Staffside, how representatives work with the Trust to ensure staff voices are heard and provides contact details for accredited representatives from recognised trade unions and professional organisations.

We have a robust staff engagement approach which includes regular culture cafes at sites across the Trust to hear their voices and provide information on how feedback has been put into action. We also have regular engagement through our culture improvement programme, called Our Future Our Way, through outreach activity by our change leaders. Regular voice is also heard through our staff networks and health and wellbeing roadshows.

Speak Up month

October was Speak Up Month. LPT values its staff voice, appreciating it is invaluable in shaping our culture and services. By encouraging both speaking up and listening, we can improve safety, reduce harm and make our services better for colleagues, service users, carers and families.

During October our Speak Up guardians, Pauline Lewitt and Chris Moyo, visited over 30 LPT sites on their Speak Up roadshows and were joined by members of our Board, network leads and Freedom to Speak Up champions. Staff members were reminded of all the avenues available to them to speak up via, encouraged to raise concerns, share ideas and good news stories, and to ask difficult questions.

Service visits

Board members conducted 14 service visits to our diverse services in September and October, alongside the 30 Speak Up roadshows. They visited a wide range of operational and enabling services and sites, including The Willows, Looked After Children, the specialist eating disorder service, integrated community specialist palliative care and MSK physiotherapy including their booking office. During these visits the Board witnessed the support teams give each other having a positive impact on their wellbeing, the service they deliver and the care they are able to give their patients. Board members listened to areas staff would like support from the Board with actions being taken away and progressed and monitored through internal executive meetings.

Listening to the patient voice is as important as the staff voice on these visits. At the Agnes Unit it was clear the ‘people carrier’ was making a significant positive impact on supporting patients to visit local areas, remaining connected to the community. The ‘breakfast clubs’ at St Lukes hospital were proving a great way for patients to start the day chatting with other patients whilst at The Willows patients spoke highly of the food, cleanliness, their bedrooms and the activities on offer.

Leicestershire SEND inspection

A three-week inspection finished on 9 October, including data and evidence submission, case file reviews and practitioner interviews. Staff were commended for their passion, commitment and knowledge.

Patient Voice

Delivering safe, outstanding care to and within our community is what drives everything we do; at the core of this is listening to our patients and learning from their experiences of our services; key to this is collaboration.

People's Council

Co-production and lived experience involvement continued to strengthen demonstrating a growing culture of partnership with patients, carers and communities. Key achievements included the recruitment of new patient and carer reviewers for the 15 Steps programme, establishment of a co-design group to develop autism feedback resources, patient and carer involvement in improving the Trust website, and increased activity from the Reader Panel to improve the accessibility and quality of patient communications. The Trust also continued to embed lived experience within leadership and quality improvement through the sixth year of the Director of Nursing Fellowship, matching lived experience advisors to Fellows and their improvement projects.

The impact of lived experience involvement is becoming increasingly visible across service improvement and organisational development. Co-produced recruitment approaches, including values-based interview questions developed with patients, carers and the Youth Advisory Board, continue to be promoted across the Trust, while co-production work within Restrictive Eating Services has improved parent and carer confidence in supporting care. In addition, several Members of the Lived Experience Network were recognised through nominations for Celebrating Excellence Awards, reflecting the significant contribution that lived experience partners make in shaping services, improving outcomes and ensuring the patient voice remains central to decision-making across LPT.

Help Shape Better Healthcare for Deaf and Hard of Hearing People

Healthwatch Leicester and Leicestershire has spoken to 110 Deaf and hard of hearing people about their experiences of accessing healthcare and has invited colleagues to an event to explore the findings and discuss what needs to happen next.

The event, held on 17 November, brought together Deaf and hard of hearing people, healthcare professionals, carers and members of the public to hear people's experiences, share perspectives and help shape future improvements to health services. Professionals working across health, social care, primary care, hospitals, mental health, community services, and equality and inclusion were also encouraged to attend. More information about the event will be available via Healthwatch's website.

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

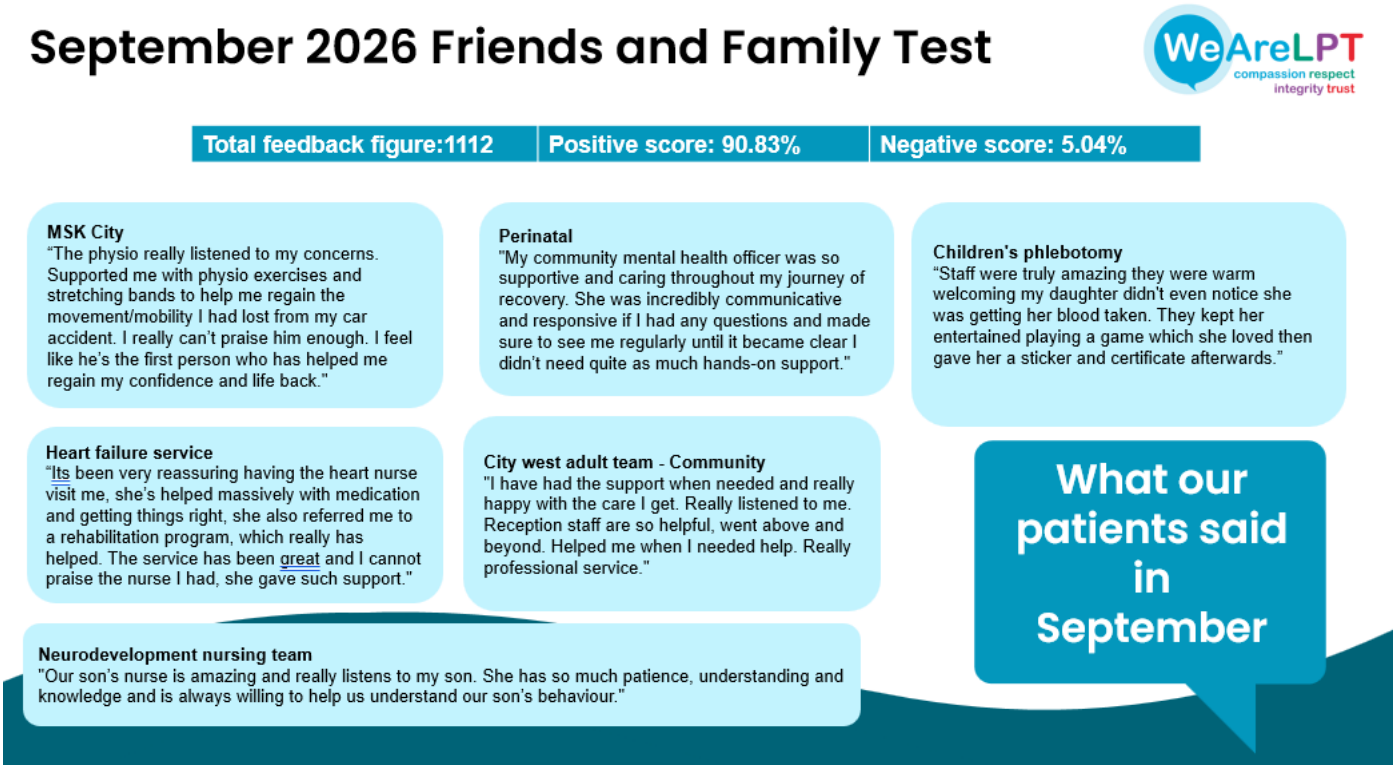
area across our sites. The DAISY Awards are an international recognition programme that celebrates nurses and midwives who go above and beyond to provide outstanding care.

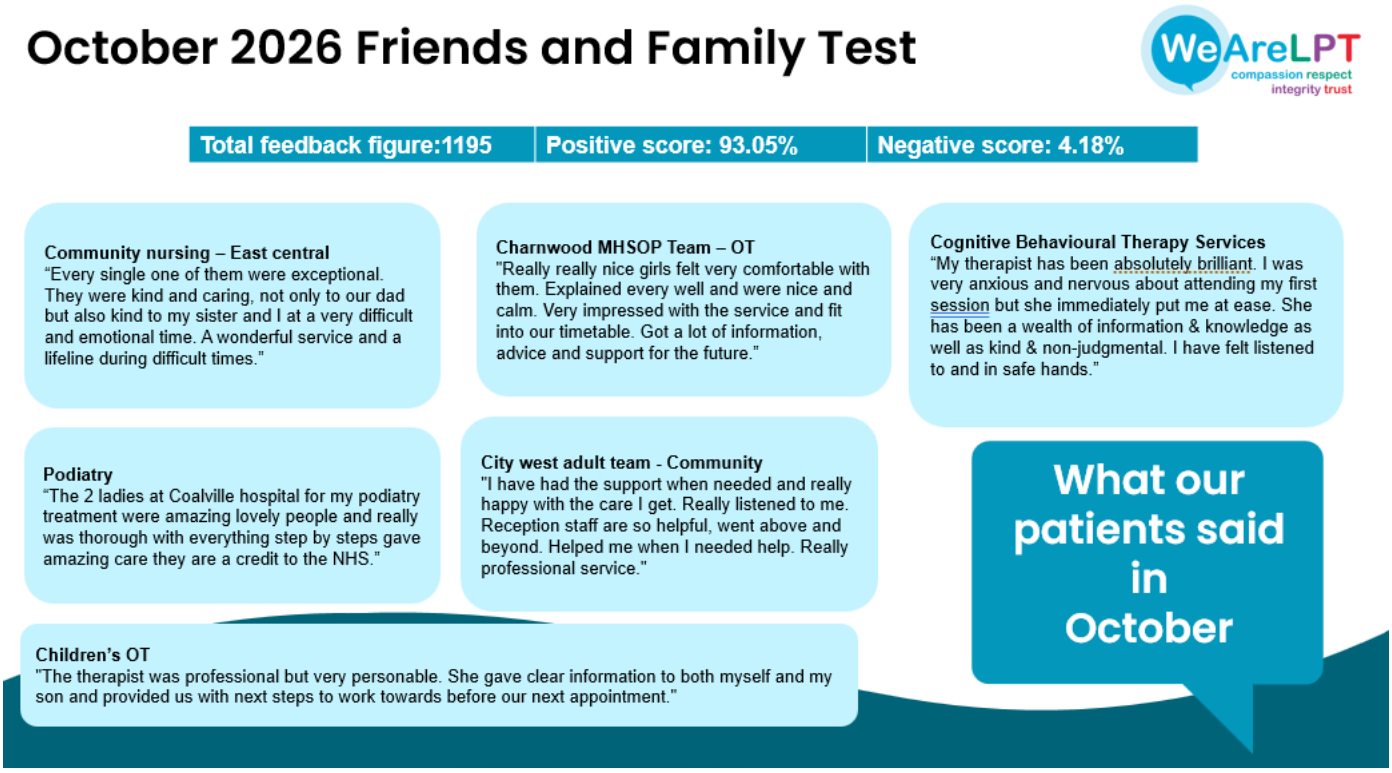
We are proud to announce two members of LPT staff recently received nominations:

- The parent of a young person under Deputy ward sister, Claire Armistead's care praised the compassion, support and dedication Claire showed to their family during an incredibly difficult time. In their nomination, the parent described Claire as "the most thoughtful and caring nurse" their daughter had received support from. The nomination highlighted Claire's willingness to go above and beyond, providing emotional support to both the young person and their family during one of the most challenging periods of their lives.
- Former deputy ward sister, Lucy Jones, was nominated by a former patient who praised her compassion, dedication and unwavering support throughout multiple admissions and recovery milestones. In their nomination, the patient described Lucy as their "biggest support" during multiple admissions, praising her compassion, honesty and commitment.

Friends and Family Test (FFT) – September and October

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 September and October 2026 our Trust received a total of 2,307 Friends and Family Test (FFT) feedback responses from our patients; with an overall positive score of 92%.





Relevant External Meetings attended since last Trust Board meeting

October 2026	November 2026
Leicester City Health & Wellbeing Board	*People Council catch up
LLR ICB Core Standards Confirm and Challenge meeting	* NHSE ASD/ADHD LIN Scoping Workshop
Monthly Midlands COO/MD/DoN with NHSE	*East Midlands Alliance Event
LNR Health Partners' Executive	* LLR Local Health Resilience Partnership
Creative Health event	* Monthly Midlands COO/MD/DoN with NHSE
Legal Team meeting	*NHP Board
NHSE ASD/ADHD LIN Scoping Workshop	

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

Proposal

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

Decision Required

Briefing – no decision required

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

Governance Table

For Board and Board Committees:	Trust Board of Directors
Paper sponsored by:	Jean Knight, Managing Director
Paper authored by:	Jean Knight, Managing Director Sam Beaty, Business Manager
Date submitted:	Xx November 2026
Name and date of other committee / forum at which this report / issue was considered:	
Level of assurance gained if considered elsewhere	☐Assured ☐ Partially assured ☐ Not assured
Date of next report:	January 2027
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

Leicestershire Partnership NHS Trust

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Trust Board 24 November 2026

Board Assurance Framework Summary

Purpose of the Report

This report provides a summary of the Group Board Assurance Framework for November 2026. The full BAF, containing tracked changes resulting from the monthly review of controls, assurances and actions is provided in the information pack.

Analysis of the Issue

No.	BAF title	Impact	Liklihood	Controls	Assurance	Current Zone	Key Change this month
1	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.	4	3	Medium	Medium	Amber	
2	If we do not continue to **evolve our partnerships and collaboratives**, we will not reduce health inequalities and deliver improved outcomes for our communities.	4	2	High	High	Green	
3	If we are unable to build a sustainable approach to the continual development our **research, innovation and professional learning capability**, our ability to attract the best people, operate on the leading edge of service delivery and exert influence within the sector will decline over time.	4	2	Medium	Medium	Green	Proposal for zone to move to Amber due to additional action required to ensure approach is sustainable.
4	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.	5	3	Medium	Medium	Red	
5	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.	5	3	Medium	Medium	Red	
6	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.	4	2	High	High	Green	
7	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.	4	3	Medium	Medium	Amber	
8	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.	5	4	Medium	Medium	Red	
9	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.	4	3	Medium	Medium	Amber	
10	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.	5	4	High	Medium	Red	
11	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.	4	4	Medium	Medium	Amber	
12	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.	4	4	Medium	High	Amber	

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Proposal

- To support the movement of BAF03 to zone amber for increased oversight whilst additional controls are implemented.
- To continue regular executive director led updates across the Group on each area of the BAF.
- Decision making regarding proposed changes to the BAF take place at the Group Strategic Executive Board and Group Trust Board.

Decision Required

None

Governance Table

For Board and Board Committees:	Trust Board 24 November 2026
Paper sponsored by:	Kate Dyer Director of Governance and Risk
Paper authored by:	Kate Dyer Director of Governance and Risk
Date submitted:	13 November 2026
Name and date of other committee / forum at which this report / issue was considered:	None
Assurance level gained elsewhere	NA
Date of next report:	26 January 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:	N/A
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

Leicestershire Partnership and
Northamptonshire Healthcare
Associate University Group

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Joint Nominations and Remuneration Committee Terms of Reference

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

Version	Date	Author
1.1	November 2026	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 Partnership Agreement, the Fit and Proper Persons Requirement, and the Code of Governance for NHS provider trusts.

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.

I	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 people team 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 Group Chair or by a Deputy Trust Chair if the Group Chair is not present.

Four Non-Executive Directors: two from each Trust, including the Deputy Trust Chair from each Trust and 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.

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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 the People Team; 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?

J

Level 1, 2 and 3 Alert, Advise and Assure (AAA) Highlight Report
LPT Committee/Group: Quality and Safety Committee
Date of Meeting: 22nd October 2026
Meeting Chair and Report Author: Josie Spencer Non-Executive Director & Deputy Trust 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/26/106	Jean Knight	It was confirmed that the that non-recurrent ICB funding for the ADHD service would end on 31st October 2026. The service has reduced expenditure by not replacing some leavers but remains approximately £45,000 short of the previous £310,000 funding. The loss equates to around five whole-time equivalent nurses from a service of approximately fifteen, reducing capacity by about one third against a waiting list of approximately 10,000 for assessment and 1,000 for treatment. The funding discussion had concluded, and in-year mitigations were being pursued	04 05		

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Safety Forum AAA Report	QSC/26/114	Dr Bhanu Chadalavada	The future of the system Transferring Care Safely group (TCS) had initially been raised as an alert because changes within the ICB could result in the group being stood down. Following escalation through the system quality meeting, support for retaining the necessary functions through revised arrangements has been achieved and the issue can now be considered as advisory and will remain under review.	04 05		

ASSURE: Inform the Board where positive assurance has been received

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Group Chief Nurse/Executive Director of Nursing, Allied Health Professionals (AHPs) and Quality update	QSC/26/104	Linda Chibuzor	The Committee received strong assurance regarding the current staff flu vaccination programme. As of 15th October 2026, LPT reported an uptake of 23% against an overall target of 52%. Over 1000 staff had received the vaccine.	05		
LPT Medical Director update	QSC/26/104	Dr Bhanu Chadalavada	The Committee received an update on the statutory biological sex code of practice and associated guidance. Ward privacy and dignity audits have commenced within LPT and the review indicated that there could be mixed-sex accommodation breaches. These will continue to be reported, with clinical safety plans developed for relevant scenarios and legal advice obtained. Work concerning staff facilities was expected to take longer. In addition progress was reported on the joint strategic research oversight arrangements, including monthly meetings with partner organisations, forensic research input and the Trust being named	05 03		

T H R I V E

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

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
			as a contracting organisation for two NIHR Research for Patient Benefit grants in eating disorders.			
Complaints Annual report 2025-26 summary	QSC/26/111	Linda Chibuzor	The Committee were assured by Complaints Annual report 2025-26 (a summary of the full Complaints Annual is appended to this report). The Committee welcomed the clear structure of the annual report and noted reductions in reopened complaints and low levels of Ombudsman investigations. It was acknowledged that complaints performance has improved following implementation of a quality improvement plan.	05		
Arts in Mental Health Annual report 2025-26	QSC/26/112	Linda Chibuzor	The Arts in Mental Health service supports recovery through creative opportunities and the report provides information about the delivery of approximately eleven projects and 6,000 contacts, including work linked to the Riverside Festival, gardening, comedy, writing, transition and digital workshops. Work is aligned to the Thrive strategy and relies in part on external funding. The Committee considered that sufficient assurance had been provided about the service. However, the Committee requested that future reports included stronger evidence on access, variation and outcomes.	05		
Annual Review of Committee Effectiveness, Terms of Reference and Workplan	QSC/26/121	Kate Dyer	The Committee received a summary of recommendations following feedback and discussion at the August 2026 Committee. It was agreed to retain director level attendance due to this being a formal committee of the Board. Scheduling arrangements will be reviewed, including closer alignment with the Northamptonshire committee cycle and the practical needs of those in Group roles and a future new Non-Executive Director. The information pack approach was welcomed. It was agreed that reports and Triple A summary reports would be streamlined to ensure there is the required consistency, a focus on assurance, escalation and clear			



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)
			alerts rather than volume of operational detail. The Committee agreed to add first-line assurance through patient, staff or service presentations to the agenda from the new financial year.			

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)
Group Chief Nurse/Executive Director of Nursing, Allied Health Professionals (AHPs) and Quality update	QSC/26/104	Linda Chibuzor	The Committee was delighted to hear that the Allied Health Professionals event held on 14th October 2026 was a significant success.			
Accountability Framework Meeting Triple A report	QSC/26/106	Jean Knight	The Committee were advised of a number of outstanding areas of practice including the Child and Adolescent Mental Health service (CAMHS) acuity call being longlisted for an award and the impact of the Triangle of Care work within musculoskeletal physiotherapy.	05		

T H R I V E

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

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

T H R I V E

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

Leicestershire Partnership NHS Trust

K Quality and Safety Committee – 22 October 2026

Complaints and Concerns Annual Report 2025-26 Summary

Purpose of the Report

The report provides overall assurance that appropriate governance, oversight and learning arrangements are in place for complaints and PALS management. It identifies no new strategic risks but highlights ongoing operational risks relating to access, communication and patient care which align predominantly with BAF04, together with opportunities to strengthen assurance against BAF02 through enhanced understanding of health inequalities and engagement with underserved communities.

Key areas of assurance include:

- Strong governance and oversight arrangements through the Complaints Review Group (CRG), Quality Forum, Quality Assurance Committee and Accountability Framework
- Improved complaints performance, with compliance against response time targets increasing from 53% to 84% following implementation of the Complaints Improvement Plan.
- Evidence of organisational learning, with identified actions implemented
- Effective complaint resolution, demonstrated by a low rate of reopened complaints (3.25%) and a low level of Ombudsman investigations
- Comprehensive patient experience intelligence, through triangulation of complaints and PALS data with Friends and Family Test and compliments data, providing a balanced view of patient experience and emerging risks

Risks Identified

- Delays in access to assessment, treatment and support may negatively affect patient experience, clinical outcomes, and confidence in services.
- Poor communication can impact patient understanding, engagement, experience, and trust, increasing the likelihood of dissatisfaction and escalation.

- Delays in complaint resolution may impact public confidence and reduce opportunities for timely organisational learning.

BAF04: The principal complaint themes of appointments/waiting times, communication and patient care provide important assurance regarding areas already recognised within BAF04. The report confirms that these remain the issues most frequently raised by patients and carers and therefore represent ongoing indicators of pressure within access, responsiveness, and patient experience.

BAF02: The Trust currently has limited demographic intelligence from complaints and PALS contacts. There remains a risk that some communities experiencing poorer outcomes or inequalities may be under-represented within feedback mechanisms.

K

Leicestershire Partnership NHS Trust

Trust Board 24 November 2026

Safe Staffing September 2026

Purpose of the Report

This report provides a full overview of nursing safe staffing during the month of September 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. (Staffing 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.

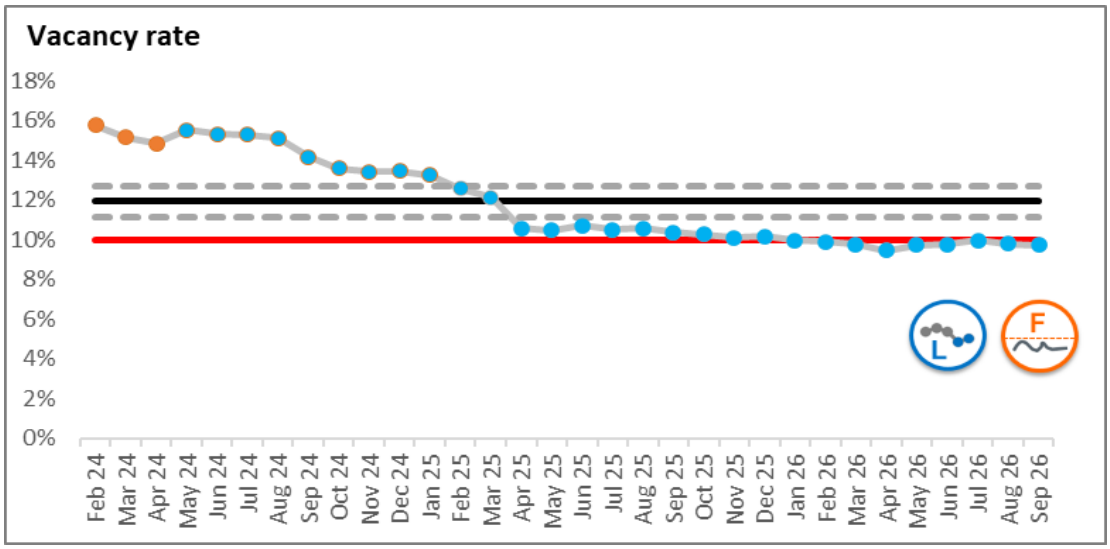
The Trust demonstrates its position regarding mandatory submission of fill rates required by the Department of Health via UNIFY and paying attention to any variance below 80% and above 110%. The upload of these figures to UNIFY occurs on the 15th of each month following review and sign off by the Group 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 September 2026, the overall Trust vacancy rate was 9.7% which is slightly below the Trust target of 10%. A reduction of 0.1% since August 2026.



Registered Nurses

- Vacancy position is at 240.4 Whole Time Equivalent (WTE) with an 11.9% vacancy rate, an increase of 0.1% since August 2026.
- Substantive registered nurses in post are 52 FTE below plan. A deep dive has taken place with majority of services on target. Directorates aware of exceptions and recruitment is on-going.
- Turnover for nurses remains at 5.5% which is below the Trust target of 10%.
- Sickness reported at 5.6% a decrease of 1.2% since August 2026.
- 6.0 WTE nursing staff (bands 5 to 8a) were appointed in September 2026.

Health Care Support Worker (HCSW)

- Vacancy position is at 193.5 WTE with a 17.8 % vacancy rate, an increase of 0.8% since August 2026.
- Turnover rate is at 9.7%. which is below our internal target of no more than 10%.
- Sickness reported at 5.9 % which is a decrease of 1.6% since August 2026.
- A total of 8.1 WTE HCSW was appointed in September 2026.

Allied Health Professionals (AHPs)

- Vacancy position is at 54.7 WTE with a 6.2% vacancy rate, no change since August 2026.
- Turnover rate remains at 7.9%, which is below our internal target of no more that 10 % turnover.
- Sickness reported at 5.0%, no change since August 2026.
- 5.3 WTE AHP was appointed in August 2026.

Medical

- Vacancy position is at 12.2 WTE with a 7.6% vacancy rate with an increase of 0.6% since August 2026.
- Turnover rate is at 10.4 %, which is slightly above our internal target of no more that 10% turnover.
- Sickness reported at 5.5% which is an increase of 1.2% since August 2026.
- No medical staff appointed in September 2026.

Temporary workforce

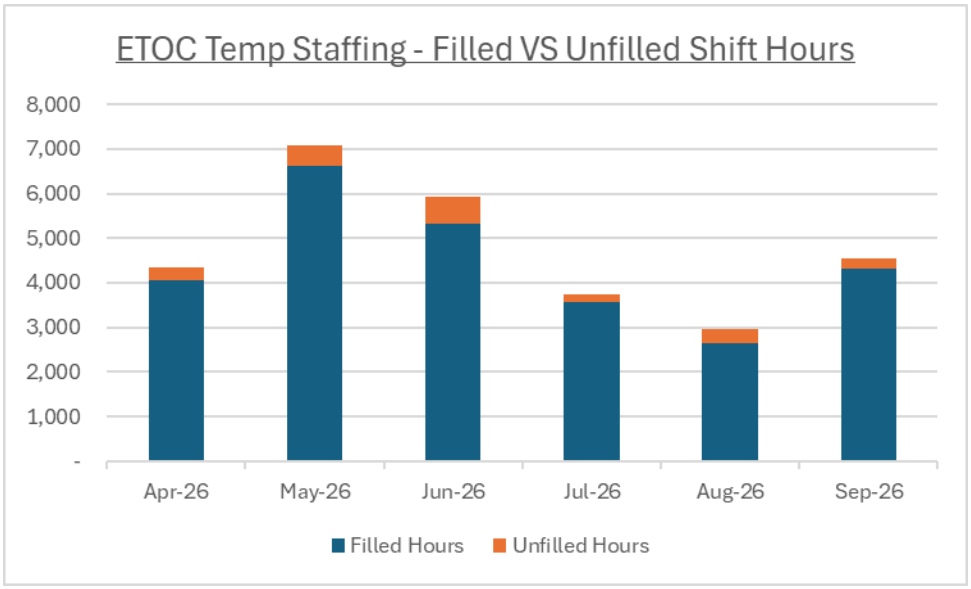
- Temporary worker utilisation rate decreased this month by 2.63% reported at 18.32% overall, of this, Trust wide agency usage decreased slightly this month by 0.29% to 0.14% overall.

Enhanced Therapeutic Observations and Care (ETOC)

Enhanced Therapeutic Observation and Care (ETOC), often referred to as enhanced care, enhanced therapeutic observations, 1:1s or specialling, is an intervention which contributes to safe and effective care of patients. Typically, ETOC is undertaken by a Healthcare Support Worker (HCSW), Registered Nurse (RN) or a Registered Mental Health Nurse (RMN).

The Trust is currently participating in cohort 4 of NHS England's ETOC quality improvement programme. When additional staffing is required above planned staffing levels to support ETOC, activity is recorded monthly and reported to NHS England as part of the programme. ETOC descriptors available on Health roster have been reviewed as part of the programme and commenced on 1st September 2026, with the aim of improving accuracy of shifts/hours requested and filled for ETOC.

Between April and September 2026, 26,550 ETOC hours were recorded, the majority of which were filled by unregistered temporary staff, with no substantive staff hours recorded. Substantive staff hours delivering ETOC are not currently captured within this dataset and are therefore excluded from the reported figures. Please see table below that details the number of ETOC hours per month and fill rate.



There is ongoing monitoring of ETOC demand and utilisation, review of observation practices to ensure ETOC is clinically appropriate and proportionate, and continued use of experienced temporary staff to maintain safe patient care. This correlates with increased HCSW fill rates and patient acuity as reported in the key areas to note in table 1 and staffing scorecard.

Right Skills

Across the Trust on average core and clinical mandatory training compliance is currently compliant (green). Paediatric Resuscitation level 3 is red at 67.9%. There are 28 staff outstanding, all with a booked place, monitored through the relevant governance groups.

- Across the Trust, on average appraisal rates and clinical supervision remain consistently compliant (green).

Right Place

In September 2026, the total Trust Care Hours Per Patient Per Day (CHPPD average), including ward based AHPs, is calculated at 11.3 CHPPD (national average 10.8) consistent with August 2026.

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

Table 1 below identifies key areas to note for September 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 at 20.2% 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. There has been a reduction with 12 wards utilising less than 20% temporary workforce of which 5 wards using less than 10%. North ward re-opened on the 1 September 2026. Ward 1 (Saint Lukes) closed temporarily 14 September 2026 for estates work and moved onto ward 3 (SL). Ward 1 (SL) will re-open 26 October 2026. **Allied Health Professional (AHP) Staffing -** Moderate Risk Rating Amber Sickness and maternity leave across west community hospital in-patient wards, recruitment in progress and band 7s working closely together to cover each ward daily. Impacting provision of consistent therapy. AHP leads continue strengthening incident reporting and introduction of job planning. The temporary ward move of ward 1 St Lukes, has provided additional capacity to one ward but had challenges with increase dependency on the other, with both wards working closely together to manage safe staffing.	**Green**
CHS In-patients	**Fill rate** RN reduced fill rate below 80% on days and nights on ward 1 (SL) and days on East Ward. Ward 1 (SL) closed on 14 September 2026 and moved onto ward 3 (SL). East Ward planned staffing is 4 RN (day) this can include a Registered Nursing Associate (RNA) who are not included in the calculation of the RN fill rate. Shifts were mitigated by Registered Nursing Associates. Safe staffing levels maintained. HCSWs fill rates above 110% on days and night shifts improvements remain in September 2026. Rutland ward had a fill rate above 110% for HCSWs on day and night shifts, due to increased patient acuity and dependency, increased Enhanced Therapeutic Observations of Care (ETOC) following transfer from acute providers requiring	**Green**

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
	additional staff to meet the patient care needs. Ward 3 (SL) also had a fill rate above 110% for RN and HCSW on day shifts and HCSW's on night shifts due to additional staff from ward 1 (SL). Enhanced Therapeutic Observations of Care (ETOC) improvement work continues with a task and finish group linked to the trust wide NHS England ETOC programme. Patients requiring ETOC are monitored in a daily meeting supported by matrons and Deputy Head of Nursing. Education has been increased and improvements to embed ETOC practice.	
CHS In-patients	**Nurse Sensitive Indicators (NSIs)** **Falls** 23 falls incidents reported, a decrease since August 2026. 22 falls incidents reported as low/no harm and 1 fall resulting in moderate harm awaiting directorate incident review. Staffing was not identified in initial review as a contributory factor. **Medication incidents** Medication incidents decreased from 13 in August to 10 in September 2026. All reported as low/no harm. **Pressure Ulcers** The number of category 2 pressure ulcers developed or deteriorated in our care has remained at 5 in September 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. **Staffing Related Incidents** The number of safe staffing related incidents decreased form 15 in August to 11 in September 2026 across 5 sites. Incidents reported were relating to staffing shortages due to sickness and a shortage of therapy staff. All staffing related incidents reported as low/no harm.	**Green**
DMH In-patients	**Staffing** High percentage of temporary workforce to meet planned staffing on Heather at 48.6%. Additional 4 wards all above 30% temporary workforce. High utilisation of temporary workforce was due to a number of factors	**Green**

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
	including increased acuity for patients with high-risk behaviours, increased therapeutic observations and a patient on long term one to one therapeutic observations and backfilling with additional HCSW's. 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.	
DMH In-patients	**Fill rate** Fill rate below 80% for HCSWs on the day shift continues at Mill Lodge due to a low bed occupancy and staffing adjusted accordingly. Fill rate above 110% for RN on the day shift on Aston due to rostering of additional staff hours and staff being re-deployed to other areas to support staffing pressures. Fill rate above 110% for HCSWs on day shifts on Ashby, Heather, Coleman, Gwendolen, Kirby and Langley. Fill rate above 110% for HCSWs on night shifts on Ashby, Aston, Beaumont, Griffin, Heather, Coleman, Kirby Langley and Mill Lodge. HCSW fill rate above 110% was due to high patient acuity and dependency requiring increased therapeutic observations, patients requiring additional staff for personal care and deterioration in mental and physical health needs.	**Green**
DMH In-patients	**Nurse Sensitive Indicators:** **<u>Falls</u>** An increase in the number of falls incidents from 60 in August to 85 in September 2026. Increase in falls incidents due to patient group in Mental Health Services Older People (MHSOP). Two moderate harm incidents reported, one patient fell backwards from a chair and another patient was found sitting on the floor. Incident Service Management Review's (ISMRs) requested. All other falls were reported as low, or no harm and staffing was not identified in initial review as a contributory factor. Falls huddles are in place and physiotherapy reviews for patients with sustained falls and increased risk of falling, where themes and trends in falls are being discussed to share, learn and support safe care.	**Green**

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
	Medication Incidents The number of medication incidents increased from 12 in August to 19 in September 2026. All incidents were reported as no, or low harm and staffing was not a contributory factor. **Pressure Ulcers** One category 2 pressure ulcer reported on Gwendolen ward during September 2026 and a reduction from August 2026. **Staffing Related Incidents** DMH reported 4 incidents relating to reduced staffing levels on Bosworth, Phoenix, Griffin and Ashby and 1 further staffing incident relating to 'only 1 RN on shift' on Coleman ward. Mitigation in place, staff moved to support and backfilled with additional staff. All incidents reported as low/no harm.	
FYPC.LDA in- patient	**Staffing** 32.5% 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. Welford ED utilised 20.4% temporary workforce. Safe staffing is reviewed daily due to increased patient acuity and complexity with staffing levels adjusted accordingly. Beacon Unit continue to utilise a high number of temporary workforce with advance booking of staff. Mitigation remains in place; potential risks being closely monitored.	**Green**
FYPC.LDA in- patient	**Fill Rate** Below 80% for RN on night shifts at the Learning Disability (LD) Short Breaks. Below 80% for HCSW's on day shifts at learning Disability (LD) short Breaks and night shifts at the Beacon. Above 110% for RNs on days shifts at the Agnes unit.	**Green**

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
	Above 110% for HCSWs on day shifts at Welford (ED) and on days shifts and night shifts at the Agnes unit. The Grange and Gillivers fill rate analysis is now jointly reported as LD short breaks going forward. 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 on nights during September 2026. 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 Directorate review to support staff having an interrupted break during their shift and a training plan across LD Short breaks to improve skill set. Mitigation was provided with cross cover and staff redeployed from the Agnes unit for reduced RN fill rate on the nights shifts at LD Short breaks during September 2026. Planned staffing levels have been reviewed and adjusted accordingly at the Agnes unit from 4 RN Day and night shift to a minimum of 2 RN per shift. This is due to operating on 1 pod (below commissioned beds). Increased RN and HCSW fill rate due to additional staff being available and redeployed to support other wards/units within directorate. HCSW planned staffing levels have also been reviewed at night at the Beacon Unit and adjusted accordingly to patient acuity and complexity in support of the day unit. Welford ED continues with high patient acuity, a number of patients requiring additional staff to provide increased therapeutic observations, supervision at mealtimes and Naso-Gastric feeding.	
FYPC.LDA in- patient	**Nurse Sensitive Indicators:** **<u>Falls and medication incidents</u>** 1 fall and 1 medication incidents were reported in September 2026, and staffing was not a contributory factor.	**Green**
CHS Community	Overall community nursing Service OPEL has been level 3, working to level 3/4 actions. Amber/Red moderate risk rating.	**Amber**

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
	An increased level of pressure continues across the service, key areas of pressure are Charnwood and Hinckley & Bosworth due to reduced leadership and East Central due to staff MSK issues. Daily review of caseloads continues, review of non-essential activities, ongoing reprioritisation of visits and increased mobilisation of the hub clinical leadership to enable the service to meet essential patient visits. Specialist teams have been reaching in to provide clinical support. Ongoing review of vacancies, bank, and agency usage, Dynamic Risk Assessment (DRA) process embedded to monitor agency use to support safe staffing provision. Focus has been to ensure service provision with background quality improvement work focusing on pressure ulcers and insulin continuing. Ongoing actions from the transformation programme relating to service specification, care planning/ documentation, training/ competency have been reviewed for priority and continue to be monitored through the service Governance meeting. Weekly Community Nursing Huddle commenced to support oversight and effective escalation. 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 –** Minimal Risk Rating Green Improving picture in September some ongoing staffing challenges and maternity leave specific to two hubs, 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. However, Community Integrated Neurological and Stroke service (CINSS) is a moderate risk rating of Amber due to sickness and maternity leave within the Occupational Therapy team. 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. First Contact Practitioner service (MSK) is risk rated amber, due to Sickness in the team causing a risk to service delivery, currently providing cover from the core MSK service. MSK unable to provide long term cover due to the impact on their waiting times, further mitigations being explored. AHP CHS Speech and Language Therapy Service also rated amber due to increased sickness maternity leave and vacancies. Mitigation includes the use of bank staff to manage wait times and service delivery.	

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. Two Team Leaders currently unavailable and bank staff requested to support service delivery with limited temporary workforce availability. Further leavers expected and agency staff being considered to support service delivery. Agency staff interviewed and awaiting competencies. 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 staff leavers, being backfilled with temporary workforce. Ongoing recruitment continues to support service delivery. Mental Health Services for Older People (MHSOP) experiencing staffing shortages across Charnwood neighbourhood due to sickness. Support plan being implemented with other Community Mental Health Teams (CMHTS). West Leicester CMHT MHSOP experiencing significant reduction in staffing due to sickness. South Leicestershire team have separated into Blaby, Lutterworth and Oadby, Wigston and Harborough however staffing remains reduced due to significant sickness and annual leave. Support is being provided by other neighbourhood teams for urgent clinical activity. City East continue to review patient tracker list, case management and waiting times for Community Psychiatric Nurse (CPN) input. Dynamic Risk Assessments (DRA) are requested and supported however proving challenging in resourcing staff with appropriate level of clinical skills required. 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.	**Green**
FYPC.LDA Community	Learning Disability (LD) city and county nursing, LD access and LD Crisis Response Intensive Support Team (CRIST) continue as areas to note due to maternity leave and sickness. LDA Speech and Language Therapy (SALT) staffing reduced due to staff sickness, maternity, compassionate leave and a vacancy, recruitment started.	**Green**

Area	Situation/Potential Risks and Actions/Mitigations	Risk rating
	No change to 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 successful recruitment in progress to cover maternity leave. LDA Speech and Language Therapy staffing reduced due to extended jury service and staff sickness. Children's Occupational Therapy staffing reduced, newly recruited staff in post and awaiting 1 more post to be filled. City Healthy together team staffing improving. No change 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 remain listed as fragile services. No change to Child Adolescent Mental Health Service Young Persons team (CAMHS YPT) due to maternity and sickness, alongside significant increase in complex referral and attendance of Looked After Children (LAC) in the emergency department. New starters recruited. Mitigation continues in place with potential risks being closely monitored within Directorate. Safer staffing plans/models reviewed including teams operating in a service prioritisation basis.	

Summary

- Considering the triangulated review of workforce metrics, nurse sensitive indicators, patient feedback, and outcomes in September 2026, staffing challenges continue with clear actions in place to mitigate the risks and as such are rated overall as (Green) low risk. A small number of services are reporting Amber.
- 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 – September 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 24 November 2026
Paper sponsored by:	Linda Chibuzor Group Chief Nurse/Executive Director of Nursing, AHPs and Quality
Paper authored by:	Elaine Curtin Workforce and Safe Staffing Matron, Jane Martin Assistant Director of Nursing and Quality, Emma Wallis Deputy Director of Nursing and Quality
Date submitted:	24 November 2026
Name and date of other committee / forum at which this report / issue was considered:	Executive Management Board 3 November 2026
Level of assurance gained if considered elsewhere	☒Assured ☐ Partially assured. ☐ Not assured
Date of next report:	Bi-Monthly
THRIVE strategic alignment:	☐ **T**echnology ☐ **H**ealthy communities ☐ **R**esponsive ☐ **I**ncluding everyone ☐ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	BAF 04 Timely Access BAF 05 Patient Safety BAF 07 Culture BAF 08 Workforce resourcing strategies
Is the decision required consistent with LPT's risk appetite:	Yes
False or Misleading Information (FOMI) considerations:	None
Positive confirmation that the content does not risk the safety of patients or the public:	Yes
Equality considerations:	None

Nursing Scorecard - September 2026

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

Ward Name	Average Beds	Average Occupied Beds	% Fill Rate Registered Nursing Day	% Fill Rate Unqualified Nursing Day	% Fill Rate Registered Nursing Night	% Fill Rate Unqualified Nursing Night	% Fill Rate Allied Healthcare Professional Registered Day	% Fill Rate Allied Healthcare Professional Unregistered Day	Temporary Workers % (Nursing)	Bank % (Nursing)	Agency % (Nursing)	Overall Care Hours Per Patient Day	Medication Errors (and monthly movement)	Falls (and monthly movement)	Complaints (and monthly movement)	Pressure Ulcers Category 2 (and monthly movement)	Pressure Ulcers Category 4 (and monthly movement)	End Of Data Report
Beechwood Ward - BC03	24	23	98.9% Green	97.5% Green	100.0% Green	99.1% Green	100.0%	100.0%	12.9% Green	12.8% Green	0.2% Green	9	0 No Change	3 Up	0 Down	0 No Change	0 No Change	
Clarendon Ward - CW01	21	19	90.6% Green	106.3% Green	100.0% Green	101.6% Green	100.0%	100.0%	9.1% Green	9.1% Green	0.0% Green	10	0 No Change	3 Up	0 No Change	0 No Change	0 No Change	
Dalgleish Ward - MMDW	16	14	100.0% Green	95.5% Green	100.0% Green	98.9% Green	100.0%	100.0%	13.7% Green	13.7% Green	0.0% Green	10	1 Down	0 Down	0 No Change	0 No Change	0 No Change	
Rutland Ward - RURW	18	16	100.0% Green	112.3% Blue	100.0% Green	168.1% Blue	100.0%	100.0%	20.2% Amber	20.2% Amber	0.0% Green	10	0 Down	2 Down	0 No Change	1 Up	0 No Change	
Ward 1 - SL1	13	14	25.3% Red	29.6% Red	30.0% Red	30.0% Red	100.0%	100.0%	8.8% Green	8.8% Green	0.0% Green	18	1 Down	0 Down	0 No Change	0 Down	0 No Change	
Ward 3 - SL3	12	11	117.8% Blue	118.9% Blue	108.3% Green	158.6% Blue	100.0%	100.0%	3.1% Green	3.1% Green	0.0% Green	14	2 Up	1 Down	0 No Change	0 Down	0 No Change	
Charnwood Ward - LBCW	19	17	97.2% Green	99.3% Green	98.4% Green	102.1% Green	100.0%	100.0%	9.8% Green	9.7% Green	0.2% Green	10	0 No Change	5 Up	0 No Change	0 No Change	0 No Change	
East Ward - HSEW	28	25	74.3% Red	95.5% Green	93.3% Green	101.3% Green	100.0%	100.0%	18.2% Green	18.2% Green	0.0% Green	9	2 No Change	5 Down	0 No Change	2 Up	0 No Change	
Ellistown Ward - CVEL	20	18	94.3% Green	102.8% Green	100.0% Green	107.6% Green	100.0%	100.0%	13.9% Green	13.9% Green	0.0% Green	11	0 No Change	0 Down	0 No Change	0 No Change	0 No Change	
North Ward - HSNW	18	17	100.2% Green	90.6% Green	100.0% Green	96.9% Green	100.0%	100.0%	17.0% Green	17.0% Green	0.0% Green	10	0 No Change	1 Up	0 No Change	0 No Change	0 No Change	
Snibston Ward - CVSN	20	18	101.7% Green	97.6% Green	100.0% Green	106.7% Green	100.0%	100.0%	18.0% Green	18.0% Green	0.0% Green	9	2 No Change	2 Up	0 No Change	1 Up	0 No Change	
Swithland Ward - LBSW	21	19	96.7% Green	99.5% Green	100.0% Green	100.0% Green	100.0%	100.0%	8.5% Green	8.3% Green	0.2% Green	8	0 Down	0 Down	0 No Change	0 No Change	0 No Change	
Ward 4 - CVW4	15	14	101.0% Green	100.7% Green	98.3% Green	101.1% Green	100.0%	100.0%	15.2% Green	15.2% Green	0.0% Green	10	2 Up	1 Down	1 Up	1 Up	0 No Change	
Ashby	14	14	98.9% Green	139.8% Blue	100.3% Green	142.9% Blue	100.0%		32.8% Amber	32.8% Amber	0.0% Green	10	1 No Change	4 Up	1 Up	0 No Change	0 No Change	
Aston	17	16	114.4% Blue	99.6% Green	100.0% Green	110.8% Blue	100.0%		13.5% Green	13.5% Green	0.0% Green	7	0 Down	0 Down	0 No Change	0 No Change	0 No Change	
Beaumont	23	21	86.8% Green	106.6% Green	101.0% Green	114.6% Blue	100.0%		26.5% Amber	25.3% Amber	1.3% Green	7	0 Down	3 No Change	0 Down	0 No Change	0 No Change	
Belvoir Unit	10	5	97.6% Green	102.4% Green	101.1% Green	101.4% Green	100.0%		29.9% Amber	29.5% Amber	0.4% Green	33	0 No Change	1 Up	0 Down	0 No Change	0 No Change	
Bosworth	14	14	98.7% Green	103.6% Green	100.7% Green	100.0% Green	100.0%		20.9% Amber	20.9% Amber	0.0% Green	8	2 Up	0 No Change	1 No Change	0 No Change	0 No Change	
Griffin - Herschel Prins	6	6	107.8% Green	109.4% Green	98.3% Green	122.2% Blue	100.0%		34.6% Amber	34.4% Amber	0.2% Green	26	0 No Change	0 No Change	0 No Change	0 No Change	0 No Change	
Heather	18	18	85.0% Green	137.2% Blue	101.3% Green	135.4% Blue	100.0%	100.0%	48.6% Amber	47.3% Amber	1.4% Green	9	3 Up	2 Down	1 Up	0 No Change	0 No Change	
Watermead	20	19	97.7% Green	109.0% Green	99.7% Green	109.0% Green	100.0%		30.6% Amber	30.1% Amber	0.5% Green	8	0 No Change	2 Up	0 No Change	0 No Change	0 No Change	
Coleman	19	19	98.9% Green	120.0% Blue	100.7% Green	149.9% Blue	100.0%	100.0%	30.7% Amber	30.7% Amber	0.0% Green	15	0 Down	11 Down	0 No Change	0 No Change	0 No Change	
Gwendolen	19	17	92.2% Green	111.1% Blue	100.1% Green	100.3% Green	100.0%		14.5% Green	14.5% Green	0.0% Green	11	1 Up	20 Down	0 No Change	1 Up	0 No Change	
Kirby	23	22	100.1% Green	126.2% Blue	101.4% Green	132.5% Blue	100.0%	100.0%	26.0% Amber	26.0% Amber	0.0% Green	9	3 Up	19 Up	0 No Change	0 No Change	0 No Change	
Langley (MHSOP)	19	17	100.4% Green	154.6% Blue	103.5% Green	133.5% Blue			23.3% Amber	23.3% Amber	0.0% Green	9	2 No Change	10 Up	0 No Change	0 No Change	0 No Change	
Mill Lodge	14	7	99.1% Green	78.9% Red	99.9% Green	132.9% Blue	100.0%		11.7% Green	11.4% Green	0.2% Green	23	1 Up	11 Up	0 Down	0 No Change	0 No Change	
Phoenix - Herschel Prins	12	12	87.9% Green	86.6% Green	98.6% Green	101.1% Green	100.0%		6.6% Green	6.6% Green	0.0% Green	11	0 No Change	0 Down	0 No Change	0 No Change	0 No Change	
Skye Wing - Stewart House	30	29	99.6% Green	100.4% Green	100.1% Green	101.4% Green	100.0%		21.2% Amber	21.0% Amber	0.2% Green	6	3 Up	0 Down	0 No Change	0 No Change	0 No Change	
Willows	9	8	95.7% Green	106.0% Green	100.0% Green	102.3% Green	100.0%		12.1% Green	12.1% Green	0.0% Green	13	2 Up	2 Up	0 Down	0 No Change	0 No Change	
CAMHS Beacon Ward - Inpatient Adolescent	17	5	108.9% Green	97.1% Green	100.0% Green	76.0% R	100.0%		32.5% Amber	32.3% Amber	0.2% Green	34	0 Down	1 Down	0 Down	0 No Change	0 No Change	
Welford (ED)	15	12	96.8% Green	132.3% Blue	101.7% Green	100.0% Green	100.0%	100.0%	20.4% Amber	20.2% Amber	0.2% Green	14	1 No Change	0 Down	0 No Change	0 No Change	0 No Change	
Agnes Unit	1	2	117.0% Blue	163.8% Blue	105.0% Green	135.4% Blue			2.1% Green	2.1% Green	0.0% Green	81	0 No Change	0 No Change	0 No Change	0 No Change	0 No Change	
LD Short Breaks	2	2	88.4% Green	74.3% Red	72.8% Red	94.6% Green			1.0% Green	1.0% Green	0.0% Green	29	0 No Change	0 No Change	0 No Change	0 No Change	0 No Change	

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

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

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

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Leicestershire Partnership NHS Trust

Public Trust Board – 24th November 2026

Patient Safety & Learning Assurance Report for September/October 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 September and October 2026, there were 3775 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 61.62% of all patient incidents reported during this period and are explored in order and in more detail below. This equates to an average of 1887.5 incidents per month during September and October 2026.

Top 5 reported patient safety incidents for September and October 2026

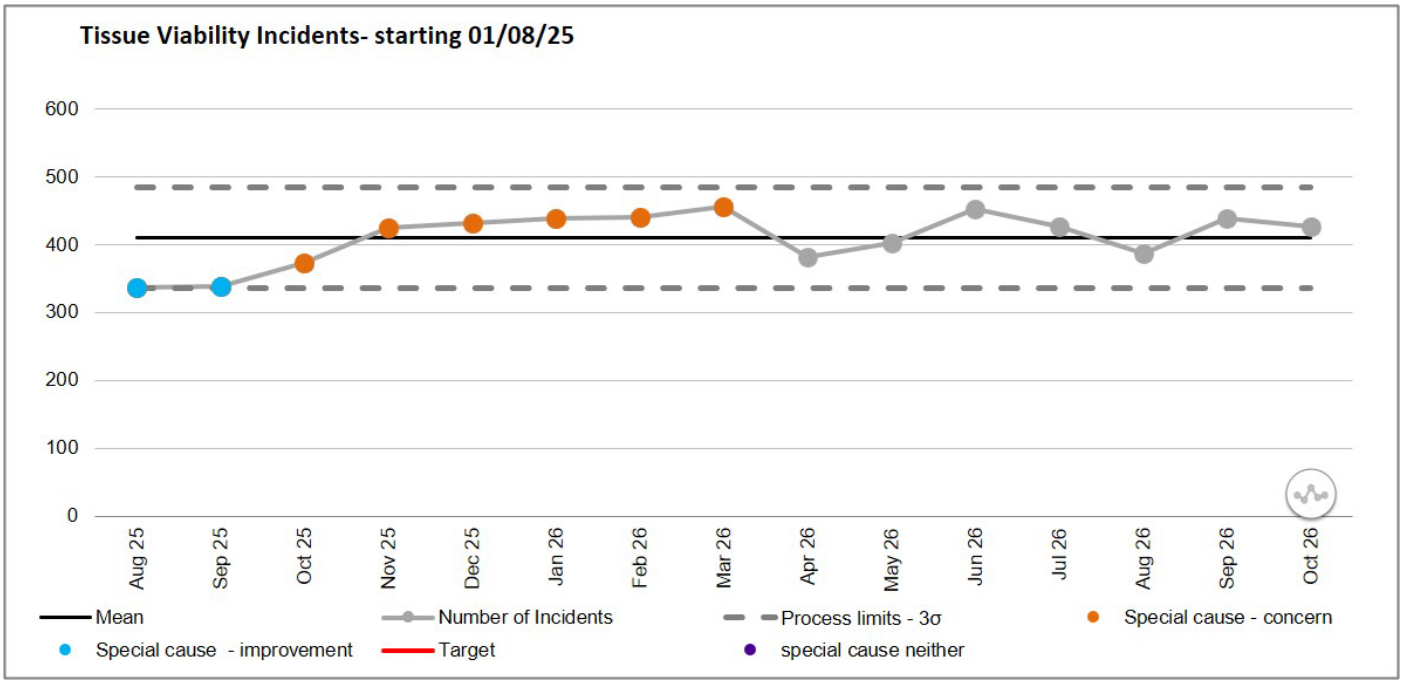
Category	Number of incidents	Directorate with highest % of the total reported
1. Tissue Viability	866	CHS (98.96%)
2. Self-Harm	506	DMH (80.04%)
3. Violence/Assault	366	DMH (90.16%)
4. Care/Treatment Using Restraint or Holds	322	DMH (98.14%)
5. Falls	266	DMH (67.29%)

Degree of harm recorded for all patient safety incidents for September and October 2026

Reported degree of harm	Number	% of total incidents reported
No Harm	2144	56.79%
Minor/Low Harm	1541	40.82%
Moderate Harm	60	1.59%
Severe Harm	5	0.13%
Death	25	0.66%

NB: these incidents were reported in September and October 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



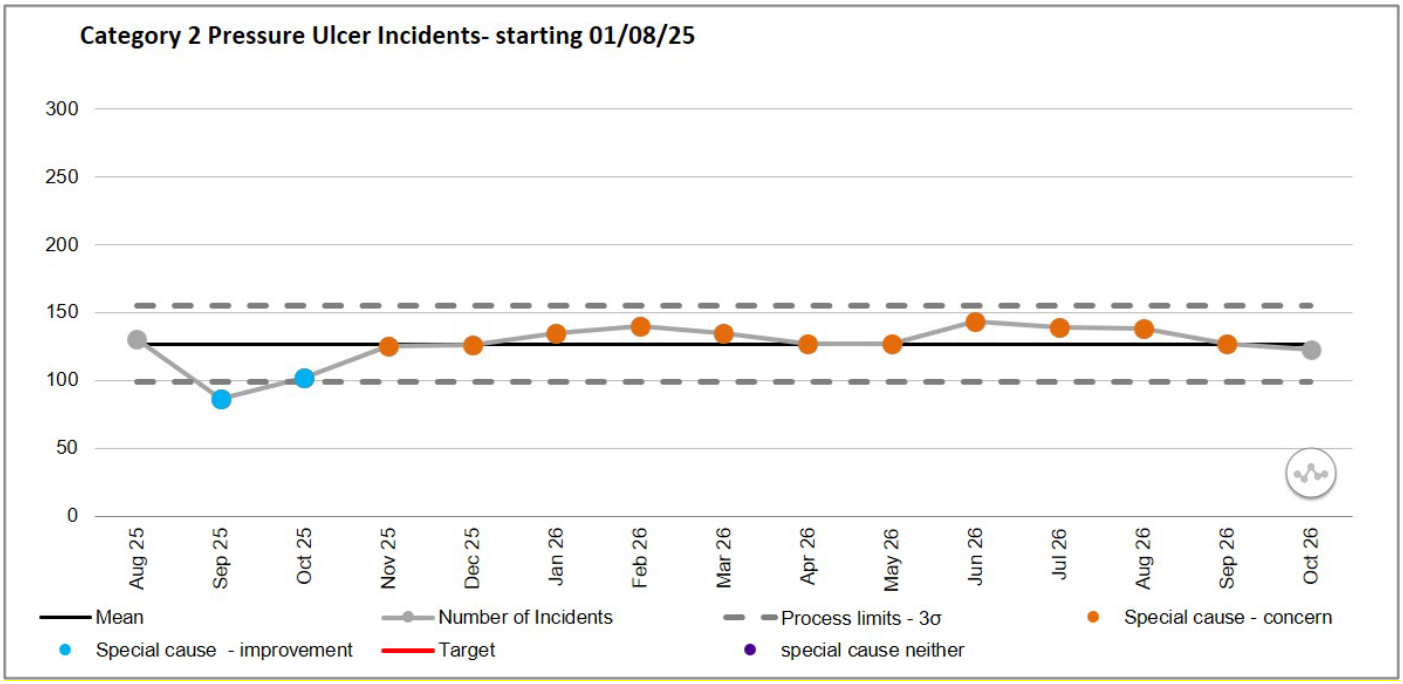
22.94% of all patient safety incidents reported relate to 'Tissue Viability' during September and October 2026; this equates to 866 incidents. This category includes pressure ulcers on admission, developed or deteriorated in our care, skin tears, scalds, wounds, and moisture associated skin damage. As Pressure ulcers (category 2,3,4 and unstageable) represent 67.21% of these, the report will focus on this aspect of patient harm.

In September and October 2026, there were 582 reported incidents where patients had been affected by category 2,3,4 and unstageable pressure ulcers reported to have developed or deteriorated in LPT care. This is a 4.49% increase in pressure ulcers reported in comparison to the previous 2 months reporting.

During this period, 563 (96.74%) were reported in Community Health Services (CHS) Community Nursing Services and 15 (2.58%) were reported in Community Hospitals (Inpatients).

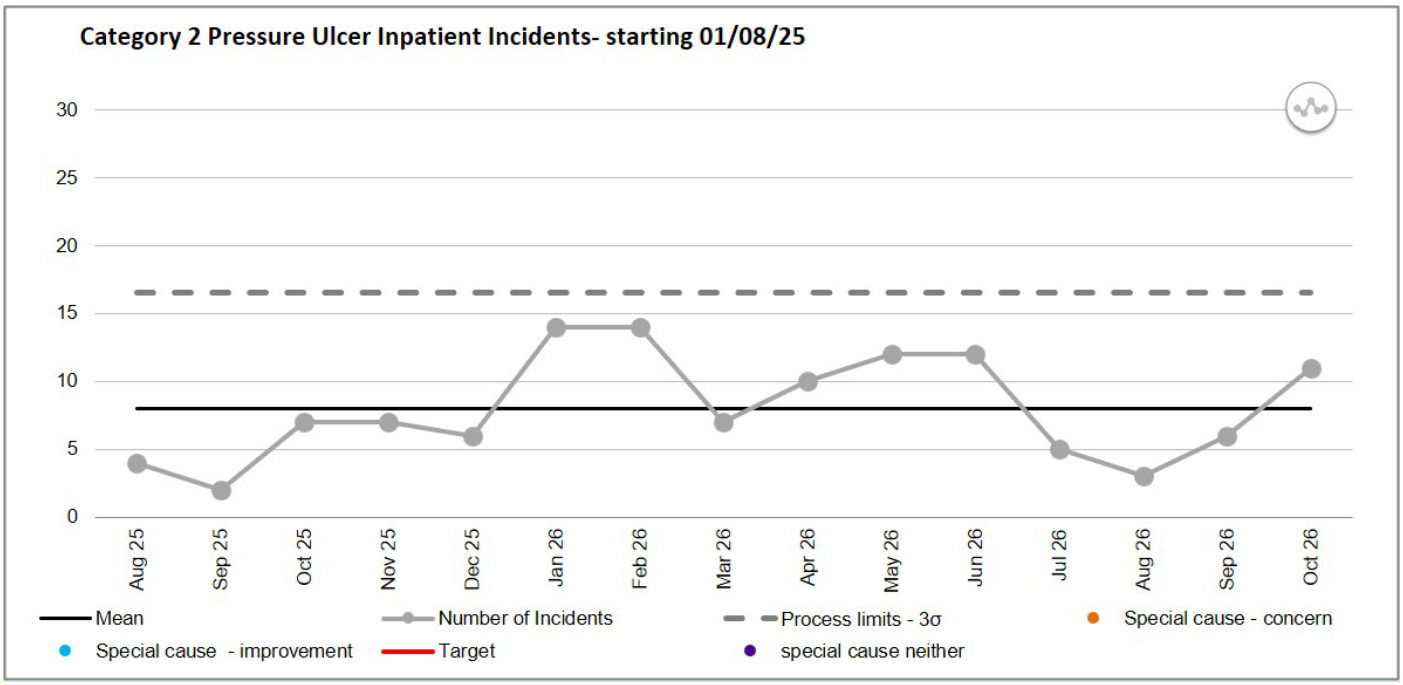
Of the remaining 4 incidents, 3 (0.52%) were reported in the Directorate of Mental Health (DMH), all of these being Category 2 Pressure Ulcers reported by Gwendolen Ward; the remaining 1 (0.17%) incident was reported in Families, Young People, Children's, Learning Disability & Autism directorate (FYPCLD), an Unstageable Pressure Ulcer reported by the Diana Service.

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



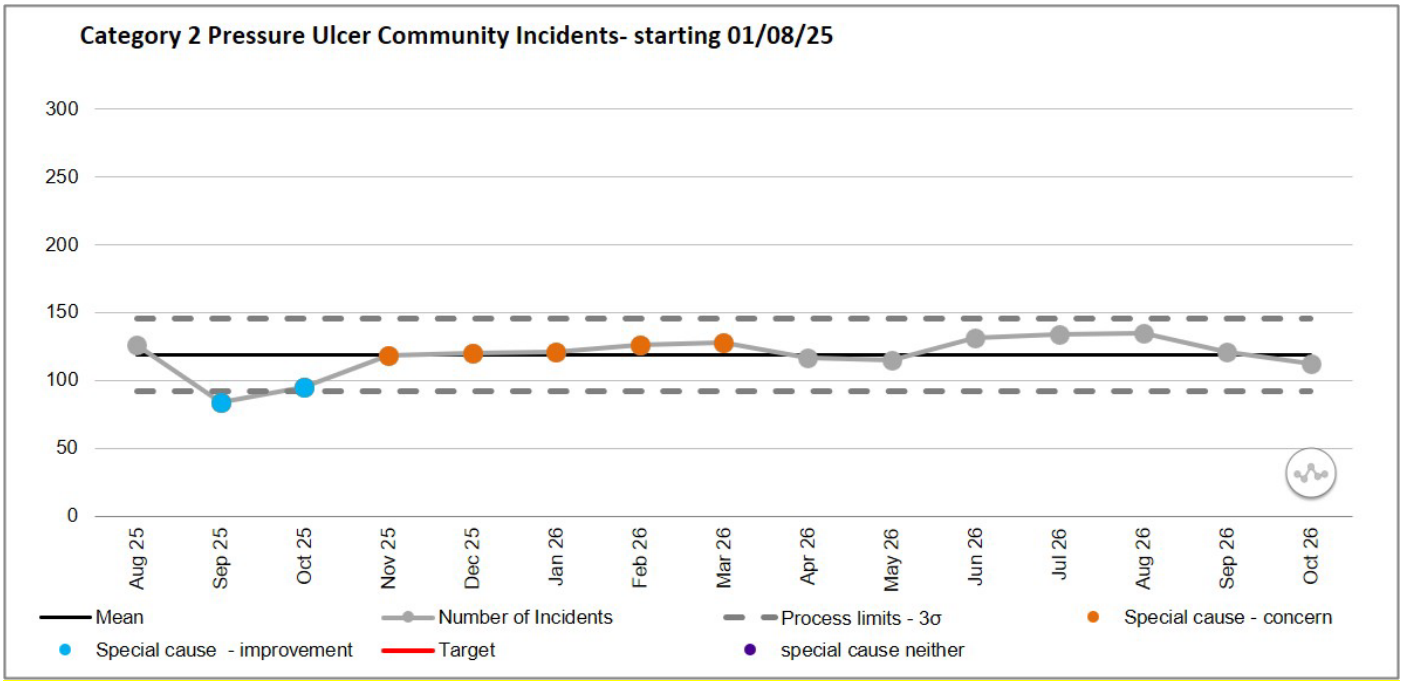
Analysis at the CHS Pressure Ulcer group has noted that there has been an increase in Moisture Associated Skin Damage (MASD) incidents leading to Category 2 pressure ulcers. Learning from the Community Hospital Quality Account priority for MASD is to be shared across community nursing hubs.

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



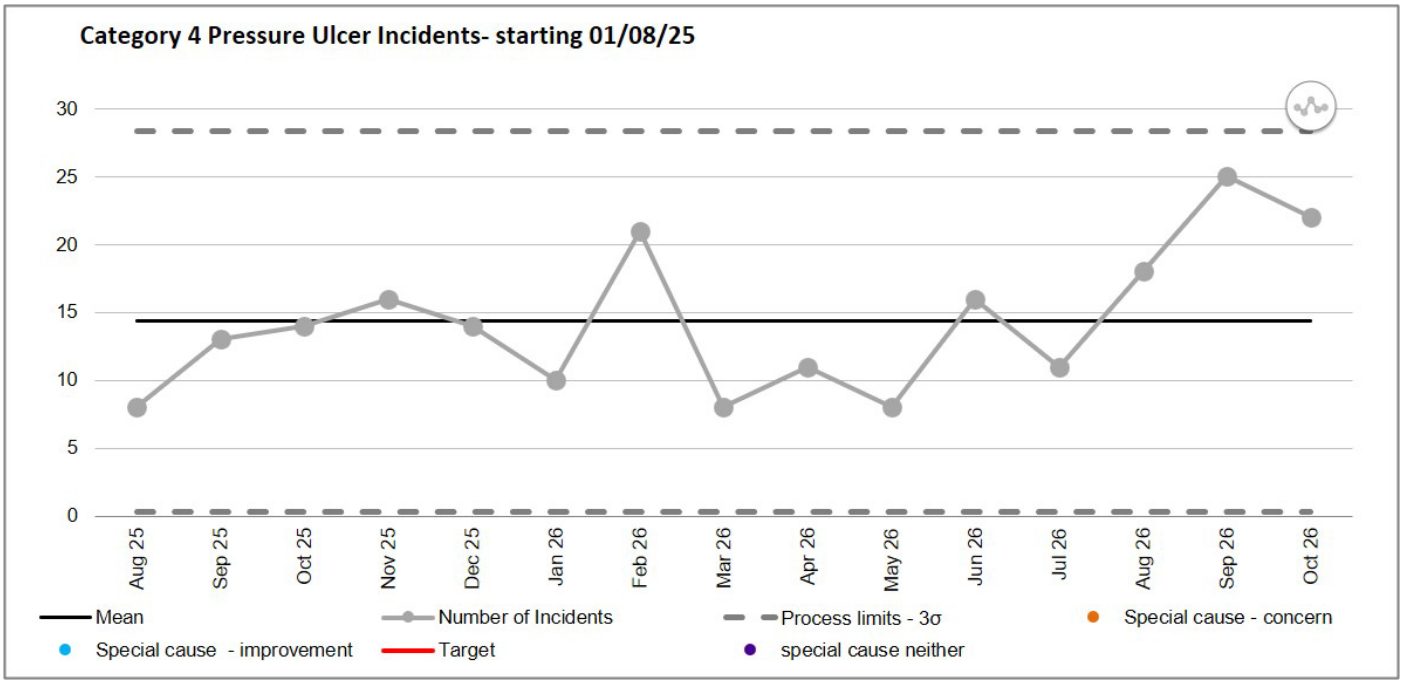
Further to seeing a previous downward trend in category 2 pressure ulcers developed in our care there has been a slight upward trajectory; Community Hospital Deputy Head of Nursing and Matrons continue with pressure ulcer huddles, learning and sharing from incidents and review of prevention work and focussed actions.

Community Category 2 pressure ulcers developed in our care.



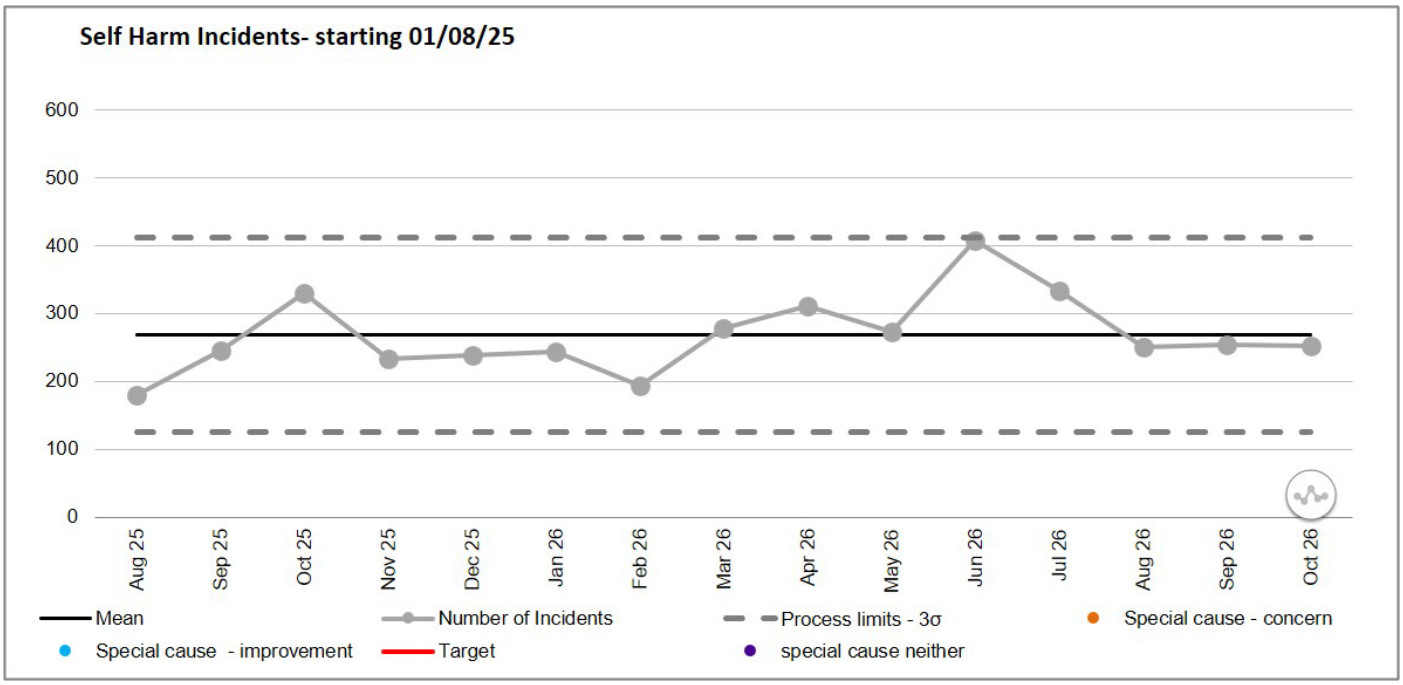
There has been no statistically significant change in Category 2 pressure ulcer incidents within Community Nursing, with SPC data demonstrating normal variation around the mean. Of the 6,683 patients on the Community Nursing caseload, 2.29% developed or experienced deterioration of a pressure ulcer while under our care.
Several improvement initiatives remain in progress. Governance arrangements have been strengthened through revised reporting processes, increasing senior nursing visibility, oversight, and the ability to assess the effectiveness of improvement actions.

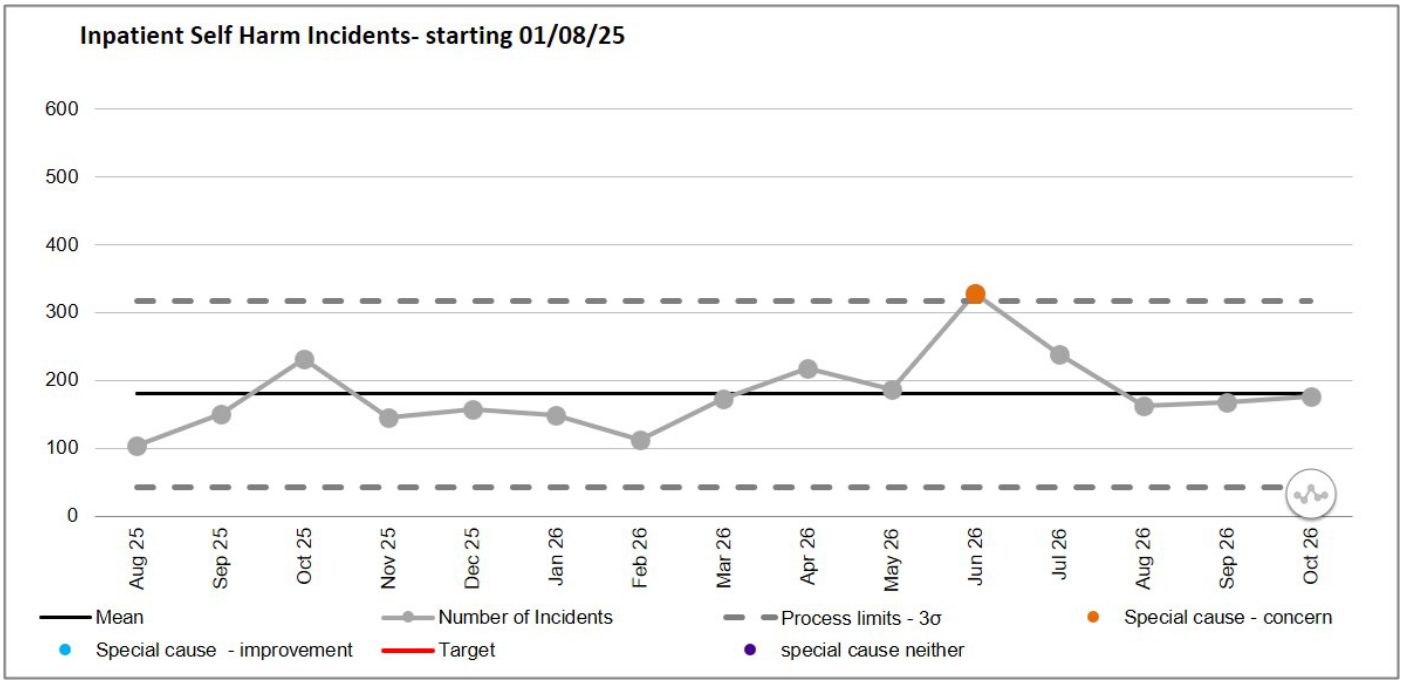
Category 4 Pressure Ulcers developed or deteriorated in our care – Trust wide.



The SPC chart shows common cause variation in Category 4 pressure ulcers developed or deteriorated in our care, with no evidence of a sustained increase in incidents.
The CHS Pressure Ulcer Delivery Group continues to oversee improvement activity informed by learning from incident reviews. Priority areas include strengthening repositioning practice, enhancing audit processes, and improving equipment management arrangements.
Collaborative work with care homes is underway to improve access to repositioning records, as differences in electronic recording systems can limit LPT staff visibility of preventative care delivered by care home staff. Addressing this issue is expected to improve assurance regarding pressure ulcer prevention and inform ongoing quality improvement activity.

2. Self-Harm – inpatient and community





There were 506 patient self-harm incidents reported during September and October 2026, this equates to 13.40% of all reported patient safety incidents during this period. Of the 506 incidents reported as patient self-harm, 344 were inpatient incidents and 162 were community incidents.

During the previous reporting period, there were 580 self-harm incidents reported across both inpatient and community settings, this shows a decrease of 12.76% 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 is 1 area with the largest number of self-harm incidents reported relative to the total number (506) of such incidents

reported. These incidents occurred on **Beaumont Ward** an inpatient admission ward based at the **Bradgate Unit**.

Beaumont Ward – 143 incidents (28.26%) This figure involves 13 patients; this is an increase from 110 total incidents reported in the previous reporting period.

Self-Harm Incidents level of harm

Within Beaumont Ward no incidents were reported as resulting in moderate harm or above. Of the 143 incidents reported, 66 (46.15%) were classified as minor/low harm and 77 (53.85%) as no harm.

Across the service, 506 self-harm incidents were reported during the period. Of these, 2 (0.40%) were classified as major harm. Both incidents have undergone review through the incident management process, with one progressing to a full incident review.

A further 6 incidents (1.19%) were initially classified as moderate harm. Two of these have been reviewed through the incident review process, with one progressing to a full review. The remaining four incidents are currently under review, and it is anticipated that the level of harm recorded may be revised following completion of the managers review.

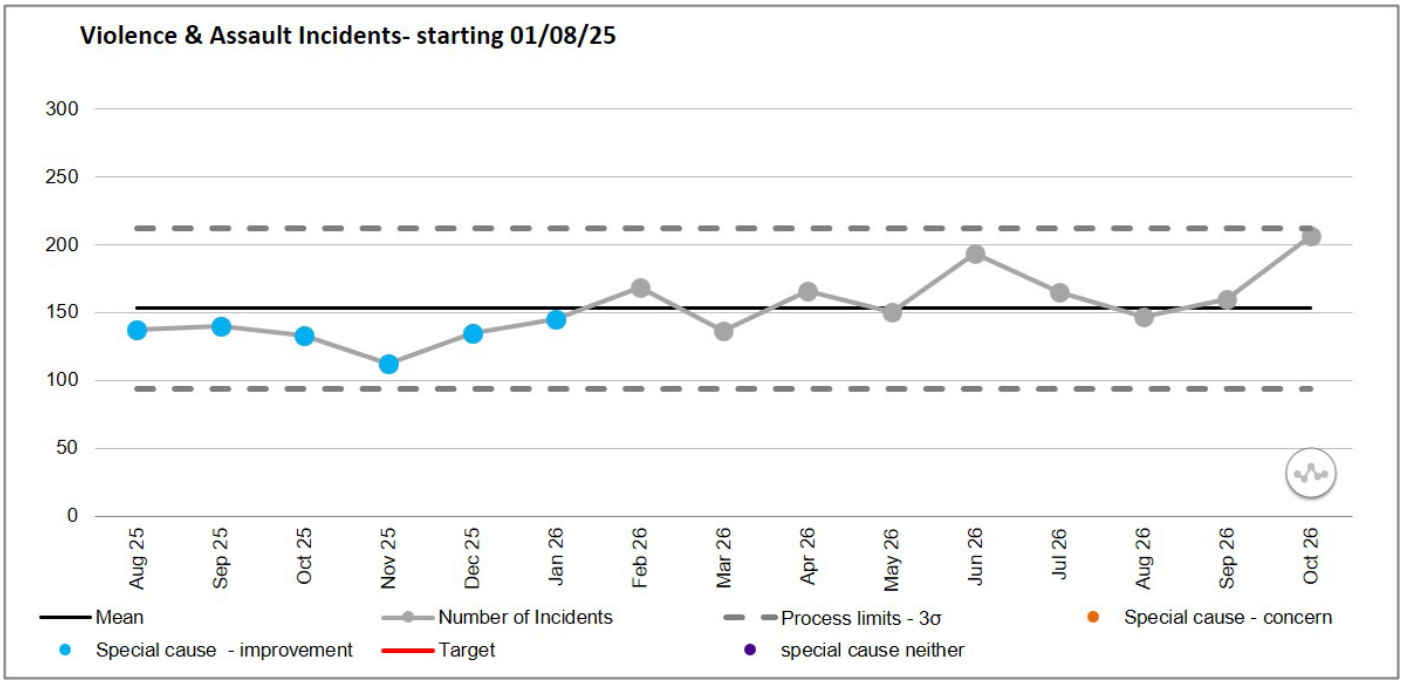
The majority of self-harm incidents resulted in either minor/low harm (265 incidents, 52.37%) or no harm (233 incidents, 46.05%), indicating that serious harm remains uncommon despite the high volume of reported incidents.

3. Violence & Assault

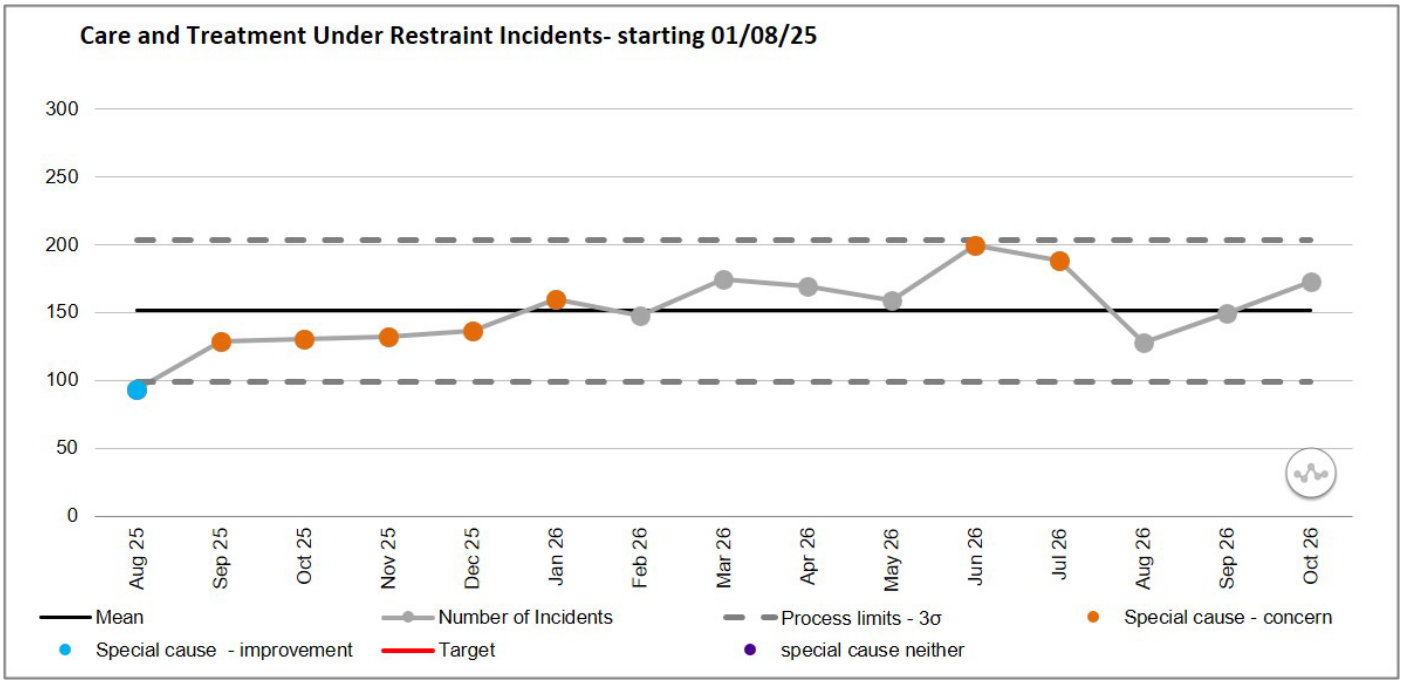
There were 366 incidents of violence and assault reported during September and October 2026. These incidents are reported under the category's patient violence towards other patients, people not employed by the trust and incidents of disruptive behaviour towards others. This represents 9.70% of all reported patient safety incidents. During the previous reporting period, there were 307 violence and assault incidents reported, this shows an increase of 19.22% during the current reporting period.

The number of violence and assault incidents has been analysed and over the reporting period, there are 3 areas with the highest number of incidents reported relative to the total number (366) of violence and assault incidents, Belvoir Ward (male psychiatric intensive care unit – PICU) with 63 (17.21%) incidents, Griffin Ward (female psychiatric intensive care unit – PICU) with 31 (8.47%) incidents, and Mill Lodge with 31 (8.47%) incidents. Of these 366 incidents, 185 (50.55%) were reported as physical disruptive behaviour.

Of the 366 incidents reported as Violence and Assault, 1 (0.27%) was recorded as catastrophic/death, 2 (0.55%) was recorded as moderate harm. These 3 incidents will be reviewed at the trusts Incident Review and Learning Meeting (IRLM) to consider if a further review is required. 113 (30.87%) were recorded as minor/low harm, and 250 (68.31%) were recorded as no harm.



4. Care and Treatment Under Restraint



There were 322 incidents where holds were used to support care delivery during September and October 2026, representing 8.66% of all reported patient safety incidents during this period. During the previous reporting period, there were 315 incidents reported where holds were utilised, therefore this shows an increase of 2.22% during the current reporting period.

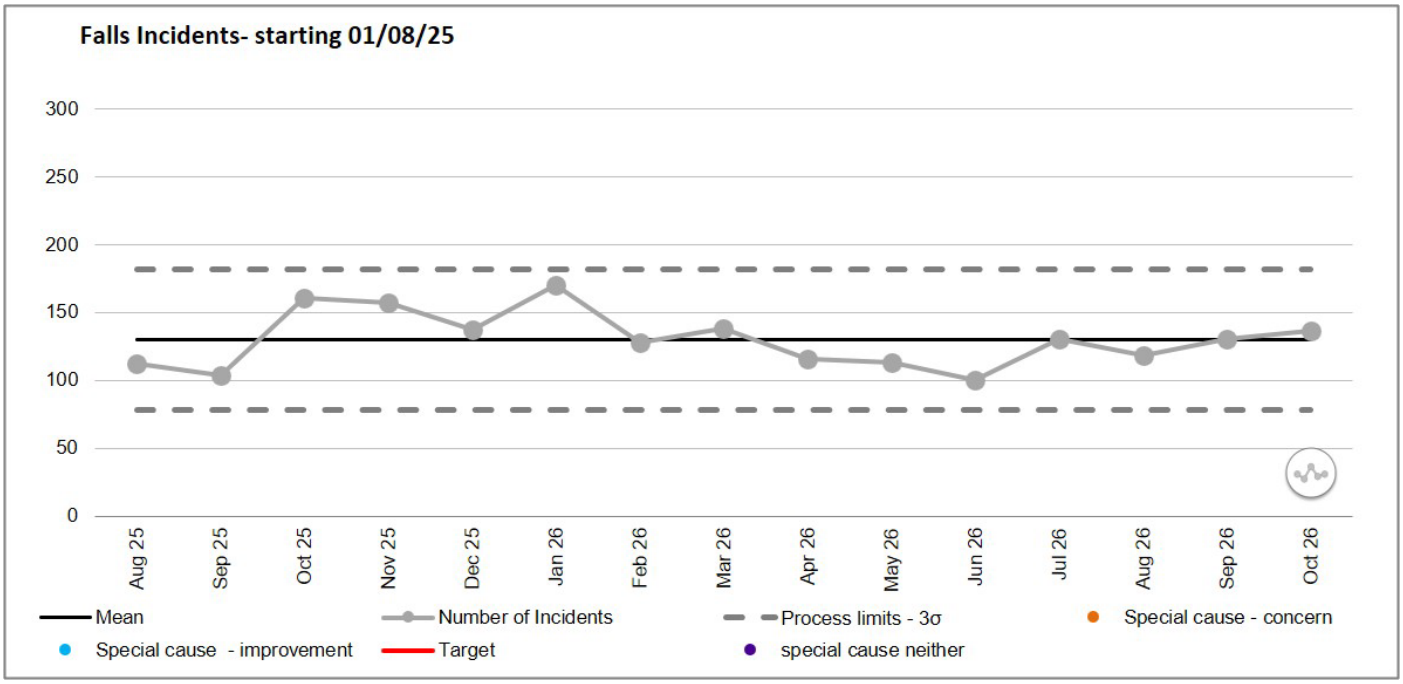
The reporting of incidents using holds currently fall into 2 categories; those related to the use of restraint holds for management of violence, aggression, and acute self-harm and those where holds have been utilised to support care activities such as carrying out feeding regimes or personal care – washing and changing incontinence wear. The Least Restrictive Practice Group has scoped additional training options for 'clinical holding' and the clinical trainers received clinical holding training to train others in October 2026.A training needs analysis commences in November

2026 to understand the staff groups requiring training with some identified teams undertaking clinical holding more regularly being prioritised.

The analysis of incidents where holds have been used to deliver care shows that over the reporting period, there have been 3 areas with a significant number of incidents reported relative to the total number (322) 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 191 (59.32%) incidents, compared to 198 during the last reporting period, due to a patient requiring holding during personal care. The other areas with a significant number of holds were Coleman Ward with 38 (11.80%) incidents, and Gwendolen Ward with 34 (10.56%) incidents.

Overall, of the 322 incidents reported where restraint or holds were utilised, 37 (11.49%) were reported as minor/low harm, and 285 (88.51%) were reported as no harm.

5. Falls



During September and October 2026, 266 falls incidents were reported, accounting for 7.05% of all patient safety incidents and representing a 9.02% increase from the previous reporting period. The highest numbers of falls were reported from Gwendolen Ward (42), Coleman Ward (31), and Kirby Ward (28).

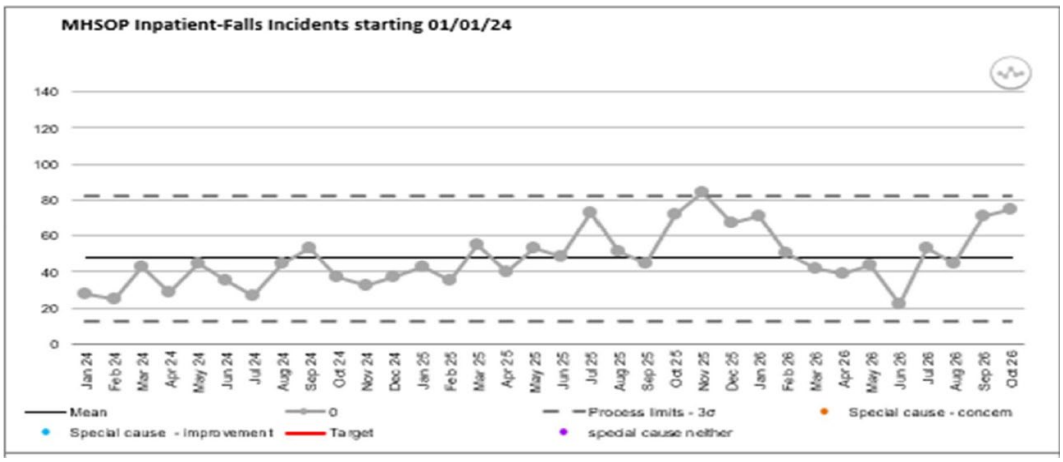
The majority of falls resulted in no harm (59.40%), with 38.35% resulting in minor harm. Six incidents were initially graded as moderate harm; however, one is being regraded following review, one is undergoing a full investigation, and four remain under directorate review. This suggests the final number of moderate harm incidents may reduce following completion of the review process.

Update from Falls Steering Group

DMH

MHSOP

Numbers of falls in MHSOP has shown a steady rise since June



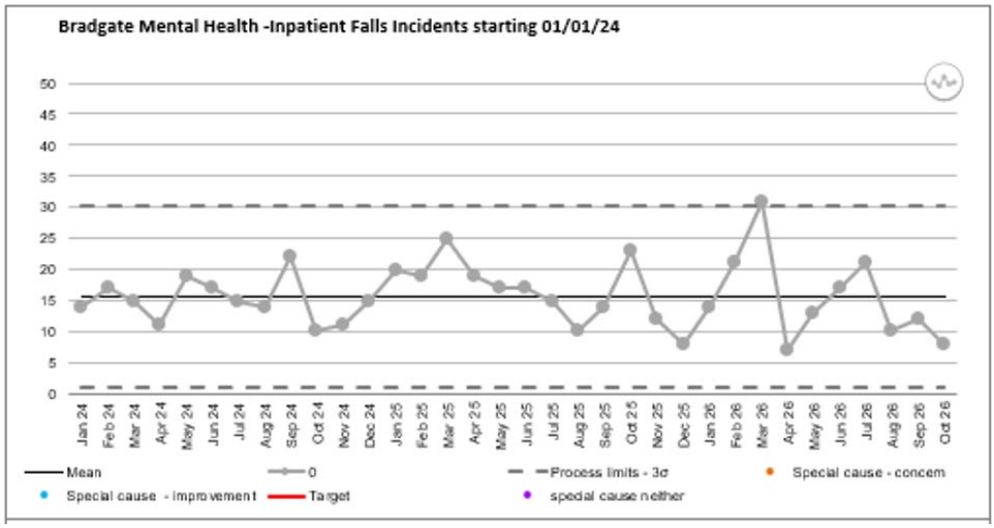
Falls activity was concentrated within Gwendolen Ward, Coleman Ward and Kirby Ward. A proportion of incidents on Gwendolen and Mill Lodge related to patients intentionally placing themselves on the floor, while repeat falls contributed significantly to reported activity across all three wards. Kirby Ward experienced a temporary increase in falls during September, with a notable reduction in October. The two moderate harm falls reported during the period occurred on Gwendolen and Coleman wards and involved a patient assessed as low falls risk who subsequently presented with increased infection markers, and a highly agitated patient respectively. On Mill Lodge, increased incident numbers were largely attributable to two patients with complex mobility needs, one of whom experienced eight falls during October despite mitigation measures being in place.

2026	Gwendolen	Kirby	Coleman	Langley	Mill lodge
May	23	6	4	10	1
Jun	13	3	3	3	0
July	14	13	11	6	9
August	21	1	12	7	4
September	**20**	**19**	**11**	**10**	**11**
October	**22**	**9**	**20**	**12**	**12**

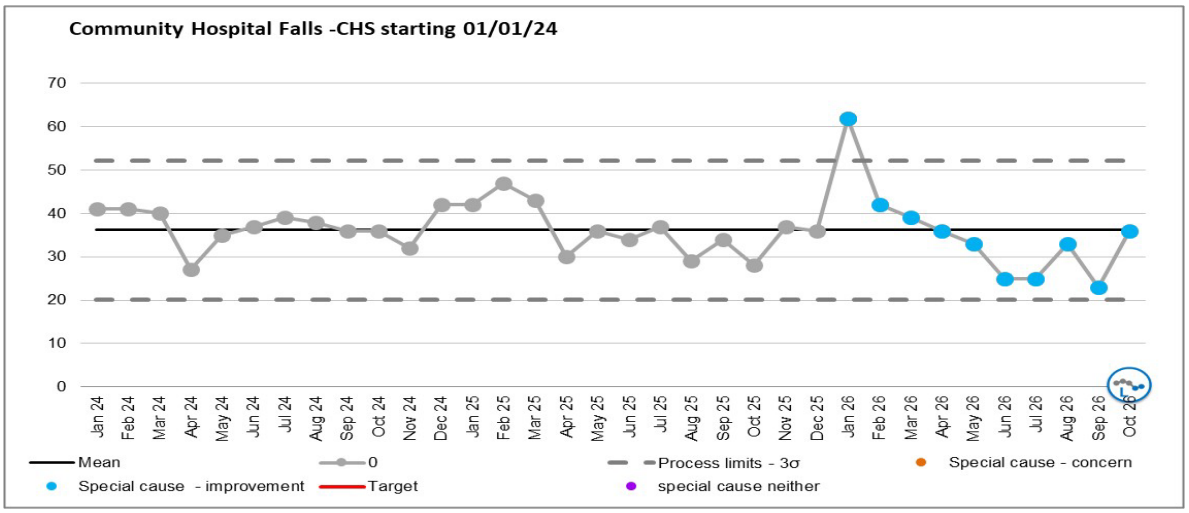
The Falls incidents are reviewed and analysed regularly in the DMH Falls Group and numbers of falls often relate to the patient cohort at the time and their individual presentations. Themes from review of incidents include need for improved MDT working in identification and planning regarding medical causes of fall risks. The team are working with medics on Systmone templates to support falls prevention and reviews.

Bradgate Unit and Rehab Wards

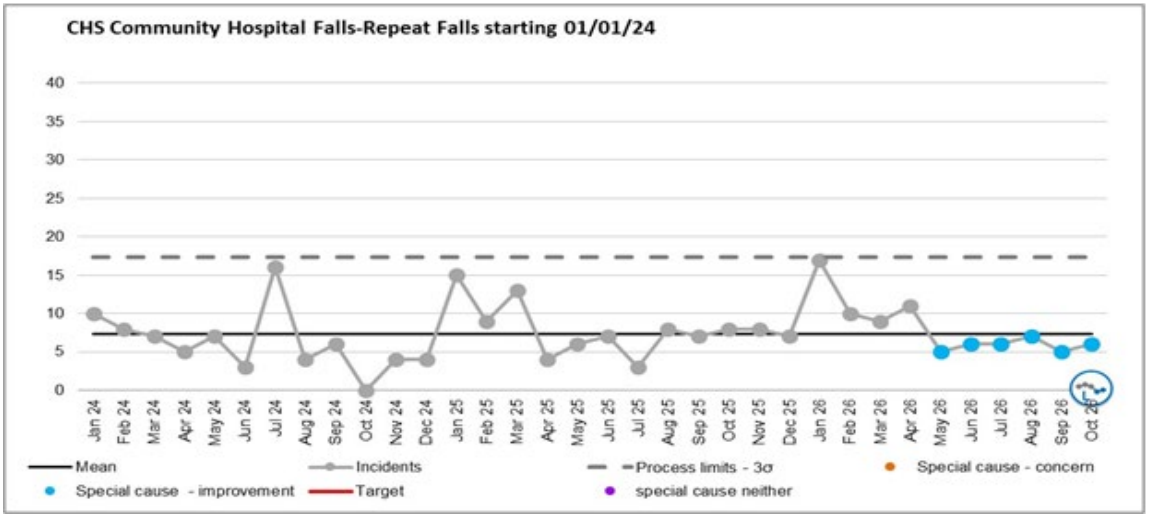
There is nothing to note for the Bradgate or Rehabilitation (Rehab) wards. Incidents are reviewed regularly and there are no themes and issues are addressed individually. There is continued work to improve post falls processes particularly on Rehab wards where there are less incidents and consequently less confidence and competence with process.



CHS



Following a drop in number of falls in September data shows an increase in October, however numbers of repeat falls remain stable.



2026	East	Clarendon	Charnwood	Coalville Wd 1	Swithland	Coalville Wd 2	Beechwood	St Lukes Wd 1	Rutland	Dalgleish	Coalville Wd 4	St Lukes Wd 3	North
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
Sept	**5**	**3**	**5**	**2**	**0**	**0**	**3**	**0**	**2**	**0**	**1**	**1**	**1**
Oct	**2**	**3**	**4**	**4**	**2**	**4**	**8**	**3**	**1**	**1**	**3**	**1**	**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 continues to be high. There is only one falls that does not have a Post falls huddle recorded.

FYPC/LDA

Only one incident reported in September / October where a patient on the Beacon Unit placed themselves on the floor. Falls mainly related to clinical presentations (e.g. epilepsy) and engagement in physical activity. They are working on improving falls risk assessment process to reduce risk as far as possible. Due to low numbers the directorate provide quarterly reviews into the Falls Steering group and are next due to report back in November.

Other updates:

- The Review of Prevention of Falls Trips and Slips policy is underway involving reps from each directorate.

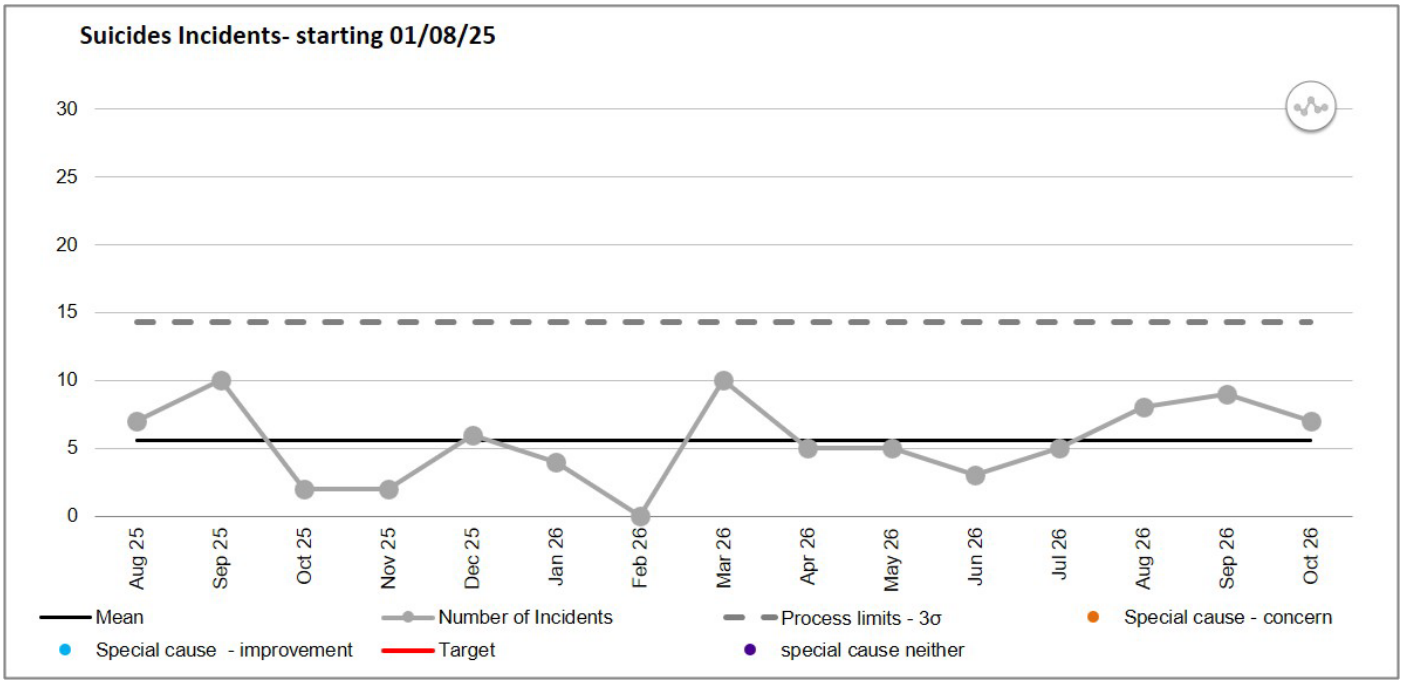
- LPT are now registered for the National Audit for Inpatient Fractures (NAIF)
  This audit will retrospectively review the care any patient over 65 who has sustained a fracture, head injury or spinal injury as a result of a fall on inpatient wards.

- 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

- Work is progressing around management and reporting of patients who place themselves on the floor.

Suicide Prevention

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



Between October and November 2026 there were 8 deaths by suicide among individuals known to LPT. During the same reporting period in 2025 there were 4 deaths by suicide

As of 1st November 2026, there have been 66 deaths by suicide or suspected suicide among individuals known or previously open to LPT, this is 7 more than during the same period in 2025.

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

Of the 66 individuals known to LPT who died by suicide / suspected suicide 49 were male, the majority were white British.

Each death by suicide is reviewed through the weekly Rapid Review Meeting to identify immediate learning, themes, and actions.

Themes, Learning and Actions Identified Through Rapid Reviews

Key themes identified over the past two months (14 deaths) include:

- Alcohol and substance misuse, including the impact of significant drug use on both mental and physical health.
- Social factors, including loneliness and isolation.
- The significance of physical health conditions, including chronic illnesses and newly diagnosed serious health conditions such as stroke and cardiac disease.
- Student wellbeing and mental health, including effective joint working with university support services.
- Challenges in engaging individuals who move between geographical localities.
- 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.

These themes will be reviewed through the Suicide and Self Harm Prevention Group to consider opportunities to mitigate these and where not possible for LPT themes are shared with the Leicester, Leicestershire and Rutland Suicide Prevention group to consider.

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.

Learning from Deaths (LFD)

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.

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

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

- There were 4 notifications made by LPT staff to LeDeR related to patients with a known learning disability or autism and who have died for September (2) 2026 and October (2) 2026.
- For City and Countywide reviews, there were 10 patient death notifications in September 2026 and 10 patient death notifications in October 2026.
- Of the total 20 notifications, 5 are focused, 13 are initial reviews and 2 are out of scope as they do not meet the criteria of having a diagnosed LD and/or Autism.

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	01.03.2024 (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. NHSE are collating information from organisations to asses any implementation challenges
NATPSA/2025/006/NHSPS	The incorrect recording of Penicillin Allergy as Penicillamine	20.11.2026	This alert is being led by LLRICB and involves all system partners - Recommended for closure as all actions identified for LPT have been completed.
NATPSA/2026/006/DHSC	Levemir® (insulin detemir) FlexPen® 100units/ml solution for injection 3ml pre-filled pens and Levemir® (insulin detemir) Penfill® 100units/ml solution for injection 3ml cartridges are being discontinued from end of December 2026.	30.11.2026	Head of Pharmacy/Team have worked through the actions as per the alert with system partners to ensure all actions appropriate to LPT have now been completed. Recommended for closure as all actions identified for LPT have been completed.
NATPSA/2026/005/MHRA	Patient Hoists and Slings (All Types): Risk of Death and Serious Harm from Falls	16.09.2027	Work continues this alert with leads from Health & Safety and Training & Education. A further update due in early January 2027 strengthening training element and evidence of staff completing for assurance.
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 ventilators are supplied by

			University Hospitals of Leicester only. Recommended for closure as actions identified for LPT have been all been completed.

LPT Outstanding patient safety reviews:

As of 21st October 2026

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

Overdue learning response stage	CHS	DMH	FYPC	Corporate
Allocation	0	2	0	0
Information Gathering	0	4	0	0
Awaiting TOR	0	0	0	0
Report Drafting	0	0	0	0
Awaiting specialist review	0	0	0	0
SMART Action Planning	0	0	0	1
Directorate Sign off Stages	1	0	0	2
Right to Reply Staff	0	3	0	1
Submission to CPST	0	0	0	0
Directorate Post Exec Review	0	0	0	0
Right to reply family	1	2	0	6
Ops Director	0	0	0	0
Exec Review	1	0	0	0
Total Learning Responses Overdue	**2**	**9**	**0**	**4**

Current Position

As of 21st October 2026, there were 62 open investigations. 23 DMH, 20 Corporate, 14 CHS and 5 FYPC/LDA.

- Of these 15 are overdue and of these 4 are in right to reply with patient or family.
- 9 DMH (39.13 %) are overdue, 1 is the legacy STEIS (for incident December 2022) delayed by police and court process (commenced October 2023, fluctuating consent to allow family to be involved and the patient wanting to participate in the investigation, and liaison with the secure services clinical team. This is being signed off in directorate and is due for onward review at Exec Director level.
- 4 Corporate (20 %) are overdue all are within the various phases of sign off.
- 2 CHS (14.29 %) are overdue.
- 0 FYPC/LDA are overdue.

There is one corporate investigation that is on hold on the instruction of HM Coroner.

Duty of Candour

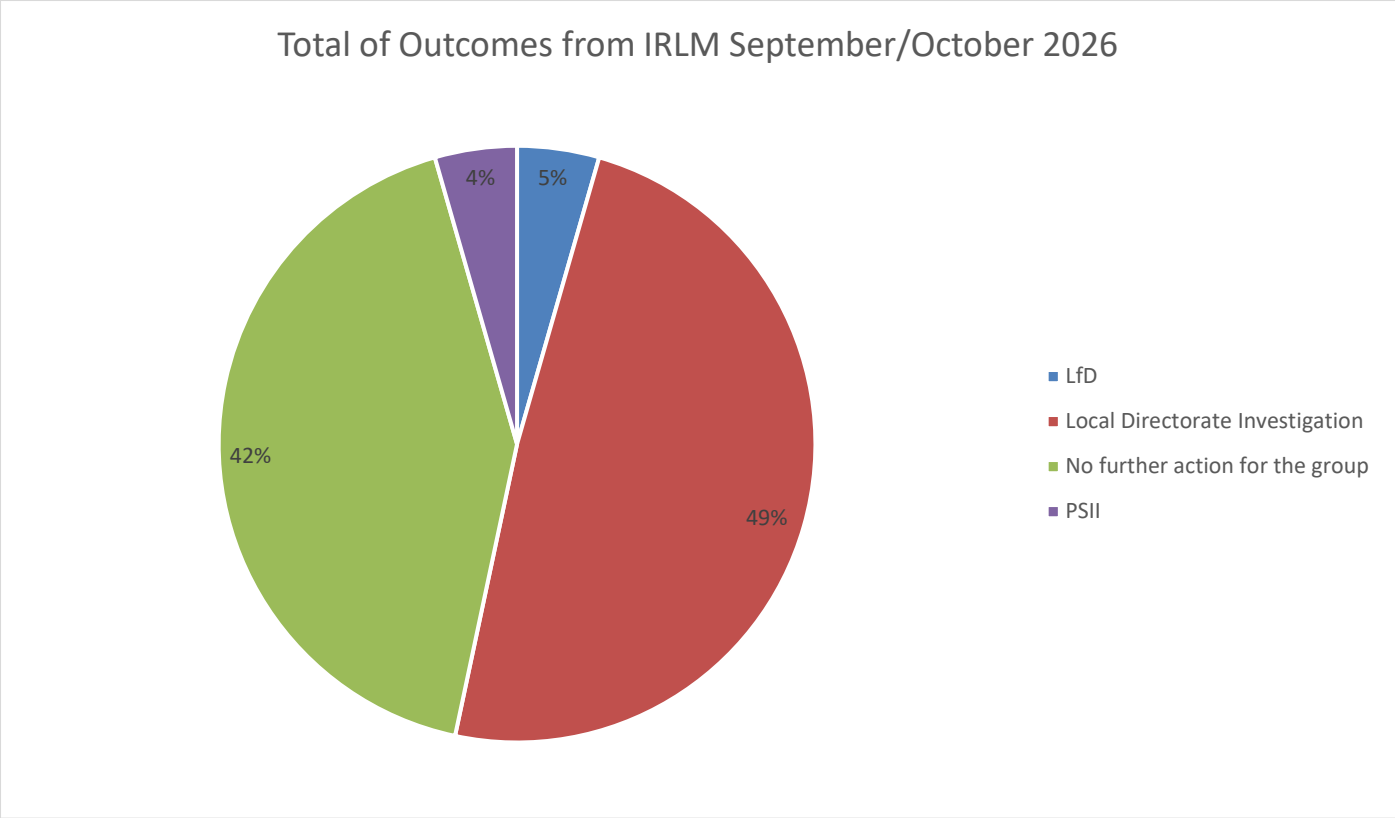
There was no statutory duty of candour breaches during this period. We continue to follow 'being open' which is inbuilt in-Patient Safety Incident Response Framework (PSIRF) principles of compassionate and positive engagement with patients/families.

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)

45 cases were reviewed at IRLM during September and October 2026. 2 (4%) Patient Safety Incident Investigation (PSII) was declared during this reporting period 19 (42%) were identified as having already identified any learning and actions put in place. There were 22 (49%) Local Directorate reviews requested to explore appropriate actions, 2 (5%) 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 August 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 November 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	27
CHS	13
FYPC/LDA	22
Enabling	3
TOTAL	**65**

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
Sept -Oct 2026	168	7	175
Total	8350	231	8581

Decision Required

Briefing – no decision required.

Governance Table

For Board and Board Committees:	Trust Board
Paper sponsored by:	Linda Chibuzor, Group Chief Nurse/ Executive Director of Nursing, Allied Health Professionals (AHPs) and Quality
Paper authored by:	Tracy Ward, Head of Patient Safety. Patient Safety Specialist
Date submitted:	16/11/2026
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:	January 2027
THRIVE strategic alignment:	☐ **T**echnology ☐ **H**ealthy communities ☒ **R**esponsive ☐ **I**ncluding everyone ☐ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	**BAF 5** – if we do not continue to review and improve our systems and processes for patient safety, we may not be able to provide the best experience and clinical outcomes for patients and their families
Is the decision required consistent with LPT's risk appetite:	
False or Misleading Information (FOMI) considerations:	
Positive confirmation that the content does not risk the safety of patients or the public:	
Equality considerations:	

Level 1, 2 and 3 Alert, Advise and Assure (AAA) Highlight Report
LPT Committee / Group : Finance and Performance Committee
Date of Meeting: 20 August 2026
Meeting chair and Report Author: Melanie Hall / Val Glenton

Leicestershire Partnership NHS Trust

M1

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

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

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

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Finance Report Month 4 2026/26	LPT/26/089	LPT Chief Finance Officer / Director of Mental Health Service	FPC was assured by the overall financial performance being on plan (see below) but noted a number of areas which presented a risk to year end performance: • The DMH overspend now stood at £1.4m which was an increase of £300k from the previous month, driven largely by the additional cost of private beds to support capacity, The overspend for CHS had increased by £67k to £661k, one of the contributing factors was a significant under delivery of CIPs which would be subject to a deep dive at the next FPC. • Capital expenditure stood at £2.6m against a forecast outturn of £20m which was £3.9m below planned spend at month 4 of £6.5m. The underspend was partly due to delays in commencing Public Dividend Capital schemes, mainly the £3m worth of Constitutional Standards/Left Shift schemes. The CS/LS schemes had been approved but governance requirements needed to be met before funding could be drawn	BAF10 BAF11		

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
			down and start dates set. Estates and operational teams were reaching the end of their capacity to manage and deliver the volume of schemes that were still coming through and a revised capital forecast was being developed to provide a more meaningful comparison against actual expenditure.			

ASSURE: Inform the Board where positive assurance has been received

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Board Assurance Framework	FPC/26/085	Deputy Director of Governance and Risk	Five BAF risks were mapped to FPC relating to cyber security and digital disruption, therapeutic environment, capital funding, 2026/27 financial position and NHS reforms. FPC received assurance that robust systems were in place to secure an effective risk framework and acknowledged the need for broader measurement of the risk mechanism which the Audit and Risk Committee would take forward. FPC also received assurance from a deep dive into the new BAF risk 12 *(tighter restrictions due to NHS reforms and Performance Oversight Framework)* which may impact on the pace of service transformation across communities. The NHS 10 Year Plan had identified a need to radically reform the NHS's financial architecture, operating model and its care philosophy. Three key controls were being applied to manage the impact of the risk; engagement and collaboration with regulators, policy makers and system partners; development of infrastructure to monitor internal performance and drive planning; and the identification of opportunities for accelerating transformation within the current landscape.	BAF01 BAF09 BAF10 BAF11 BAF12		
Annual Effectiveness Review	FPC/26/087	Deputy Director of Governance and Risk	The committee noted it had been effective during 2025/26 as it had fulfilled its terms of reference (ToR). FPC agreed its ToR for 2026/27 subject to clarification on minor issues raised mainly relating to committee membership and quoracy. The updated ToR for 2026/27 are appended to this report for the Board's approval.	N/A		

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Finance Report Month 4 2026/26	LPT/26/089	LPT Chief Finance Officer / Director of Mental Health Services	• The planned year to date I&E deficit of £1.8m had been delivered at month 4 and the rate of overspend had slowed. • Better Payment Practice Code, agency spend and cash were all performing well and there were no specific concerns about the year end position. • Information on productivity measures was included for the first time and would be reported on regularly going forward. At the end of March 2026, LPT had achieved a 5.1% implied productivity metric which was above the 2% year on year productivity improvement that NHSE had set all Trusts to achieve. • A deep dive into DMH CIP delivery was undertaken, 50 schemes were in place for 2026/27 and all were delivering with the exception of 1 which was the reduction in private bed use. DMH had seen an unprecedented demand for beds in the first quarter of 2026/27 which was driving the position for private beds. • In addition to the finance report, the Committee received a verbal update on the Group Value Programe. A Triple A report from the Transition Group would be brought to the October meeting	BAF10 BAF11		
PLiCS Post Submission 2025/26 Update	FPC/26/090	LPT Chief Finance Officer	The nationally mandated Patient Level information Costing System (PLiCS) submission for 2025/26 had been completed in line with national guidelines. It was not currently clear when the national outputs would be issued. The finance team was implementing a new costing system which would make extracting data from patient level costing detail easier and more meaningful.	BAF11		
LPT & NHFT Collaborative, Commissioning & Contracting Group	FPC/26/094	Group Director of Strategy and Partnerships & Partnerships Manager	The Committee was assured and noted the mitigations in place for two advise items to note from the triple A report; • An increase in bed availability from one provider within the collaborative in the Adult Eating Disorder Inpatient Service was creating a financial pressure which was being reviewed. • The NHS England quarterly review of LDA and SEND. Rates of CYP autism admissions regionally were over target and the reasons for this were being investigated.	BAF11		

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Joseph Rowntree Foundation Anchor Progression Framework Evaluation	FPC/26/095	Group Director of Strategy and Partnerships	An indicative anchor progression assessment had been undertaken and LPT was assessed as a mature level 3 Inclusive Anchor Institution. FPC endorsed the interim JRF maturity scoring and the proposed ongoing evaluation, methodology, annual monitoring and action planning approach.	N/A		
Transformation & Quality Improvement Delivery Group Triple A	FPC/26/098	Managing Director / Deputy CEO	FPC received assurance and noted the mitigating investigation and actions being taken to address estates capacity in the MH transformation programme which had been raised as an alert.	BAF09		
Group Digital Plan 2025-2030	FPC/26/099	Director Digital Services	FPC received assurance on the depth of the draft plan and proposed progress reporting methodology. The committee acknowledged the need for staff to receive adequate training on IT systems to give them confidence to use them as well as on ensuring patients were not excluded by not being able to access services in a digital way. The final version of the plan would be presented to the Group Digital, Data and Technology Committee for approval and to Group Strategic Executive Board.	BAF01		
Green Plan Resourcing	FPC/26/100	Partnerships Manager	FPC received assurance on the range of broader financial benefits available through sustainability projects and that there were currently no identified funding gaps impacting the delivery of the Trust Green plan 2025–2028.	BAF09 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)
Transformation & Quality Improvement Delivery Group	FPC/26/098	Managing Director / Deputy CEO	The pilot of the Beacon Day Service was supporting a blended approach model between inpatient and day services with particular benefit noted for children with eating disorders.	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			

Level 1, 2 and 3 Alert, Advise and Assure (AAA) Highlight Report
LPT Committee / Group : Finance and Performance Committee
Date of Meeting: 29 October 2026
Meeting chair and Report Author: Melanie Hall / Val Glenton

Leicestershire Partnership NHS Trust

M2

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

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

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

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
Finance Report Month 6 2026/26	LPT/26/115	LPT Chief Finance Officer	FPC was assured by the overall financial performance being on plan (see below) but noted areas which presented a risk to year end performance: • DMH was c£1.8m overspent and CHS £775k at M6 but robust controls were in place and improvement was being seen. • Year to date under delivery of CIP at £987k was being offset by the over delivery of corporate schemes. • Capital expenditure stood at £4.2m against a forecast outturn of £19.8m which was £4.9m below planned spend of £9.1m at month 6. A request had been made to NHS England to defer £2.5m for constitutional standards and left shift schemes but it had been rejected and agreement on a revised approach was still awaited.	BAF10 BAF11		
Group Value Programme	FPC/26/116	NHFT Chief Finance Officer	LPT analysis showed a cost increase versus peers of c£10m which largely reflected changes in scope and accountment treatment. LPT's key areas of focus going forwards would be on digital, corporate nursing and the HR opportunity. The existence of different HR processes across	BAF11	N/A	N/A

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
			LPT and NHFT had been identified as a barrier which would continue to slow delivery unless addressed. FPC agreed to ask the Joint People and Culture Committee to monitor this issue.			
Progress of the SNOMED CT Project	FPC/26/122	Joint Director of Health Intelligence, Planning and Performance	FPC received an update on the key challenges the project faced but noted LPT was not dissimilar to other Trusts within the East Midlands Alliance. Progress remained slow but actions had been agreed by the Executive Management Board on next steps.	N/A	N/A	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)
Board Assurance Framework	FPC/26/112	Deputy Director of Governance and Risk	FPC received assurance that robust systems were in place to secure an effective risk framework. Six BAF risks were mapped to FPC relating to cyber security and digital disruption, partnerships and collaboratives, therapeutic environment, capital funding, 2026/27 financial position and NHS reforms. In-depth discussion took place on the process of updating and completing risk actions and on the development of the Corporate Risk Register. Discussion also took place around how risks identified in plans such as the digital and green plans were reviewed for corporate or strategic escalation.	BAF01 BAF02 BAF09 BAF10 BAF11 BAF12	N/A	N/A
Finance Report Month 6 2026/26	LPT/26/115	LPT Chief Finance Officer	• A planned year to date I&E deficit of £2.1m had been delivered. The operational overspend within that was £1.9m which was a favourable movement of £52k from the previous month. • Best, likely and worst-case directorate scenarios had improved with some Trust-wide mitigations now more certain. The best case remained break-even but a £2.5m residual risk remained in the likely case. FPC noted scenarios could not capture unforeseen pressures such as consultant industrial action. • FPC received strong assurance on CHS and FYPCLDA year end achievement of CIP through a deep dive. The committee recognised	BAF10 BAF11	N/A	N/A

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
			estate moves and commissioning decisions were detrimentally impacting some wider transformational programmes.			
LPT & NHFT Collaborative, Commissioning & Contracting Group	FPC/26/118	NHFT Chief Finance Officer	The Committee noted the mitigations in place for two advise items. The first related to the transition of GP IT and the second related to the LLR Mental Health Collaborative and the increasing financial impact of Right to Choose activity.	BAF11	N/A	N/A
East Midlands AED Collaborative Q1 2026/27 Report	FPC/26/119	NHFT Chief Finance Officer	FPC noted a spike in bed use in the first quarter in each of the preceding two years but it was unclear whether this represented a recurring pattern or coincidence. A review of expenditure of an Inpatient Prevention Programme was taking place to establish how effective it was. LPT held the lead provider financial risk but there was currently no reason to escalate financial concerns as mitigations were in place for funding risks.	BAF11	N/A	N/A
Accountability Framework Meeting	FPC/26/120	Managing Director / Deputy CEO	An advise item was reported around fire risk associated with the roof space at the Bradgate Unit. An assessment had been carried out and the issue was being monitored through EMB and the Health and Safety Committee, and tracked through the Quality and Safety Committee for assurance.	BAF09	N/A	N/A
Integrated Board Performance Report Month 6 2026/27	FPC/26/121	Managing Director / Deputy CEO	FPC received assurance on the progress being made to reduce 52+ week waits in some services but acknowledged there were ongoing waiting list challenges in other services. FPC welcomed development of the IBPR with actions tracked and trajectories now in place.	BAF04	N/A	N/A
Group Digital Plan 2025-2030 – Deep Dive Into Outcome11 & 12	FPC/26/124	Joint Deputy Digital Director	A deep dive took place into outcome 11 (*safely and securely adopt AI*) and outcome 12 (*use data to drive decision making*). FPC was assured on the management of programmes and recognition of risk. Discussion focused on the wider debate on AI and risk / impact across organisational processes and reputation. Discussion at Group Board was recommended.	BAF01	N/A	N/A
Estates and Facilities Business Summary Report	FPC/26/126	NHFT Chief Finance Officer	A summary of Estates and Facilities Performance for September 2026 was presented. Overall Estate compliance with statutory standards was above 84% which was an improvement from the previous report. The	BAF09	N/A	N/A

Agenda Item:	Reference:	Lead:	Description:	BAF (L1)	CRR (L1 & L2)	Directorate Risks (L3)
			target for open reactive jobs had been achieved and was reported at just below 8%. In terms of capital projects, progress was now being made on the urgent fire precaution works at the Bradgate Unit. The total duration of roof space works was expected to take up to two years to complete but would be accelerated if possible.			
Green Plan Delivery Dashboard Report	FPC/26/128	NHFT Chief Finance Officer	FPC commended first sight of the completed dashboard and received assurance on progress of actions. A deeper dive into carbon footprint tracking would be undertaken at the February 2027 committee meeting.	BAF09 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)
Accountability Framework Meeting Summary	FPC/26/120	Managing Director / Deputy CEO	The commencement of a pilot of the first Management and Supervision Tool dashboard in Charnwood Neighbourhood Mental Health Team was reported as celebrating outstanding. This was a significant achievement that would provide huge benefits to the service.	N/A	N/A	N/A
Transformation & Quality Improvement Delivery Group Triple A Report	FPC/26/123	Managing Director / Deputy CEO	FPC noted the fantastic work being done across the whole Trust to make improvements, specifically; • The insulin pen recycling scheme, approximately 25% of the insulin pens supplied by LPT had been recycled through the scheme. • The podiatry heel pain project which enabled patients to manage their heel pain, thereby reducing waiting lists. • The launch of work between the Midlands Dementia Programme and Memory Service for people with mild cognitive impairment. • The reduction of readmission rates to the Community Enhanced Rehabilitation Team.	N/A	N/A	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			

N

Trust Finance Report for the period ended **31 October 2026**

For presentation at the **TRUST BOARD meeting** **24th November 2026**

Contents

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3. Executive dashboard – overall performance against targets

4. Summary report of financial position

Appendices

A. Statement of Comprehensive Income

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C. Agency staff expenditure charts

D. Better Payment Practice Code performance

E. Capital programme update

F. Statement of Finance Position, cash and working capital

G. Risk adjusted best, likely and worst case I&E forecast (including NHSE scenarios return)

H. Expenditure run-rate analysis

I. Productivity growth

Executive dashboard - overall performance against targets

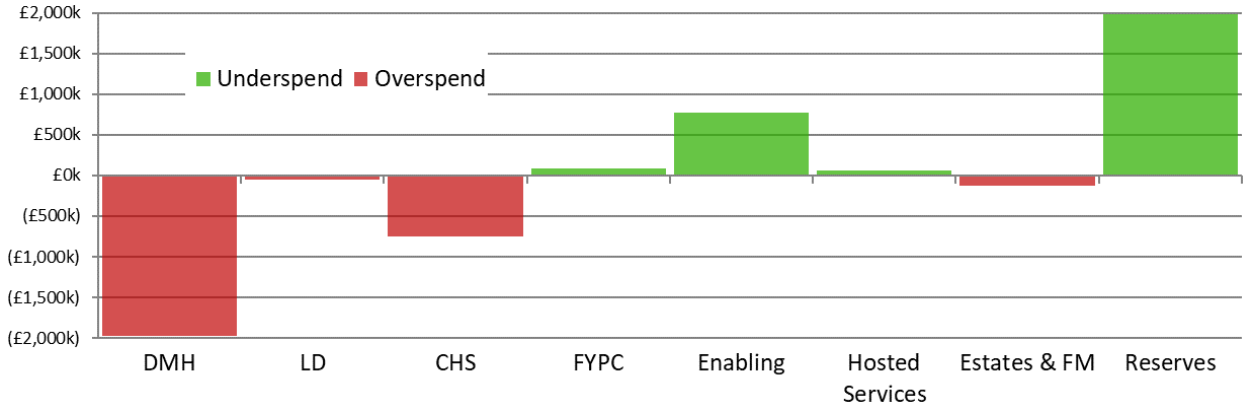
Statutory targets	Year to date	Year end f'cast	Comments	Further detail
1. Income and Expenditure break-even.	A	G	The Trust is reporting a YTD deficit of £1.97m at the end of October (in line with plan). The forecast year end position is currently a breakeven, also in line with plan.	APP. A
2. Remain within Capital Resource Limit (CRL).	G	G	The YTD capital spend for October is £4,920k, 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 October 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 7 (October) are £13.9m, 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	A	G	YTD agency spend at the end of October is £2,955k. This is lower (£123k) than planned YTD spend, and remains well 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 and in month achieved 2 of the 4 targets.	APP. D
Internal targets	**Year to date**	**Year end f'cast**	**Comments**	**Further detail**
8. Achieve retained cash balances in line with plan	G	G	The cash balance is £27.1m at the end of October. This is £11.4m 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. October's cash level of £27.1m was 23 days.	APP. F
10. Deliver capital investment in line with plan	A	G	YTD capital expenditure is £4,920k. This is below planned spend for the month. See 'Capital Section' in summary report.	APP. E

Summary report – financial position as at 31 October 2026

YEAR TO DATE POSITION

- The overall year-to-date income and expenditure plan - being a planned YTD deficit of £1,967k - has been achieved at the end of October (month 7).
- Within the wider position, the collective year-to-date operational (directorate) budget position shows an overspend of £1,979k.
- Central reserves are underspent by £1,979k, offsetting the operational overspends and delivering the overall plan 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** reports a £1,971k overspend at the end of month 7. Medical services, inpatient wards and private beds are the main pressures. The cost improvement programme forecasts a £652k shortfall linked to private bed usage. Recovery measures focus on reducing locum and bank costs and increasing income. Agency spending is forecast at £3.4m, around £1.7m below last year, and shifts fell by 40 in September.
- **The Community Health Service** reports a M7 overspend of £751k which is a £24k favourable movement during the month. The expenditure run rate fell further due to St Lukes ward 1 being temporarily closed and with staff being redeployed. Staff redeployment supported the further reduction in bank/agency use and delivery of the September & October CIP. VPN unit costs reduced which released a benefit of £26k. Safer staffing funds for North, Coalville ward 1 and Rutland wards were profiled into the position from October, further improving the position. The wider directorate overspend

includes the impact of the c£1.8m negative budget cause by prior-year CIPs being delivered non-recurrently.

- **The FYPC** budgets report a year to date underspend of £90k at the end of month 7. Pay budgets are slightly overspent due to the effect of negative budgets; agency spend was zero and bank costs reduced. Non-pay budgets are overspending (including medical equipment, room hire and healthcare services budgets). Income budgets are over-recovered due to Welford ward and small non-ICB contracts.

- **The LDA** budgets show a year to date overspend of £49k - which represented a favourable movement in the month from the £72k reported at the end of month 6. The Agnes Unit financial position continued to improve due to low patient numbers and investment slippage. The main pressure was linked to this years CIP and the creation of negative budgets where the savings are cash only savings. The forecast out-turn position still identifies an overspend but this has reduced compared to last month's forecast.

- **Enabling budgets** reported an underspend of £776k at Month 7 – an increase of £139k compared to Month 6. This favourable movement was supported by vacancy slippage, savings from Group roles and income generated through Education and Training.

- **Estates budgets** reported an overspend of £131k at Month 7. The position deteriorated by £29k compared to Month 6. The overspend is mainly driven by increased building and engineering costs.

- **The Central Reserves position** is underspent by £1,979k. The phasing of reserves budgets is structured to offset a level of directorate overspend in the first half of the year, but this support tapers off across the year.

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). Note that this forecast is still based on a best case scenario that factors in recovery actions requiring further development. A best/likely/worst case risk adjusted forecast outturn is included in **appendix G**.

- At month 7 the net directorate / operational overspend continues to be offset by reserves underspends. However, the reserves underspends are now tapering off with the expectation that improving directorate positions can deliver financial balance by the end of the financial year. As mentioned above, this expectation is delivered in our best case scenario and so further work is required to firm up all financial mitigations and see these move from 'best' to 'likely' case.

Finance Report for the period ended
31 October 2026

APPENDICES

APPENDIX A - Statement of Comprehensive Income (SoCI)

`Statement of Comprehensive Income for the period ended 31 October 2026	YTD Actual M7 £000	YTD Budget M7 £000	YTD Var. M7 £000
Revenue			
Total income	264,881	256,361	8,520
Operating expenses	(263,941)	(255,422)	(8,520)
Operating surplus (deficit)	**939**	**939**	**0**
Investment revenue	350	350	0
Other gains and (losses)	0	0	0
Finance costs	(1,155)	(1,155)	0
Surplus/(deficit) for the period	**134**	**134**	**0**
Public dividend capital dividends payable	(1,645)	(1,645)	0
I&E surplus/(deficit) for the period (before tech. adjs)	**(1,511)**	**(1,511)**	**0**
NHS Control Total performance adjustments			
IFRIC 12 adjustment (PFI interest adj - excl. from Con.Total)	(280)	(280)	0
Donated/government grant asset reserve adj	(176)	(176)	0
Technical adjustment for impairments	0	0	0
NHS I&E control total performance	**(1,967)**	**(1,967)**	**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:	**(1,511)**	**(1,511)**	**0**
Trust EBITDA £000	**7,838**	**7,838**	**0**
Trust EBITDA margin %	**3.0%**	**3.1%**	**-0.1%**

APPENDIX B – Efficiency savings performance

At the end of month 7, CIP performance is reported in line with the year-to-date plan which is delivery of £13.9m total savings. There is a net YTD shortfall of £1.1m within directorate schemes which is being offset by additional non-recurrent gains within corporate schemes.

Overall, forecast savings for the year deliver the total planned £27.6m savings target. The forecast year end gap in directorate schemes increases to £1.2m, with the additional corporate savings expected to continue to cover this.

CIP year-to-date performance and forecast by directorate

	M7 YTD PERFORMANCE (£000)					FORECAST (£000)				
Directorate	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	**3,233**	2,249	712	**2,961**	**(272)**	**6,795**	4,712	1,443	**6,156**	**(639)**
CHS	**3,329**	2,099	756	**2,856**	**(474)**	**5,434**	3,913	875	**4,788**	**(645)**
FYPCLDA	**2,674**	2,451	224	**2,675**	**1**	**4,980**	4,591	390	**4,980**	**0**
Enabling	**968**	738	228	**966**	**(2)**	**1,630**	1,265	383	**1,648**	**18**
Hosted (HIS)	**417**	446	11	**458**	**41**	**489**	530	20	**549**	**60**
Estates	**1,502**	710	382	**1,092**	**(410)**	**2,574**	1,520	1,054	**2,574**	**(0)**
Corporate Schemes	**1,765**	0	2,882	**2,882**	**1,116**	**5,726**	0	6,933	**6,933**	**1,207**
Unallocated Trust plans-in-progress	**0**	0	0	**0**	**0**	**0**	0	0	**0**	**0**
Total	**13,888**	**8,693**	**5,195**	**13,888**	**0**	**27,628**	**16,531**	**11,098**	**27,628**	**0**

Leicestershire Partnership NHS
NHS Trust

APPENDIX C – Agency expenditure

Dir.	2026/27 Agency Expenditure	25/26 Outturn £000s Actual	25/26 Avg mth £000s Actual	26/27 M1 £000s Actual	26/27 M2 £000s Actual	26/27 M3 £000s Actual	26/27 M4 £000s Actual	26/27 M5 £000s Actual	26/27 M6 £000s Actual	26/27 M7 £000s Actual	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	-255	-288	-263	-166	-234	-194	-187	-1,805	-2,849
	Nursing - Qualified	-1,419	-118	-65	-48	-74	-58	-43	-35	-32	-32	-35	-35	-32	-32	-354	-520
	Nursing - Unqualified	-79		0	0	-1	1	0	0	0	0	0	0	0	0	-1	-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**	**-290**	**-320**	**-295**	**-201**	**-269**	**-226**	**-219**	**-2,160**	**-3,370**
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	-45	-46	-50	-80	-70	-60	-50	-479	-789
	Nursing - Unqualified	-179		-16	-11	-5	-2	-2	0	-1	-2	-2	-2	-2	-2	-38	-48
	Other clinical staff costs	-112	-9	-5	-7	-7	-6	-5	-6	-5	-7	-7	-7	-7	-7	-41	-74
	Sub-total - CHS	-3,127	-246	**-125**	**-113**	**-98**	**-64**	**-57**	**-51**	**-52**	**-59**	**-89**	**-79**	**-69**	**-59**	**-559**	**-911**
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	-3	1	-1	-1	-1	0	0	-73	-76
	Nursing - Unqualified	-29		-3	-1	-2	-8	-2	0	0	-1	-1	-1	0	0	-16	-19
	Other clinical staff costs	-4	0	0	0	0	-3	0	-4	-4	0	0	0	0	0	-11	-11
	Sub-total - FYPC	-773	-62	**-32**	**-21**	**-49**	**-73**	**10**	**-6**	**-3**	**-2**	**-2**	**-2**	**0**	**0**	**-175**	**-181**
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	18	0	0	0	0	0	0	18	18
	Non clinical staff costs	-224	-19	-2	2	0	0	0	0	0	0	0	0	0	0	0	0
	Sub-total - Enab/Host	-172	-16	**-2**	**2**	**0**	**0**	**0**	**18**	**0**	**0**	**0**	**0**	**0**	**0**	**18**	**18**
TOTAL TRUST	Consultant Costs	-3,927	-327	-276	-279	-247	-334	-202	-255	-288	-263	-166	-234	-194	-187	-1,880	-2,924
	Nursing - Qualified	-4,803	-400	-242	-139	-219	-147	-84	-83	-77	-83	-116	-106	-92	-82	-991	-1,470
	Nursing - Unqualified	-300	-25	-26	-6	-2	-10	-4	0	-1	-3	-3	-3	-2	-2	-51	-65
	Other clinical staff costs	-130	-11	-5	-7	-7	-9	-5	9	-8	-7	-7	-7	-7	-7	-34	-66
	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**	**-329**	**-375**	**-356**	**-292**	**-350**	**-295**	**-278**	**-2,955**	**-4,525**
	Total plan:			**-476**	**-465**	**-452**	**-440**	**-427**	**-415**	**-403**	**-390**	**-377**	**-366**	**-351**	**-339**	**-3,078**	**-4,901**
	Variance to plan:			**-76**	**36**	**-23**	**-60**	**131**	**86**	**28**	**34**	**85**	**16**	**56**	**61**	**123**	**376**
	Var' to annual cap of £6,749k (monthly in12ths):			**11**	**133**	**87**	**62**	**267**	**234**	**188**	**207**	**271**	**213**	**268**	**285**	**982**	**2,224**

Agency spend for October (month 7) is £0.38m. This is lower than the planned spend of £0.40m. 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 better than plan by £0.38m.

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 M7 YTD spend also well within the cap if applied on an equal 12th's basis.

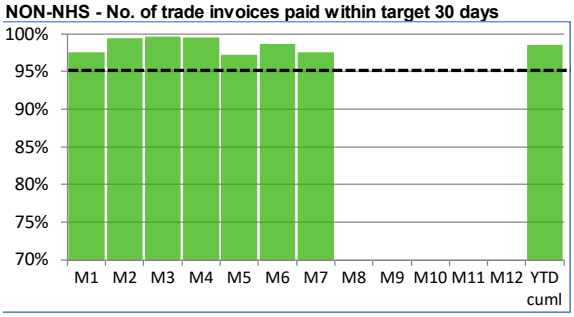
APPENDIX D – BPPC performance

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. Only 2 of the 4 targets were achieved in month. The reasons for the two non-compliant monthly targets (number of NHS invoices and value of Non-NHS invoices) are currently under review.

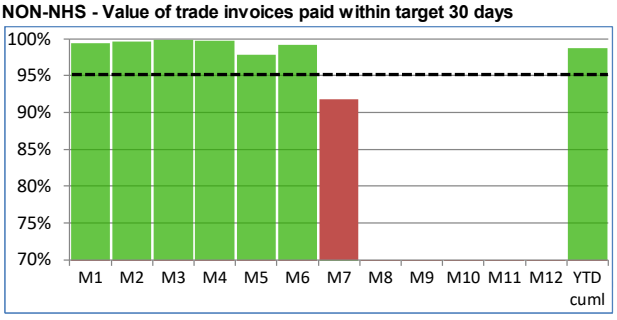
Better Payment Practice Code	October (Cumulative)		September (Cumulative)	
	Number	£000's	Number	£000's
Total Non-NHS trade invoices paid in the year	18,919	75,614	16,408	71,166
Total Non-NHS trade invoices paid within target	18,643	74,691	16,193	70,606
% of Non-NHS trade invoices paid within target	**98.54%**	**98.78%**	**98.69%**	**99.21%**
Total NHS trade invoices paid in the year	502	44,503	404	37,270
Total NHS trade invoices paid within target	481	44,101	390	36,965
% of NHS trade invoices paid within target	**95.82%**	**99.10%**	**96.53%**	**99.18%**
Grand total trade invoices paid in the year	19,421	120,117	16,812	108,436
Grand total trade invoices paid within target	19,124	118,792	16,583	107,571
% of total trade invoices paid within target	**98.47%**	**98.90%**	**98.64%**	**99.20%**

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

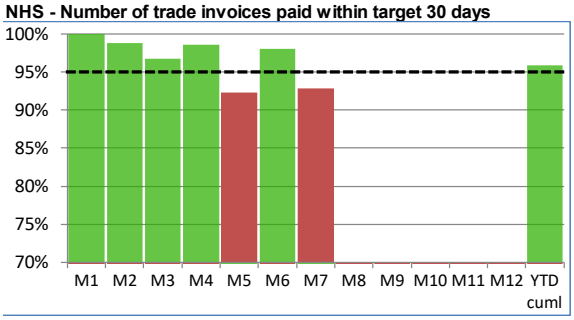
NON-NHS - No. of trade invoices paid within target 30 days



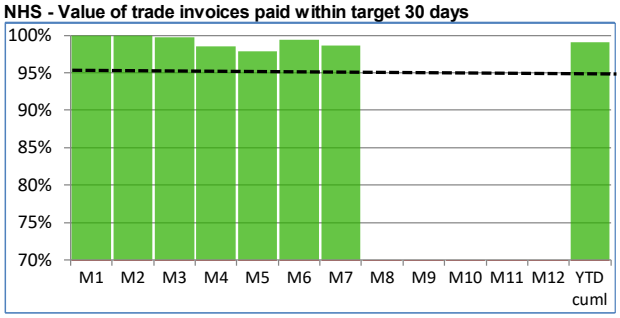
NON-NHS - Value of trade invoices paid within target 30 days



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	M07 Actual	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation	11,817	6,893	11,817	0
Cash reserves	779	(680)	1,179	400
Capital borrowings repayments	(4,117)	(2,402)	(4,117)	0
Capital grants	0	62	126	126
Total System operational capital	**8,479**	**3,873**	**9,005**	**526**
IFRS-16 new leases	**1,040**	**0**	**1,040**	**0**
MH OAPS - Deferral from 2025/26	1,800	245	1,800	0
Constitutional Standards/Left Shift	6,821	584	6,821	0
Estates Critical Infrastructure Risk (CIR)	1,550	142	1,550	0
National Programmes (PDC)	**10,171**	**971**	**10,171**	**0**
PFI capital lifecycle costs	**131**	**76**	**131**	**0**
Total Capital funds	**19,821**	**4,920**	**20,347**	**526**
Application of Funds				
Estates	**£'000**	**£'000**	**£'000**	**£'000**
Capital staffing	(510)	(262)	(562)	(52)
Estates backlog programme	(3,784)	(1,141)	(3,731)	53
Estates rolling programme	(1,420)	(550)	(1,656)	(236)
Medical devices	(170)	(98)	(195)	(25)
Directorate investment	(11,010)	(1,648)	(11,306)	(296)
PFI Agnes Unit capital lifecycle costs	(131)	(119)	(131)	0
	(17,025)	**(3,818)**	**(17,581)**	**(556)**
IM&T investment	**(1,756)**	**(1,102)**	**(1,726)**	**30**
Operational Capital	**(18,781)**	**(4,920)**	**(19,307)**	**(526)**
IFRS16 - Right of Use Leases	**(1,040)**	**0**	**(1,040)**	**0**
Total Capital Expenditure	**(19,821)**	**(4,920)**	**(20,347)**	**(526)**
(Over)/underspend	**0**	**0**	**0**	**0**

Capital expenditure to date:

Capital expenditure up to the end of October totals £4.9m, £5.6m below planned spend of £10.5m at Month 7. 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.,

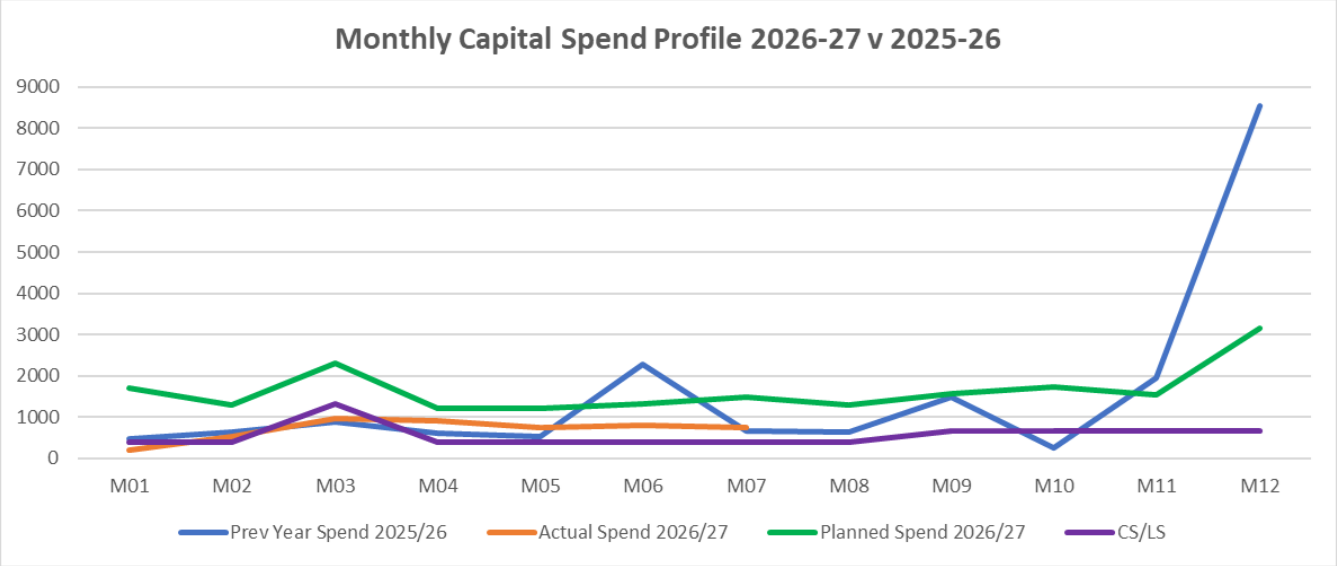
Constitutional Standards/Left Shift schemes (CS/LS) have experienced delays due to various reasons including delayed approval of schemes by NHSE, delays in sending across MOUs, an lack of clarity in "high-level" schemes. The following table shows the current status of all schemes over £500k, the current spend, and the annual forecast against each one:

Schemes over £500k	M07 Planned Spend £'000	M07 Actual Spend £'000	M07 Variance £'000	Opening Plan £'000	Annual Forecast £'000	Current Status
Capital Staffing	(304)	(262)	(42)	(510)	(561)	Slow start on schemes earlier in year, but schemes now in progress and costs are more in line with plan
Estates Backlog - Valentine Roof	(814)	(787)	(27)	(630)	(814)	Valentine roof construction is complete - phasing adjusted to reflect spend
Estates Backlog - Site Electrical Supply	(301)	0	(301)	(500)	(500)	High voltage Cable installation for supply to New MH Hospital - 26/27 works not yet commenced
Estates Backog - Lough Generator replacement	0	0	0	(500)	(500)	Generator replacement phased in late 26/27. Works being scoped by contractor
Estates Rolling Programmes	(820)	(550)	(270)	(1,420)	(1,656)	£250k Replacement taps at Hinckley Hospital completed in July, Fire stopping scheme at Bradgate started £12k accrued costs to date, Patient staff call system commenced installations
IM&T - IT Rolling Replacements	(609)	(680)	71	(1,040)	(1,040)	Variance relates to phasing of orders placed
IM&T - On-going configurations	(420)	(392)	(28)	(716)	(716)	
Directorate Schemes						
Soundproofing Audiology Hynca Lodge	(385)	(225)	(160)	(656)	(656)	Work commenced on pod in July, GMP received for alterations to consulting rooms, works to commence in coming weeks
Acacia Full refurbishment	(911)	(156)	(755)	(1,570)	(1,561)	GMP received and approved. Stage 1 fees incurred
Thornton Ward Refurbishment	(645)	(89)	(556)	(1,300)	(1,291)	Signing off drawings. Stage 1 fees incurred
Wakerley Ward Refurbishment	0	0	0	(900)	0	Phased in from June - low spend likely late 26/27 due to relocation of staff from Valentine. Stsge 1 fees expected in 27/28 now
Coalviile Ward 3 Refurbishment	(468)	(3)	(465)	(930)	(930)	Scope to be determined - initial meetings with service in August - drawings to be agreed & to be progressed to costing.
24/7 Neighbourhood MH Centre (City)	(925)	0	(925)	(925)	(925)	Site approved. Site visits arranged to view and scope works. Lease expected later this year. IT works required and some internal works
MH Emergency Department	0	0	0	(1,000)	(1,000)	Scope to be determined - phased in late 26/27 - UHL leading works
IFRS16 Leases	(607)	0	(607)	(1,040)	(1,040)	Costs will transfer in Q3
Other Schemes value less than £500k	(3,326)	(1,776)	(1,550)	(6,184)	(7,197)	66 schemes
	(10,535)	**(4,920)**	**(5,615)**	**(19,821)**	**(20,387)**	

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.

In recent weeks the Trust has identified priority works concerning fire safety. CMG have agreed to reprioritise the capital plan to ensure these works can be expedited, but are still awaiting time frames and costs. This uncertainty is increasing the risk of utilising all capital in the current year.

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.



CS/LS = Constitutional Standards/Left Shift schemes

Capital changes since last month:

	Opening Plan	Changes	Revised Plan	Comments
	£'000	£'000	£'000	
M06 Position	**(20,409)**	**62**	**(20,347)**	
Changes to Plan over £100k				
Valentine Centre - Additional Works - redecoration		(340)		GMP higher than plan
Patient/Staff Call		(204)		GMP higher than plan
Estates Welfare Cabin & 20 ft Container		(130)		Replacement of Gardeners compound
De Montfort and Langton repurpose		175		spend level expected to be lower
Agnes / Short Breaks		335		Not expected to commence by end of financial year
Beacon Unit		351		Decision awaited - unlikely to commence in 26/27
Net Change in month		187		
Net Change in month < £100k		(125)		
Net Change in month		62		

APPENDIX F SoFP, cash and working capital

PERIOD: October 2026	2025/26 31/03/26 Audited £'000's	2026/27 31/10/26 October £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	135,011	135,041
Intangible assets	3,310	2,469
IFRS16 - Right of use (ROU) assets	19,421	18,041
Trade and other receivables	821	821
Total Non Current Assets	**158,563**	**156,372**
CURRENT ASSETS		
Inventories	461	391
Trade and other receivables	7,155	11,508
Short term investments	0	0
Cash and Cash Equivalents	20,941	27,123
Total Current Assets	**28,557**	**39,022**
Non current assets held for sale	**0**	**0**
TOTAL ASSETS	**187,120**	**195,394**
CURRENT LIABILITIES		
Trade and other payables	(26,927)	(38,188)
Borrowings	(4,958)	(4,992)
Provisions	(5,031)	(4,676)
Other liabilities	(7,701)	(9,154)
Total Current Liabilities	**(44,617)**	**(57,010)**
NET CURRENT ASSETS (LIABILITIES)	**(16,060)**	**(17,988)**
NON CURRENT LIABILITIES		
Borrowings	(39,040)	(36,888)
Provisions	(704)	(704)
Total Non Current Liabilities	**(39,744)**	**(37,592)**
TOTAL ASSETS EMPLOYED	**102,759**	**100,792**
TAXPAYERS' EQUITY		
Public Dividend Capital	112,834	112,834
Retained Earnings	(28,595)	(30,562)
Revaluation reserve	18,520	18,520
Other reserves	0	0
TOTAL TAXPAYERS EQUITY	**102,759**	**100,792**

Non-current assets

Property, plant, and equipment (PPE) amounts to £135m, and includes capital additions of £4.9m, offset by depreciation charges.

Right of Use (ROU) leased assets total £18m.

Current assets

Current assets of £39m mainly includes cash of £27.1m, and receivables of £11.5m.

Current Liabilities

Current liabilities amount to £57m with trade and other payables making up £38.2m of this balance.

Other liabilities of £9.2m mainly relate to deferred income carried over from 2025/26 and Q3 medical staffing income.

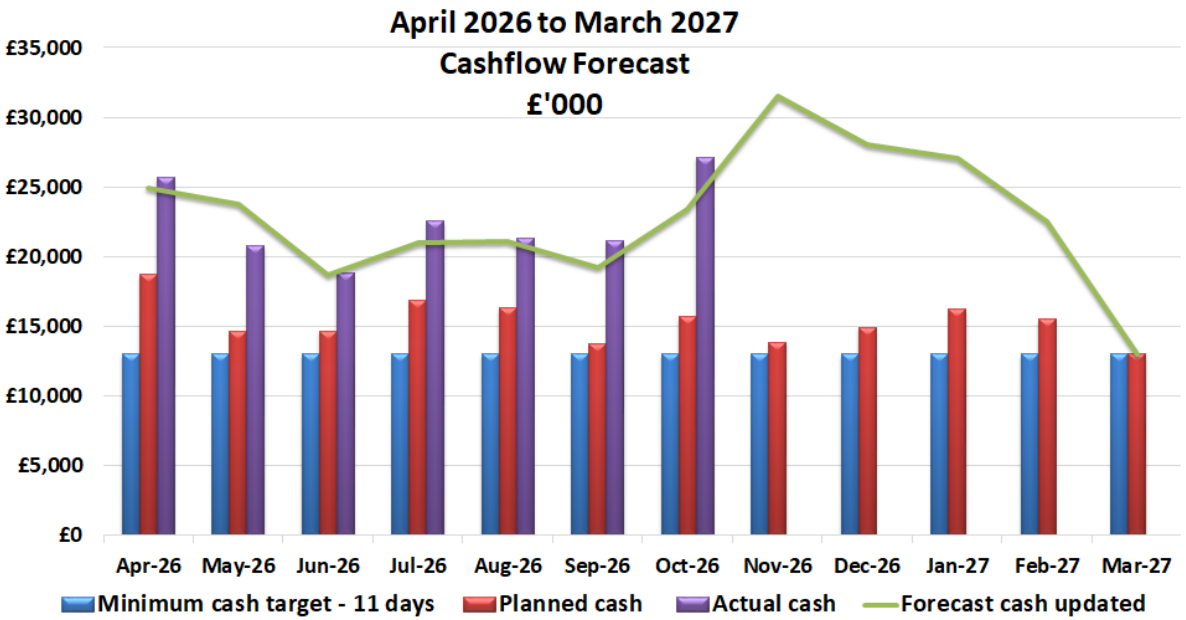
Net current assets / (liabilities) show net liabilities of £18m.

Taxpayers' Equity

October's deficit of £1.97m is reflected within retained earnings.

The Public dividend capital balance is £113m at the end of October. 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 October is £27.1m; an increase of £6.2m since the start of the year and an additional £11.4m compared to October's planned cash of £15.7m. This delivers 23 operating cash days - 10 days above the planned level of 13 days for Month 7. A higher than expected opening cash position at the start of the year and favourable working capital movements has 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 forecast are factored into the cash position.

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	23,415	31,477	28,017	27,063	22,546	13,000
Actual cash	25,664	20,760	18,856	22,531	21,289	21,115	27,123					

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	20	27	24	23	19	11
Actual cash days	22	18	16	19	18	18	23					

Receivables

Current receivables (debtors) total £11.5m, an increase of £4.4m since the start of the year. The increase mainly relates to accruals and prepayments.

Receivables	Current Month October 2026					
	NHS	Non	Emp's	Total	% Total	% Sales Ledger
	£'000	£'000	£'000	£'000		
Sales Ledger						
30 days or less	828	2,059	4	**2,891**	**23.45%**	**57.4%**
31 - 60 days	602	128	4	**734**	**5.95%**	**14.6%**
61 - 90 days	314	241	0	**555**	**4.50%**	**11.0%**
Over 90 days	500	153	204	**857**	**6.95%**	**17.0%**
	2,244	2,581	212	**5,037**	**40.85%**	**100.0%**
Non sales ledger	1,891	4,580	0	**6,471**	**52.49%**	
Total receivables current	**4,135**	**7,161**	**212**	**11,508**	**93.34%**	
Total receivables non current		821		821	**6.66%**	
Total	**4,135**	**7,982**	**212**	**12,329**	**100.00%**	**0.0%**

Debt greater than 90 days stands at £857k; this is an increase of £149k 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 7 is 6.95% (last month: 5.52%). The increase mainly relates to an outstanding debt with UHL exceeding 90 days.

The bad debt provision is £181k and covers all outstanding Non-NHS debt greater than 12 months. £5k of ex-employee debt has been written off since the start of the financial year, of which £3k relates to salary sacrifice schemes.

Payables

The current payables position in month 7 is £38.2m – an increase of £11.3m since the start of the year. The increase relates to the inclusion of expenditure accruals due to invoices not yet received for goods and services provided. Other liabilities of £9.2m mainly relate to deferred income for the Provider Collaborative and the receipt of Q3 medical staffing income.

APPENDIX G Risk adjusted forecast outturn & NHSE return

The table below shows a range of risk adjusted forecasts under best, likely and worst case assumptions.

The continuing improvement in the directorate overspend rates has led to a further improvement in the operational / directorate year end likely risk-adjusted forecast (£5m overspend at M3 / £3.6m at M6 / £2.9m at M7). This improvement has been partially offset by the assumed pay award funding shortfall, but the overall net Trust forecast has still seen a positive movement.

The best case forecast shows an I&E break-even (delivering our plan target), but does assume a level of directorate recovery (directorates' best cases) still to be confirmed. The overall likely case shows a deficit of £1.7m (£2.4m at M6).

DIRECTORATES	VARIANCE		
	BEST CASE	**LIKELY FOT**	**WORST CASE**
	£000	**£000**	**£000**
DMH	(2,871)	(3,232)	(3,967)
CHS	(1,000)	(1,200)	(2,200)
FYPC	300	200	100
LD	0	(100)	(200)
ESTS	0	(112)	(512)
ENABLING	1,664	1,464	1,000
HOSTED	200	100	(200)
TOTAL DIRECTORATE FOT VARIANCE:	**(1,707)**	**(2,880)**	**(5,979)**

CORPORATE / NOT ALLOCATED	**BEST CASE**	**LIKELY FOT**	**WORST CASE**
	£000	**£000**	**£000**
Delivery against orginal plan gap mitigations / contingencies			
£2.0m NON-REC EXP GAINS TARGET (over or under achieved):	1,268	825	0
Release of Transformation funding:	1,000	1,000	1,000
Sub-total - position re: original plan gap mitigations:	**2,268**	**1,825**	**1,000**
Other mitigations identified to date			
Interest receivable gain over budget:	350	250	150
Sub-total after further mitigations target:	**2,618**	**2,075**	**1,150**
Other Corporate/Trust wide pressures			
Pay award funding shortfall (assuming funded at CUF):	(911)	(911)	(911)
Nursing band 5 job eveluation (TBC):	0	0	(1,000)
TOTAL CORPORATE PRESSURES / MITIGATIONS:	**1,707**	**1,164**	**(761)**
TOTAL TRUST	**0**	**(1,716)**	**(6,740)**

NHS England (Midlands) 'High / Medium / Low' return

To allow NHS England to assess the level of risk and opportunity in the midlands NHS region, a formal return was issued to capture 'high, medium and low*' financial scenarios and how these compare to a 'do nothing' scenario.

The Trust's current risk adjusted forecast outturn reporting format supports this approach, allowing our well understood 'best, likely and worst' case scenarios to map to the NHSE return headings.

NHSE have encouraged organisations to include forecasts better than plan where possible, to improve the sector-wide position. Given that it is only in our best case forecast that we deliver plan / break-even, our return indicates that LPT cannot improve on the planned position.

A summary of the return data is shown below:

Summary output

Leicestershire Partnership NHS Trust

	Base case (do nothing)
	£'000
Plan - excluding DSF	0
YTD actuals - excluding DSF	-2,085
Forecast - Excluding DSF	-1,374
Base case (do nothing)	-3,459
Variance to Plan	-3,459

	Low scenario (downside case)	Medium scenario (most realistic delivery case)	High scenario (best credible / stretching outcome)
	£'000	£'000	£'000
Material risks to delivery	-3,281	0	0
Interventions	0	1,743	3,459
Revised closing position	-6,740	-1,716	0
Variance to plan	*-6,740*	*-1,716*	*-0*

Note:

- *In the NHSE return, the 'low' scenario equates to our 'worst case' and 'high' = our 'best case'.
- The 'do nothing' base case assumes a continuation of the current position but with no 'new' mitigations being reflected, and with no worst case risks included.
- The YTD position assumed in the NHSE template is M6. Within LPT, the M7 position had already been finalised ahead of the return.
- The return was submitted 11th November.

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. The Enabling forecast assumes a cost increase in M12, relating to a provision for transformation costs.



It should be noted that there has been some modest investment into the Trust (IPS Employment Support and MHST services) and new costs are now on line. Funded investment and similar costs can complicate any analysis of underlying trends. A 'normalised' run-rate position is therefore included on the next page to aid this analysis.

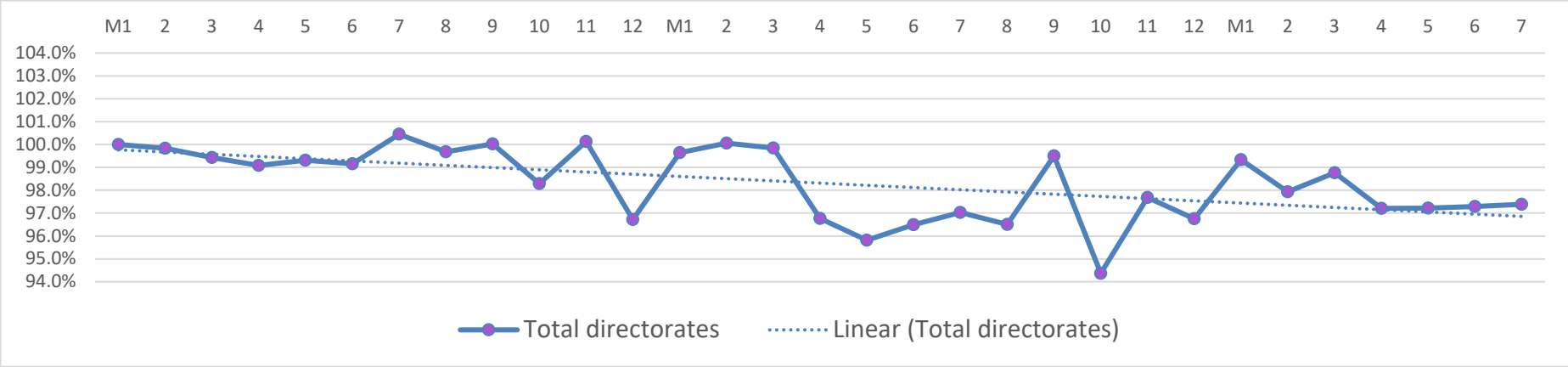
APPENDIX H2 - Historical pay expenditure run-rate analysis

The graph below shows total directorate pay costs over the past 2.5 years (from the start of financial year 2024/25). Month 1 in year 2024/25 has been set as the base year (100%) - percentages have been used to allow a clearer understanding of movements.

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

Plotting a linear trend line affords a clear view of the general direction of travel and this shows that we have reduced underlying costs by c. 3% in the last 2-and-a-half years. The national external ('net') cost reduction target over the 2024 - 2027 period is c. 5% (1.1% in 24/25 and 2.0% each year in 25/26 and 26/27). Whilst the proper comparison cannot be conducted until 26/27 has concluded, this would suggest that our position needs to improve across the remaining months of the financial year (although note that the graph focuses on pay, and so non-pay savings or additional income are not included)

It is encouraging to note that whilst costs rose above trend in the first 3 months of this year, since month 4, this variance has almost been eliminated.



APPENDIX I – Productivity Growth

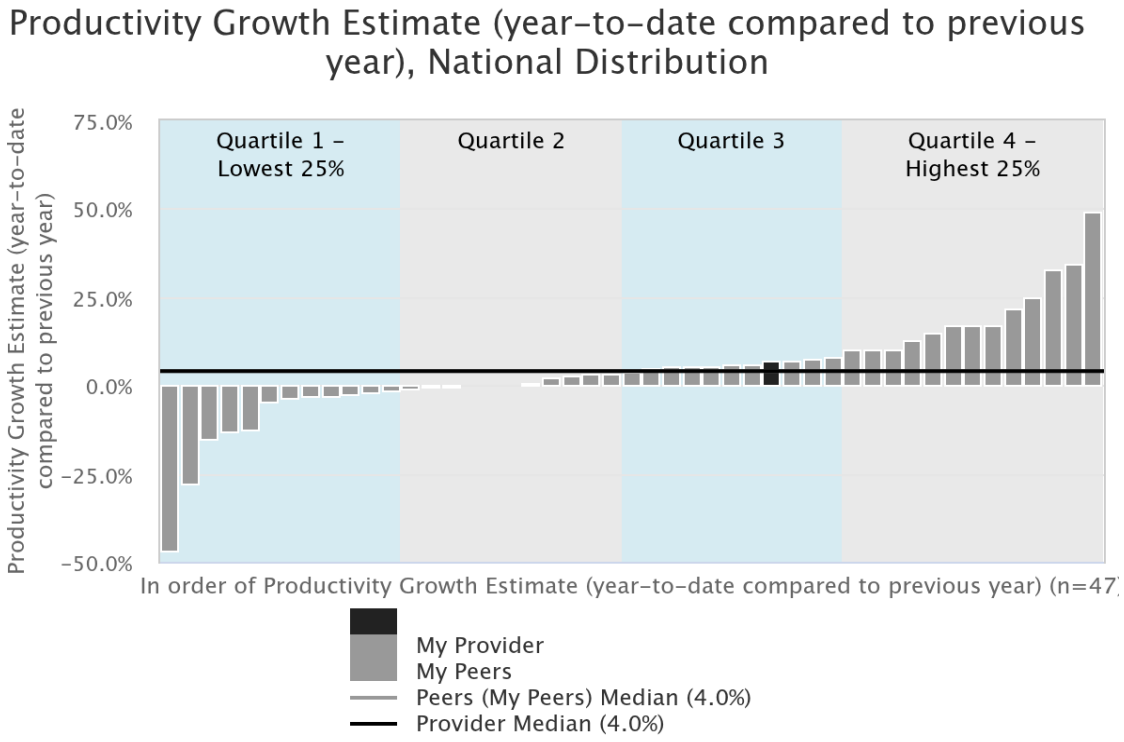
Implied productivity growth analysis data published on Model Health has recently been updated, using data as at end of June 2026.

LPT reported 6.7% estimated productivity growth for April to June 2026 compared with the same period in 2025. This is based on 6.5% growth in cost-weighted activity with a 0.2% reduction in real-terms resources, suggesting improved resource utilisation.

	%
Real Term Resource Growth (Apr to Jun 26 compared to same period previous year)	-0.20%
Cost Weigted activity growth (Apr to June 26 compared to same period previous year	6.50%
Productivity Growth Estimated (Apr to June 26 compared to same period previous year	**6.70%**

	%
Provider Median	**4.00%**

LPT ranked 17th among 47 organisations, placing it in Quartile 3, the upper-middle performance group. Our growth exceeded the peer median of 4.0% by 2.7 percentage points.



Governance Table

For Board and Board Committees:	Trust Board meeting, 24th November 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:	16th November 2026
Name and date of other committee / forum at which this report / issue was considered:	None
Level of assurance gained if considered elsewhere	☐ Assured ☐ Partially assured ☐ Not assured
Date of next report:	Trust Board standing agenda item
THRIVE strategic alignment:	☐ **T**echnology ☐ **H**ealthy communities ☐ **R**esponsive ☐ **I**ncluding everyone ☐ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	BAF 11 - Inadequate control, reporting and management of each Trust's 2026/27 financial position could mean we are unable to deliver our financial plan resulting in a breach of our statutory duties and medium-term financial plan.
Is the decision required consistent with LPT's risk appetite:	Yes
False or Misleading Information (FOMI) considerations:	N/A
Positive confirmation that the content does not risk the safety of patients or the public:	Yes
Equality considerations:	None



O

Public Trust Board – 24 November 2026

Integrated Board Performance Report – October 2026 (Month 7)

Purpose of the Report

To provide the Trust Board with an overview of Trust performance against an agreed set of KPI's for October 2026 (M7 of 2026/27).

Analysis of the Issue

The report is presented to the Accountability Framework Meeting after it has been presented to the Trust Board due to the timing of meetings. Details in relation to the indicators in the report are contained in the individual exception reports.

Waiting Times:

- LPT is seeing favourable wait time trends across a number of areas, where 52+ week waits are falling and service-specific wait time compliance is improving. This is owing to a mixture of successful recruitment, intensified patient tracking/ wait list management, and additional infrastructure (such as new access points within Neighbourhood teams).
- Demand for assessment of neurodiversity continues to impact wait time experience in key areas and presents one of the greatest risks to NOF. 52+ week waits in Community Paediatrics is currently 7,831, however when ND is excluded the service has shown zero 52+ week waits since August 2026. Similarly, when ND is excluded CAMHS has shown zero 52+ weeks waits since September 2026.
- 18 & 52-week wait times are challenged within Memory Clinics due to medic workforce vacancies and sickness absence across nursing staff. Recovery planning is in place, modelled to increase weekly appointments by 85% (overseen by Clinical Director and Lead Consultants).
- Whilst 94% of patients are waiting within 18-weeks for CINSS, the 6-week RTT standard remains challenged by growing demand. New group work offers and dictation software will improve productivity, whilst increased bank capacity and Clinical Assessment Days are being explored to support backlog clearance.
- CAMHS Eating Disorder (Urgent/ 1-week) RTT shows a fluctuating performance trend – with target achievement in 7 out of the 12 previous months. Intensified (bi-weekly) patient tracking

has been implemented to identify early intervention and bring about sustained target achievement.

NHS Oversight Framework:

- Finance metrics within NOF continue to show a stable picture of high performance, adhering to planned forecasts, and favourable to previous years with regards relative difference in costs (95.1%).
- Aside from waiting times, focus areas remain in mental health length of stay, where system dependencies increase CRFD rates. Tracking is undertaken frequently and this has been raised with system partners as a concern.
- Significant work continues to improve recording of reporting of paired outcome scores across community mental health services, particularly in Adult MH services. CYP MH services are also improving and remain favourable to national averages in this area.
- Consistently good performance continues to be seen in MH readmission rates, 72-hour follow-up rates, and MH crisis response rates.

People & Workforce:

- The Trust shows a positive level of long-standing stability across a range of workforce indicators – turnover, workforce diversity, training standards, appraisal and supervision.
- LPT reports in segment 1 for four out of five Staff Survey metrics.
- Sickness absence continues to show an increasing trend since March 2026, for which there is a proportionate financial impact. Recovery plans include HR support for policy compliance and a set of tactical audit recommendations (such as process changes and support to managers where sickness rates are highest).
- Fill rates for Registered Nursing fell below 80% on two occasions in October. This related to ward closures (where patients were cared for elsewhere), and respite care (where cross-cover arrangements are in place between Grange and Gullivers units).

Quality & Safety:

- 100% compliance in gatekeeping assessments prior to acute MH admission.
- 30-day readmission rates remain at 0% for children, and low for those aged 16+ years.
- Complaints and concerns continue to fluctuate within control limits.
- There are currently no patients in Long Term Segregation.

Other Points of Note

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

- The issue identified in relation to referral numbers to Adult ADHD continues to be investigated and as a consequence data from April 2026 has now been removed whilst a full understanding of the underlying issue and the necessary actions can be confirmed.
- The reduction in Community Hospital bed occupancy is due a data quality issue linked to the recording of planned bed closures at St Luke's Hospital, it was anticipated this would be resolved for this month's report but this has not been possible, this is now expected to be resolved ahead of next month's report.
- CHS Delayed Transfers of Care (DToC) - it is proposed that from November reports this measure is replaced by numbers clinically fit for discharge / no criteria to reside (as per national guidance) aligning this measure with DMH.
- Flu vaccination performance data for staff is now incorporated, with reporting included within both the NHS Oversight Framework and Workforce Dashboard.
- Flu vaccination for patients over the age of 65 will be added from next month.
- The Vacancy Rate metric has achieved target performance for nine consecutive months and has demonstrated a stable position over the last four reporting periods. This metric is no longer subject to exception reporting.

Decision Required

The Accountability Framework Meeting is asked to:

- Note areas of high performance and improvement
- Note areas of challenged performance and mitigating actions.
- Approve the Performance Report

Governance Table

For Board and Board Committees:	Accountability Framework Meeting
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:	17.11.2026
Name and date of other committee / forum at which this report / issue was considered:	Trust Board
Level of assurance gained if considered elsewhere	☐Assured ☐ Partially assured ☐ Not assured
Date of next report:	
THRIVE strategic alignment:	☐ **T**echnology ☒ **H**ealthy communities ☒ **R**esponsive ☒ **I**ncluding everyone ☒ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	BAF3.2 - Without timely access to services, we cannot provide high quality safe care for our patients which will impact on clinical outcomes.
Is the decision required consistent with LPT's risk appetite:	Yes
False or Misleading Information (FOMI) considerations:	None
Positive confirmation that the content does not risk the safety of patients or the public:	Yes
Equality considerations:	None identified

NHS
Leicestershire Partnership
NHS Trust

Integrated Board Performance Report

October 2026 (Month 7)

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** 	Core Mandatory Training Compliance for substantive staff / % of staff from a BME background	Adult NMHT / DPS 52Wks / Children's Physiotherapy 52 wks	Waiting Times: CBT 52 wks / TSPPD 52 wks / Medical_Neuro 52 wks / Stroke & Neuro / Speech Therapy / Community Paediatrics Treatment 52 Wks / CAMHS - Treatment waits
	Common Cause 	Gatekeeping MRSA Infection Rate / Clostridium difficile infection rate Normalised Workforce Turnover / Staff with a Completed Annual Appraisal / % staff clinical supervision		Safe staffing - Day Waiting Times:Children's Audiology / CMHT 52 Wks
	Special Cause - Concern 			Sickness Absence Waiting Times: ADHD / Memory Clinic / Community Paediatrics / ADHD 52 weeks / Community Paediatrics 52 wks assessment / MHSOP Memory Clinic 52 Wks / All Neurodevelopment 52 Wks

TRUST EXCEPTION REPORTS SUMMARY - Consistently Failing Target

Operational Performance - Waiting Times						
Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	SPC Assurance	SPC Trend
Adult Psychiatry - Neighbourhood Mental Health Teams Access (6 weeks routine) - Incomplete pathway	>=95%	Sep-26	79.0%	75.8%	F	H
Memory Clinic (18 week local RTT) - Incomplete pathway	>=92%	Sep-26	49.0%	46.5%	F	L
ADHD (18 week local RTT) - Incomplete pathway	>=92%	Sep-26	4.0%	3.6%	F	L
CINSS (6 weeks) - Incomplete pathway	>=95%	Sep-26	48.5%	50.7%	F	H
Speech Therapy - Voice, Respiratory and Dysfluency - Routine (6 weeks) - Incomplete pathway	>=95%	Sep-26	64.3%	53.0%	F	H
Community Paediatrics (18 weeks) - Incomplete pathway	>=92%	Sep-26	6.6%	7.1%	F	L
Childrens Audiology (6 week wait for diagnostic procedures) - Incomplete pathway	>=99%	Sep-26	31.0%	29.5%	F	

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

Workforce						
Sickness Absence	<=5.0%	Sep-26	6.5%	6.2%	F	H

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	Oct-26	0	0	?	L
Cognitive Behavioural Therapy	0	Oct-26	13	12	F	L
Dynamic Psychotherapy	0	Oct-26	0	0	?	L
Therapy Service for People with Personality Disorder	0	Oct-26	0	0	F	L
Medical/Neuropsychology	0	Oct-26	48	48	F	L
ADHD (18 week local RTT) - assessment waits	0	Sep-26	8414	8278	F	H
MHSOP Memory Clinics (18 week local RTT) - assessment waits	0	Sep-26	44	38	F	H
Community Paediatrics - assessment waits	0	Sep-26	7831	7834	F	H
Community Paediatrics Treatment (excl ND)	0	Oct-26	0	0	F	L
All Neurodevelopment (inc CAMHS, SALT, PAEDS)	0	Oct-26	1558	1582	F	H
CAMHS - Treatment waits (excl ND)	0	Oct-26	0	0	F	L
Children's Physiotherapy	0	Oct-26	0	0	P	L

TRUST EXCEPTION REPORTS SUMMARY - Consistently Achieving Target

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

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%	Oct-26	100.0%	96.8%	P	

Workforce						
Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	SPC Assurance	SPC Trend
Normalised Workforce Turnover (Rolling previous 12 months)	<=10%	Oct-26	7.4%	7.3%	P	
Core Mandatory Training Compliance for substantive staff	>=85%	Oct-26	98.4%	98.8%	P	H
Staff with a Completed Annual Appraisal	>=80%	Oct-26	94.6%	94.9%	P	
% of staff from a BME background	>=22.5%	Oct-26	34.0%	34.0%	P	H
% of staff who have undertaken clinical supervision within the last 3 months	>=85%	Oct-26	93.1%	93.6%	P	

Trust Headlines

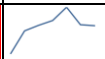
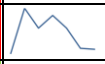
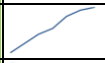
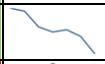
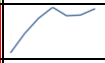
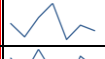
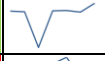
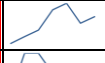
Overall CQC rating (provision of high-quality care) = 2 **CQC Well Led rating = 2** **Q1 Overall NOF Rating = 2**

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 and reported within the IPR have plans in place to deliver improved compliance with contractual and / or operational planning targets; the impact of these plans are illustrated by the improvement trajectories included on the relevant pages of this report. Trajectories 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 has been re-established with a small increase in compliance, bringing the service in line with its trajectory. Referrals continue to be high making delivery exceptionally challenging. Compliance in Adult Speech and Language Therapy continues 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. Compliance for Community Integrated Stroke and Neurology Services has further deteriorated this month with the service seeing a trend of increasing referrals and challenged by reduced capacity due to sickness and maternity leave; robust oversight continues to support a return to an upward trajectory. 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 showed a deteriorating position against the 18 week target; whilst referrals are reducing for the service the volume of long waits over 104 weeks negatively impacts on compliance with the national target. Measures are in place to transform provision to address the long standing imbalance between demand and capacity, contributing to improved productivity and new deliver service transformation. Memory Services and Adult ADHD saw a small improvement in their overall compliance; although demand continues to exceed capacity actions are in place to improve productivity and deliver transformation which will support sustaining longer-term improvement All services continue to implement transformation plans and productivity improvements including system-wide	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. This has reduce reported numbers waiting alongside ensuring robust mechanisms to monitor the timing of follow-ups with clear routes for escalation where these become a concern. Psychological therapies continue to make good progress in reducing the number of over 52 week waiters. Therapy Services for People with Personality Disorder (TSPPD) have implemented a revised pathway working closely with the neighbourhood teams enabling the service to focus on reducing the numbers of long waits and continue to report zero over 52 week waiters as did Dynamic Psychotherapy (DPS). Cognitive Behavioural Therapy (CBT) continues to balance assessment and treatment activity to manage numbers of over 52 week waiters and although these increased to 13 this month, the overall downward trend continues. The number of children waiting for treatment for ND disorders has decreased slightly this month, continuing a longer-term downward trend however the number waiting over 52 weeks for a first appointment continues to grow. We anticipate that these will show a reduction in the coming months as the impact of the additional clinics funding through GIRFT start to be seen. Numbers waiting over 52 weeks increased Memory Services and Adult ADHD and remained static in Medical Psychology. The increase in the overall numbers waiting over 52 weeks, and the longest waits within this, continue to increase due to increasing numbers of long waits for services for 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.	Gatekeeping assessments returned to 100% compliance in October following a short period of slightly reduced performance. September saw little change in the overall numbers of patient safety incidents, and there was a fall in the number and % of these resulting in severe harm or death. More detail on these incidents including any themes is contained within the Safety Assurance Report provided to Trust Board on a bi-monthly basis. Performance against the 72 hour follow-up standard was sustained at 91% in August 2026 (this data is extracted from the national mental health core data pack and is reported in arrears) continuing long-term compliance with this target. Changes in the number of complaints, concerns and compliments were within the expected tolerance. The numbers of wards not meeting safer staffing standards was below target for both day and night remains above the target of zero with 2 wards non-compliant for night shifts and 2 for day shifts. Details behind these are included in the metric exception report. Numbers of seclusions remained stable at 13 with no episodes of restraint reported. The number of restrictive practices increased from 231 to 270 but this remains below longer terms numbers. Numbers of Category 2 pressure ulcers developed in LPT care decreased whilst numbers in Categories 3 and 4 increased. The number of repeat falls reduced slightly from 45 to 43 whilst medication errors increased from 79 to 86 but remains below longer term numbers. The 'clock' for annual health checks restarts on 1 April each year and compliance, whilst appearing low, is improving, is in line with plan and benchmarks well against the national position.	Performance against workforce standards continues to be high with sickness absence the only area where standards are consistently not met and are increasing. Further detail and actions in place to address this are contained within the exception report. The costs associated with sickness absence increased in month in line with higher levels of sickness reported.	Delivery against MH length of stay (3 month rolling average) was below trajectory for adult and PICU and MHSOP beds but continues to improve. The 3 month rolling average for adult and PICU was 52.8 days compared to 53.2 days last month against a target of 48.5. Performance for beds for older people also improved this month with a 3 month rolling average of 76 days compared to 76.5 days in September, this is against a target of 72.8 days. There were no inappropriate out of area placements or bed days in October, maintaining delivery against our target of zero. Compliance with the target for adults to wait no more than 18 weeks for community services remained high at 99.5% compared to 99.4% in September. Although the plan for the % of children waiting 18 weeks or less was exceeded, % compliance with the 18 week target remains low and fell from 21.2% to 19.1%. This low level of compliance is driven by the long waits for children requiring audiology and neurodevelopmental interventions – all other CYP community services are fully compliant with the 18 week national target. The number of CAMHS patients not meeting the 104 week meaningful help standard decreased in October falling from 228 to 132 with a target of 225. We continue to expect to meet our year-end target of zero and remain above plan. The percentage of children waiting over 6 weeks for a diagnostic test (audiology) increased to 72.5% in month but remains above target in line with recovery measures in place. Numbers waiting over 52 weeks (all children waiting for ND interventions) were above plan. Performance continues to be below planned levels for community contacts for adults and children, a trend seen for several months and is being investigated.	The NoF dashboard contains an up to date position for all indicators using a mix of local and national data and these are 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 exceptions of a number of metrics in the Access to Services domain. Areas of concern are over 52 week waits for community services and % of children waiting over 104 weeks for meaningful help. We anticipate an improvement in both of these areas in the coming months due to additional clinics in community paediatrics and focused data quality work around 104 week waits however these are not expected to impact on our overall NoF scores until Q3. This updated NoF dashboard will continue to 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.

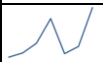
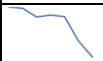
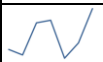
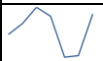
NHS Oversight Framework 2026-27

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	Oct-26	56.3%	56.8%		
	Trust	*Monthly*	% of community wait list, where patients are waiting more than 52-weeks	Oct-26	37.1%	36.1%		3.04
	Trust	*Monthly*	% discharged from CMH with 2+ contacts & a paired outcome score (Adults)	Oct-26	10.2%	8.4%		
	Trust	*Monthly*	% discharged from CMH with 2+ contacts & a paired outcome score (CYP)	Oct-26	49.0%	42.6%		
	National	*Monthly*	% of CYP waiting 104+ weeks for a 'Help-Based Clock Stop'	Aug-26	28.0%	25.0%		
Experience of care	Trust	*Monthly*	% of intermediate care beds occupied by patients with 'no criteria to reside'	Oct-26	30.7%	24.5%		
	Trust	*Monthly (in arrears) (3-month average)*	Mean length of stay for adult acute and PICU inpatients (at point of discharge)	Oct-26	52.8	53.2		
	Trust	*Monthly (in arrears) (3-month average)*	Mean length of stay for older adult acute inpatients (at point of discharge)	Oct-26	75.1	76.5		2.13
	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	Oct-26	0.0%	0.0%		
	National	*Quarterly (rolling 12 months)*	% of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	Mar-26	15.6%			1.54
	Trust	*Monthly*	% of adult acute/ rehab discharged who have a follow-up appt within 72-hours	Oct-26	93.9%	90.8%		
Patient safety	Trust	*Monthly*	% Urgent MH crisis referrals to receive 1st face-to-face contact within 24-hours	Oct-26	88.7%	82.4%		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	2026/27	£0k	£313k		
	Trust	*Monthly (Year to date)*	Variance to Plan (Year-to-date)	Oct-26	£0	£0		1.55
	Trust	*Monthly*	Combined Finance Score	Oct-26	1	1		
	National	*Annual Plan*	Relative Cost Difference (National Cost Collection Index)	2024/25	95.1%			
	National	*Monthly*	Data Quality Maturity Index	Oct-26	92.8			
People	Trust	*Monthly (in arrears) (Rolling twelve months)*	Sickness Absence Rate	Sep-26	6.0%	5.9%		
	Trust	*Monthly*	Temporary staffing cost	Oct-26	£374,630.00	£328,400.00		
	Trust	*Monthly*	% of frontline Healthcare Worker Flu Vaccine administered by the NHS	Oct-26	33.0%			1.91
	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

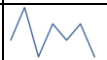
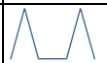
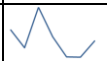
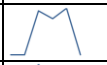
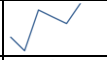
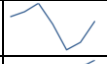
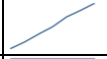
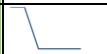
Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Operational Planning	TRUST	Monthly (3 month rolling)	Average Length of Stay in Adult Acute & PICU MH Beds	<=48.5	Oct-26	52.8	53.2				
	TRUST	Monthly (3 month rolling)	Average Length of Stay in Older Adult Acute MH Beds	<=72.8	Oct-26	76.0	76.5				
	TRUST	Monthly	Active inappropriate adult acute mental health out of areas placements (OAPs)	0	Oct-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%	Oct-26	99.5%	99.4%				
	TRUST	Monthly	Percentage of people on waiting lists per system who are waiting 18 weeks or less - CYP Services	Plan=18.3%	Oct-26	19.1%	21.5%				
	TRUST	Monthly	Community Services waiting list over 52 weeks	Target =0 Plan=7442	Oct-26	7914	7862				
	TRUST	Monthly	Attended Community Care Contacts - CHS	Plan=90629	Oct-26	83164	84296				
	TRUST	Monthly	Attended Community Care Contacts - FYPC	Plan=10919	Oct-26	9830	10763				
	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=225	Oct-26	132	228				
	TRUST	Monthly	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	Target = 0% Plan=98.7%	Oct-26	72.5%	65.4%				
	TRUST	Monthly	Reliance on specialist inpatient care for adults with a learning disability and/or autism	23	Oct-26	28	27				
	TRUST	Monthly	Reliance on specialist inpatient care for children with a learning disability and/or autism	3	Oct-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		Oct-26	30.7%	24.5%				
	TRUST	Monthly	Out of Area Placement - Inappropriate Bed Days	0	Oct-26	0	0				
	TRUST	Monthly	Occupancy Rate - Adult Acute & PICU MH Beds (excluding leave)	<=85%	Oct-26	89.9%	88.6%				
	TRUST	Monthly	Occupancy Rate - Older Adult Acute MH Beds (excluding leave)	<=85%	Oct-26	84.0%	88.5%				
	TRUST	Monthly	Occupancy Rate - Community Beds (excluding leave)	>=93%	Oct-26	84.3%	87.6%				
	TRUST	Monthly	Delayed Transfers of Care/Clinically Ready for Discharge - Trust	<=3.5%	Oct-26						
	TRUST	Monthly	Clinically Ready for Discharge (CRFD) - DMH	<=3.5%	Oct-26	12.8%	10.5%				
	TRUST	Monthly	Delayed Transfers of Care (DTOC) - CHS	<=3.5%	Oct-26	0.2%	0.3%				
	TRUST	Monthly	Admissions to adult facilities of patients under 18 years old	0	Oct-26	0	0				

Quality & Safety Dashboard

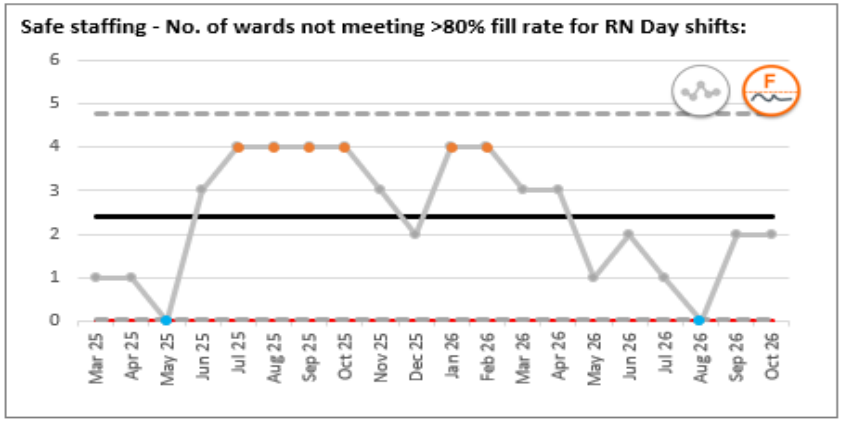
Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Quality Account	TRUST	Monthly	The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period	>=95%	Oct-26	100.0%	96.8%				
	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		25/26	6.3	6.6				
	TRUST	Monthly	The percentage of inpatients discharged with a subsequent inpatient admission within 30 days - 0-15 years		Oct-26	0.0%	0.0%				
	TRUST	Monthly	The percentage of inpatients discharged with a subsequent inpatient admission within 30 days - 16+ years		Oct-26	3.7%	3.5%				
	TRUST	Monthly	The number of patient safety incidents reported within the Trust during the reporting period		Oct-26	1951	1968				
	TRUST	Monthly	The rate of patient safety incidents reported within the Trust during the reporting period		Oct-26	69.0%	69.2%				
	TRUST	Monthly	The number of such patient safety incidents that resulted in severe harm or death		Oct-26	12	21				
	TRUST	Monthly	The percentage of such patient safety incidents that resulted in severe harm or death		Oct-26	0.6%	1.1%				
	MHSDS	Monthly (a quarter in arrears)	72 hour follow up after discharge (aligned with national published data)	>=80%	Aug-26	91.0%	91.0%				
Quality & Safety	TRUST	Monthly	No. of Complaints		Oct-26	40	28				
	TRUST	Monthly	No. of Concerns		Oct-26	48	50				
	TRUST	Monthly	No. of Compliments		Oct-26	205	161				
	TRUST	Monthly	Safer staffing - No. of wards not meeting >80% fill rate for RNs - Day	0	Oct-26	2	2				
	TRUST	Monthly	Safer staffing - No. of wards not meeting >80% fill rate for RNs - Night	0	Oct-26	2	2				
	TRUST	Monthly	Care Hours per patient day		Oct-26	11.3	11.3				
	TRUST	Monthly	No. of Long term Segregations		Oct-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		Oct-26	13	13				
	TRUST	Monthly	No. of episodes of prone (supported) restraint		Oct-26	0	2				
	TRUST	Monthly	No. of episodes of prone (unsupported) restraint		Oct-26	0	1				
	TRUST	Monthly	Total number of Restrictive Practices		Oct-26	270	231				
	TRUST	Monthly (In Arrears)	No. of Category 2 pressure ulcers developed or deteriorated in LPT care		Sep-26	128	146				
	TRUST	Monthly (In Arrears)	No. of Category 3 pressure ulcers developed or deteriorated in LPT care		Sep-26	16	6				
	TRUST	Monthly (In Arrears)	No. of Category 4 pressure ulcers developed or deteriorated in LPT care		Sep-26	15	12				
	TRUST	Monthly (In Arrears)	No. of repeat falls		Sep-26	43	45				
	TRUST	Monthly	No. of Medication Errors		Oct-26	96	79				
	TRUST	Monthly	LD Annual Health Checks completed - YTD		Oct-26	41.3%	35.2%				
	MHRA	Monthly	National Patient Safety Alerts not completed by deadline		Oct-26	1	1				
	TRUST	Monthly	MRSA Infections	0	Oct-26	0	0				
	TRUST	Monthly	Clostridium difficile infections	Annual <=12	Oct-26	0	0				
	UHL	Monthly (In Arrears)	E.coli bloodstream infections		Sep-26	0	0				
	GOV	Monthly (YTD)	Percentage of people aged 65 and over who received a flu vaccination		Oct-26						

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

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

Mean	Lower Process Limit	Upper Process Limit
2	0	5



Analytical Commentary

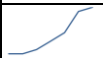
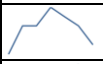
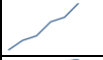
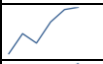
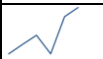
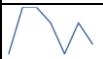
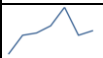
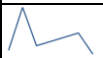
The metric is showing a common cause variation with no significant change. The metric will consistently fail to meet the target as demonstrated by the target line falling above the process limits.

Operational Commentary

Actions	Timescales	Consequences	RAG
CHS Ward 1 (St Lukes) - Closed on 14 September for estates works and moved to Ward 3 **LD** Short breaks - 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 on days for the month in both services. Mitigation provided through cross cover			

Achievements

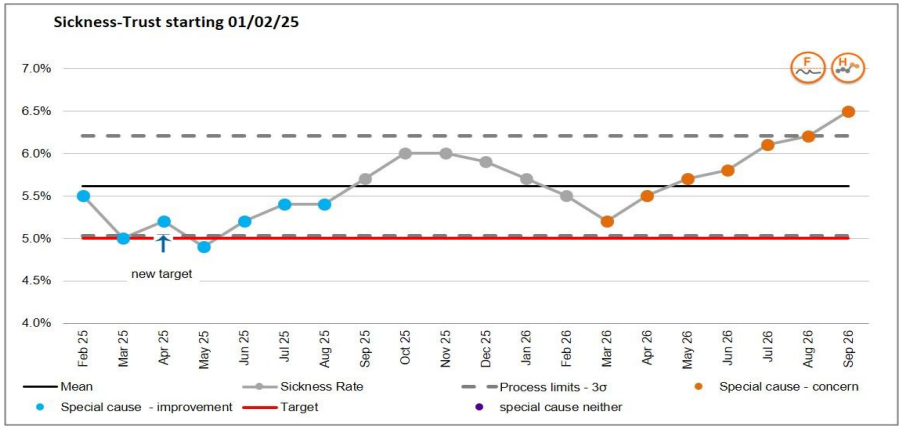
Workforce Dashboard

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%	Oct-26	7.4%	7.3%				
	TRUST	Monthly	Vacancy Rate	<=10%	Oct-26	9.5%	9.7%				
	TRUST	Monthly (In Arrears)	Sickness Absence	<=5.0%	Sep-26	6.5%	6.2%				
	TRUST	Monthly (In Arrears)	Sickness Absence Costs		Sep-26	£1,457,082	£1,445,436				
	TRUST	Monthly (In Arrears)	Sickness Absence - YTD	<=5.0%	Sep-26	6.0%	5.9%				
	TRUST	Monthly	Core Mandatory Training Compliance for substantive staff	>=85%	Oct-26	98.4%	98.8%				
	TRUST	Monthly	Staff with a Completed Annual Appraisal	>=80%	Oct-26	94.6%	94.9%				
	TRUST	Monthly	% of staff from a BME background	>=22.5%	Oct-26	34.0%	34.0%				
	TRUST	Monthly	Staff flu vaccination rate (frontline healthcare workers)		Oct-26	33.0%					
	TRUST	Monthly	% of staff who have undertaken clinical supervision within the last 3 months	>=85%	Oct-26	93.1%	93.6%				

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

	Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
TRUST	<=5.0%	6.0%	6.0%	5.9%	5.7%	5.5%	5.2%	5.5%	5.8%	5.8%	6.1%	6.2%	6.5%
DMH		7.1%	7.3%	6.8%	6.6%	6.1%	5.8%	6.2%	6.5%	7.1%	7.3%	7.1%	7.0%
CHS		6.5%	6.3%	6.0%	6.0%	6.2%	5.4%	5.8%	5.7%	5.1%	5.2%	5.7%	6.2%
FYPCLDA		5.5%	5.9%	6.3%	5.6%	5.4%	5.4%	5.9%	6.3%	6.5%	6.8%	6.8%	7.2%

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



Analytical Commentary

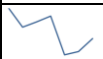
The metric is showing special cause variation of a concerning nature due to higher values. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

Operational Commentary

Actions	Timescales	Consequences	RAG
360 Assurance audit to take place focusing on: - Are expected working practices for managing attendance being applied promptly, consistently, and fairly across the Trust - Are colleagues appropriately supported to enable them to safely return to work following long term sickness absence at the earliest opportunity.	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	Oct-26	£0	£0				
	TRUST	Monthly	Variance to Plan – efficiency (£000)	>=0	Oct-26	£0	£0				
	TRUST	Monthly	Variance to Plan – capital spend (£000)	£0	Oct-26	£694k	£525k				
	TRUST	Monthly	Variance to Plan – agency spend (£000) - YTD	>=0	Oct-26	£28k	£86k				
	TRUST	Monthly	Agency Spend % of Total Pay - YTD	<=1.87%	Oct-26	1.23%	1.01%				
	TRUST	Monthly	Agency annual expenditure cap – FOT performance	<=6,749,000	Oct-26	£4,525,000	£4,535,000				
	TRUST	Monthly	Bank annual expenditure cap – FOT performance	<=20,361,000	Oct-26	£20,361,000	£20,361,000				

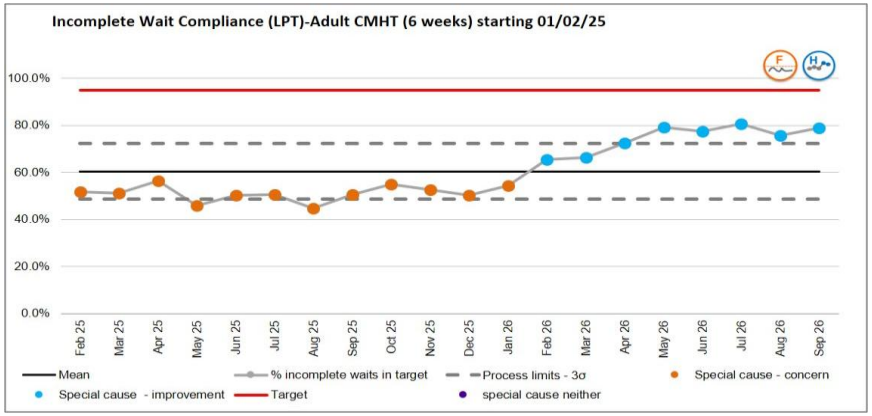
Operational Performance - DMH Waiting Times Dashboard

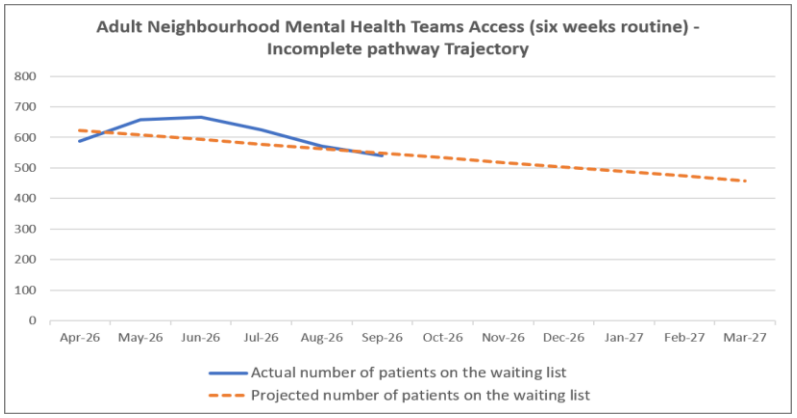
Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Operational Performance - Access Waiting Times	TRUST	Monthly (In Arrears)	Adult Psychiatry - Neighbourhood Mental Health Teams - Access (6 weeks routine) - Incomplete pathway	>=95%	Sep-26	79.0%	75.8%				
	TRUST	Monthly (In Arrears)	Memory Clinic (18 week Local RTT) - Incomplete pathway	>=92%	Sep-26	49.0%	46.5%				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - Incomplete pathway	>=92%	Sep-26	4.0%	3.6%				
	TRUST	Monthly (In Arrears)	Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral - complete pathway	>=60%	Sep-26	77.8%	61.5%				
Operational Performance - 52 Week Waits	TRUST	Monthly (In Arrears)	Adult Psychiatry - Neighbourhood Mental Health Teams - Assessments waits over 52 weeks - No of waiters	0	Sep-26	0	0				
	TRUST	Monthly (In Arrears)	Adult Psychiatry - Neighbourhood Mental Health Teams - Assessments waits over 52 weeks - Longest waiter (weeks)		Sep-26	47	43				
	TRUST	Monthly	Adult Psychiatry – Neighbourhood Mental Health Teams – Treatment waits - No of Waiters	0	Oct-26	0	0				
	TRUST	Monthly	Adult Psychiatry – Neighbourhood Mental Health Teams – Treatment waits - Longest Waiter		Oct-26	23	19				
	TRUST	Monthly	Cognitive Behavioural Therapy - Treatment waits - No of waiters	0	Oct-26	13	12				
	TRUST	Monthly	Cognitive Behavioural Therapy- Treatment waits - Longest waiter (weeks)		Oct-26	64	72				
	TRUST	Monthly	Dynamic Psychotherapy - Treatment waits - No of waiters	0	Oct-26	0	0				
	TRUST	Monthly	Dynamic Psychotherapy - Treatment waits - Longest waiter (weeks)		Oct-26	51	49				
	TRUST	Monthly	Therapy Service for People with Personality Disorder - Treatment waits - No of waiters	0	Oct-26	0	0				
	TRUST	Monthly	Therapy Service for People with Personality Disorder - Treatment waits - Longest waiter (weeks)		Oct-26	0	14				
	TRUST	Monthly	Medical/Neuropsychology - Treatment waits - No of Waiters	0	Oct-26	48	48				
	TRUST	Monthly	Medical/Neuropsychology- Treatment waits - Longest Waiter		Oct-26	117	113				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	Sep-26	8414	8278				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - assessment waits over 52 weeks - Longest waiter (weeks)		Sep-26	278	274				
	TRUST	Monthly (In Arrears)	MHSOP Memory Clinics (18 week local RTT) - assessment waits over 52 weeks - No of waiters	0	Sep-26	44	38				
	TRUST	Monthly (In Arrears)	MHSOP Memory Clinics (18 week local RTT) - assessment waits over 52 weeks -Longest waiter (weeks)		Sep-26	96	92				

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

DMH	Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
	>=95%	54.9%	52.5%	50.4%	54.4%	65.5%	66.2%	72.5%	79.3%	77.3%	80.5%	75.8%	79.0%
No of Referrals		539	474	476	520	598	659	511	531	595	650	523	553

Mean	Lower Process Limit	Upper Process Limit
60.5%	49.0%	72.0%





Analytical Commentary

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

Operational Commentary

Actions	Timescales	Consequences	RAG
Substantive recruitment to Consultant posts with recruitment plan in place. 3 substantive Consultants recruited to date. 1.00 w.t.e substantive consultant commencing on 02/11/26 1.00 w.t.e. substantive ST6 commencing on 02/11/26 for 3 months, before moving into consultant post. Weekend caseload review commencing end of November 2026 to support reduction in waiting lists via appropriate safe discharges. It is expected that that the impact of this will be evident in 3-4	Mar-27	Increase capacity and reduce waiting times.	
Additional actions to increase capacity and improve flow include: • 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 clincial 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.	

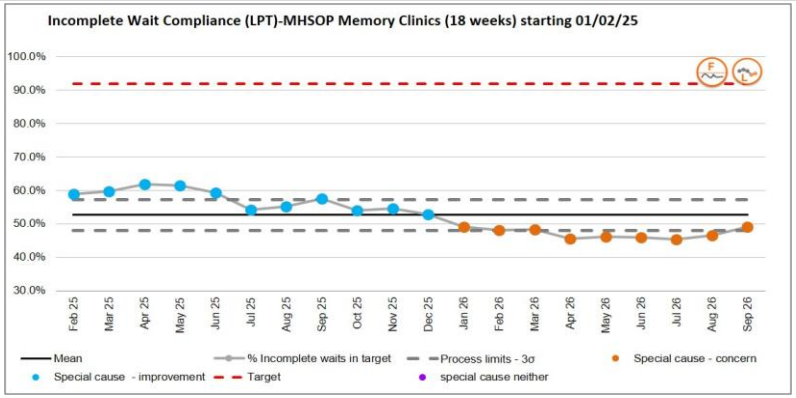
Achievements

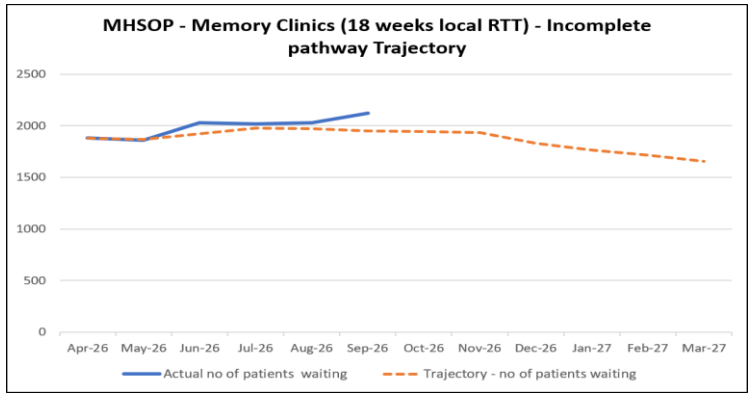
% compliance shows an improving trend with significant improvement seen in last two quarters

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

DMH	Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
	>=95%	54.0%	54.6%	52.9%	49.1%	48.1%	48.3%	45.6%	46.1%	45.9%	45.3%	46.5%	49.0%
No of Referrals		267	224	230	234	227	267	184	184	265	277	228	302

Mean	Lower Process Limit	Upper Process Limit
52.7%	48.0%	57.0%





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 WTE medic and mitigated through 0.4 WTE. GP with Special Interest and 0.4 w.t.e 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. 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.	Sep-26	Increase capacity enabling waiting times / number of over 52 waits to be reduced.	
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.	

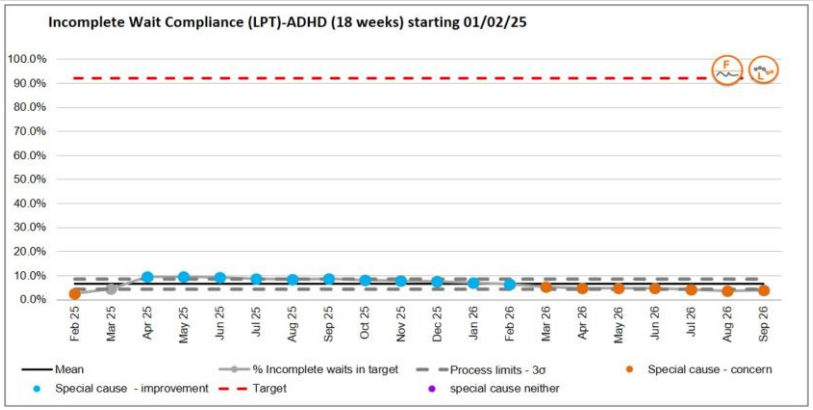
Achievements

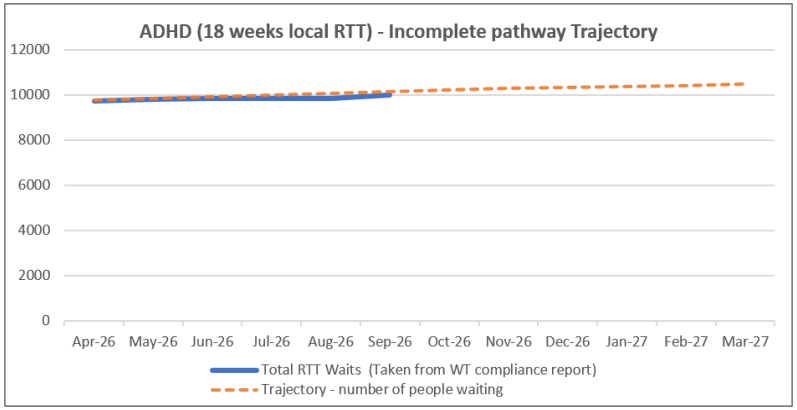
One Stop Clinics and Advanced Dementia Pathway have enabled new approaches to be implemented which offer significant benefit to patients and carers in terms of waiting time and patient experience.

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

DMH	Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
	>=95%	8.2%	7.8%	7.6%	7.1%	6.6%	5.4%	4.7%	4.9%	4.8%	4.1%	3.6%	4.0%
No of Referrals		251	257	222	197	216	221	TBC					

Mean	Lower Process Limit	Upper Process Limit
6.5%	4.0%	9.0%





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

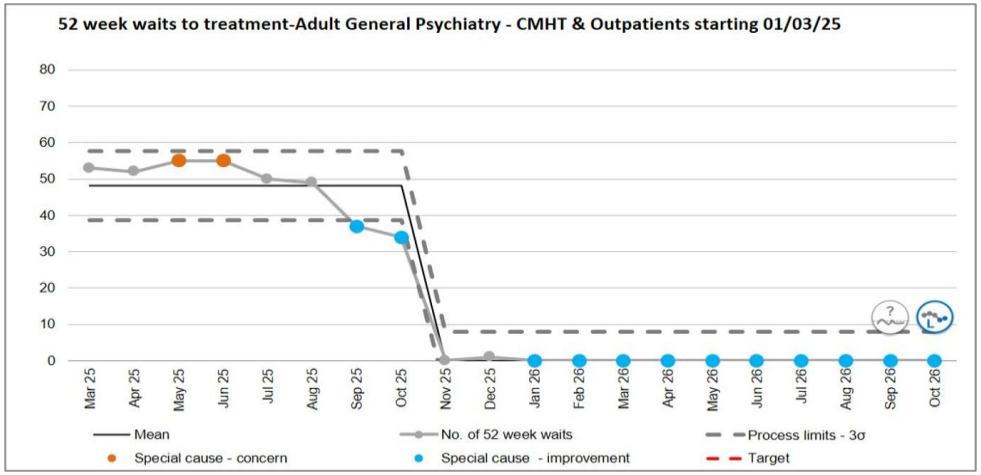
Actions	Timescales	Consequences	RAG
System-wide transformation of ADHD pathway to improve access and reduce waiting times. Will focus on piloting AI Scribe to support improved efficiency across the pathway enabling increased availability of clinical appointments. Working with ICB and HEIM to assess opportunites 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.	
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, LHIS, 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.	

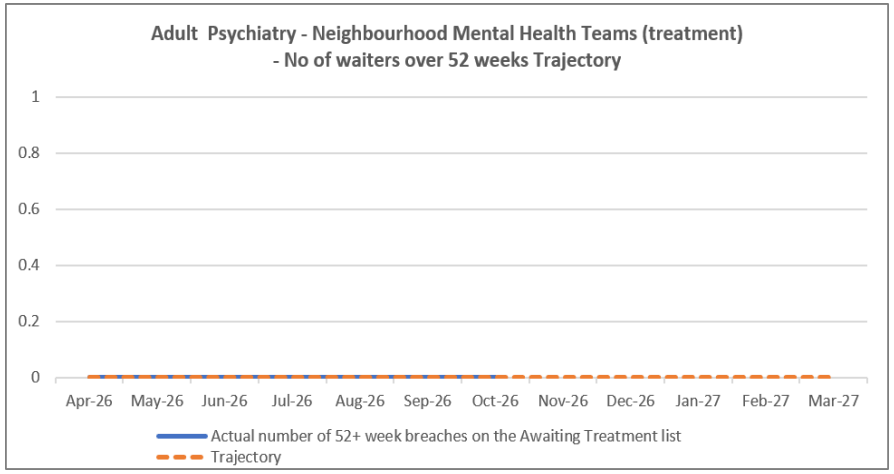
Achievements

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

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

Mean	Lower Process Limit	Upper Process Limit
0.1	-7.9	8.1





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 special cause for improvement.

Operational Commentary

Actions	Timescales	Consequences	RAG
Sustaining this position will be supported by the actions identifed in the exception report for NMHT 6 week waits	N/A	No over 52 week waits remains sustainable in longer term	N/A

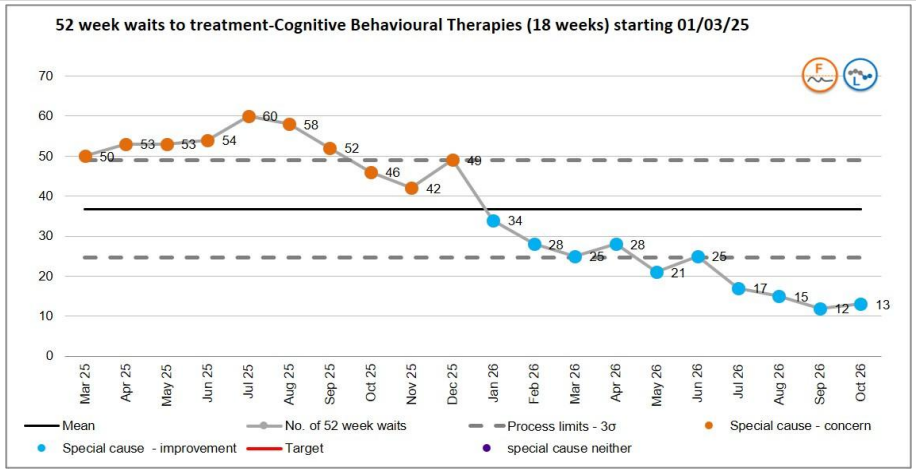
Achievements

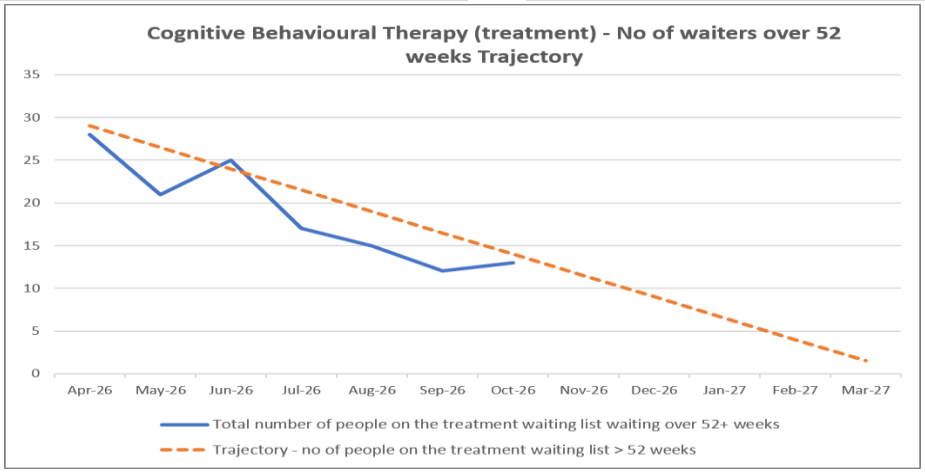
Work to review waiting lists, clinical activity and data recording, treatment waits in excess of 52 weeks expected to eliminate trestment waits with ZERO waits reported since Dec 2025.

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

DMH	Target	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
	0	42	49	34	28	25	28	21	25	17	15	12	13

Mean	Lower Process Limit	Upper Process Limit
36.8	24.6	48.9





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
Neighbourhood Mental Health Teams (NMHTs) now positioned as the access point ("front door") for all Cognitive Behavioural Therapy (CBT) referrals; will streamline referral management, improve consistency, and strengthen integration across services. However operational pressures are impacting on implementation timelines and overall service flow. 95% of referrals coming into the service now via the new referral pathways allowing the team to support the daily huddles. Expect all referrals to be via new referral pathway by end of November 2026.	Nov-26	Implementation of new referral pathway completed. Direct referrals to CBT close on 2nd November 2026.	
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.	Complete	Enhanced productivity whilst also focusing on clinician wellbeing and realistic caseload management.	

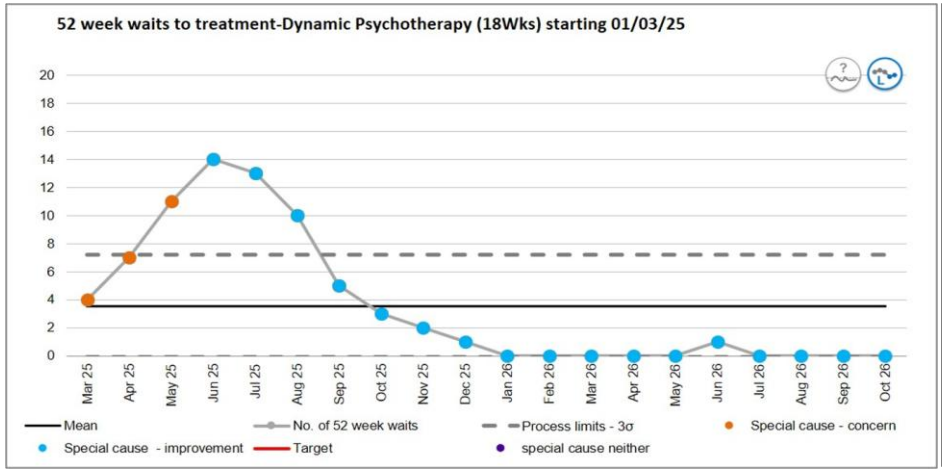
Achievements

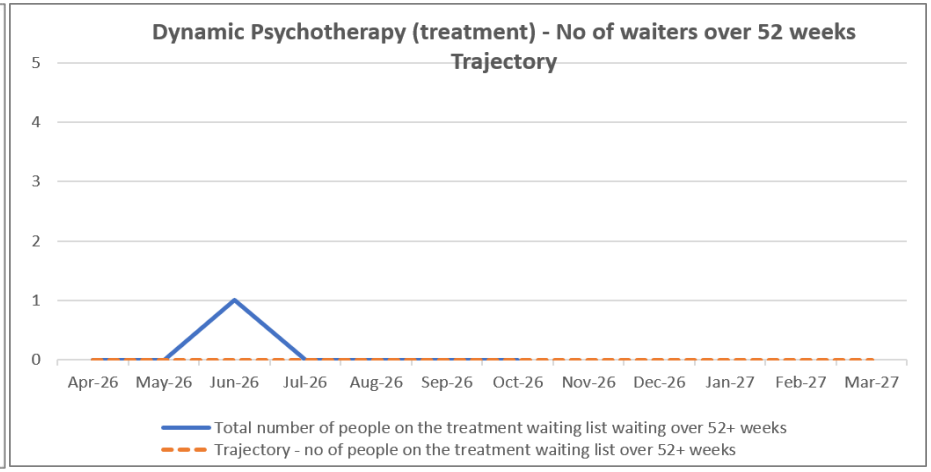
Maintaining 100% compliance for 13 week access KPI for past 12 months and maintaining progress with continual reduction of numbers of 52 weeks waiters in line with current trajectory.

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

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

Mean	Lower Process Limit	Upper Process Limit
3.6	-0.9	7.2





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 special cause for improvement.

Operational Commentary

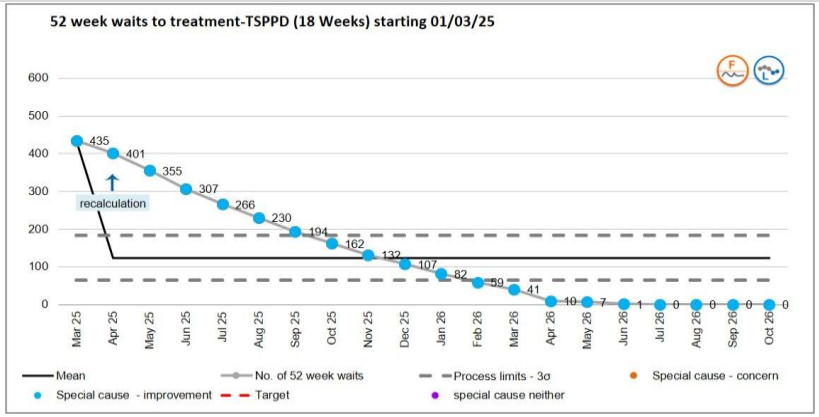
Actions	Timescales	Consequences	RAG
From 2/11/26 all referrals to DPS will go through the Neighbourhood Mental Health Teams, with adjustments to the new front door process enabling referrals to be picked up following discussion in the consultor meeting/daily huddle.	Complete	Joined-up approach will improve flow, ensure patients are seen by the most appropriate service and reduce repeat assessments.	

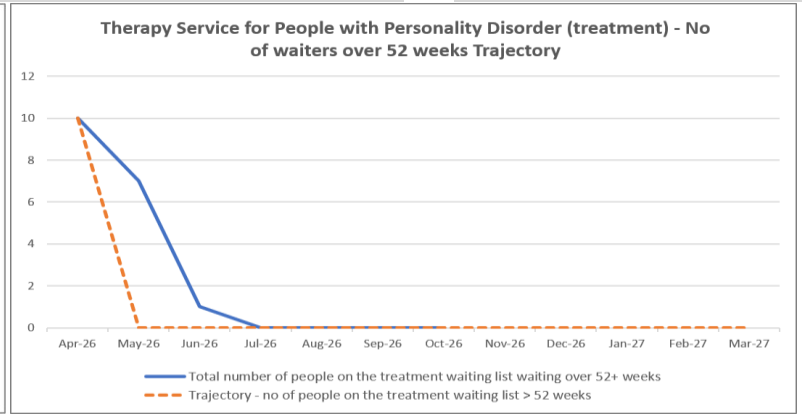
Achievements

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

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

Mean	Lower Process Limit	Upper Process Limit
123.9	64.6	183.2





Analytical Commentary

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

Operational Commentary

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 cohorts to continue in City East and City West throughout Autumn/Winter. Training cohorts in Hinckley, Bosworth, Blaby and Oadby, Wigston, Harborough will run in Jan-April 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. Implementation 2nd November 2026.	Complete	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. Working group to continue led by Suki Basey (Consultant Psychology Lead, Neighbourhood Mental Health Teams).	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 continue until Dec 2026. Comms and engagement for urgent care and inpatient services to be arranged.	Jan-27	Improve service offer, increase efficiency, and reduce waits.	

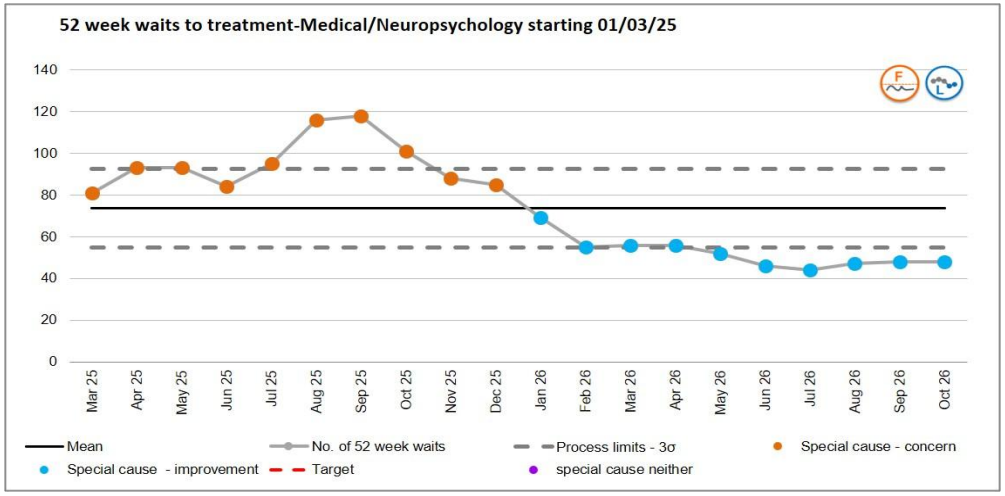
Achievements

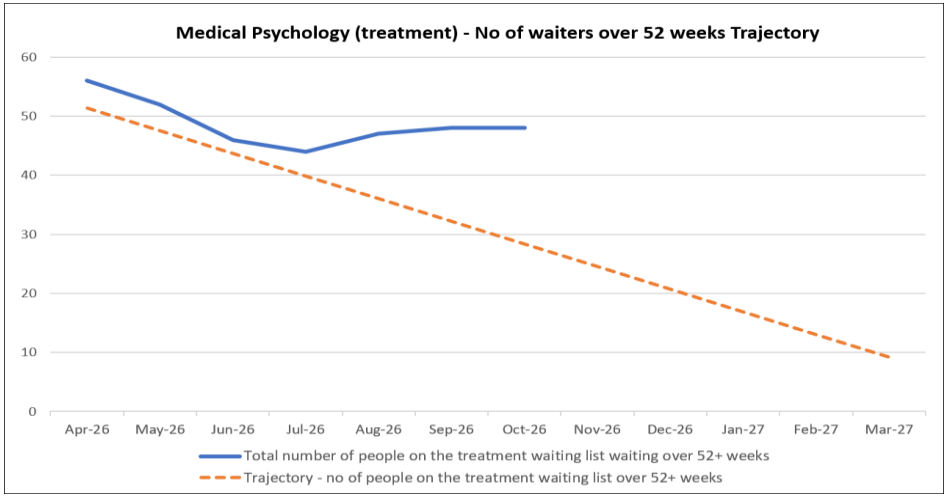
TSPPD referrals now come through Neighbourhood Teams

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

DMH	Target	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
	0	88	85	69	55	56	56	52	46	44	47	48	48

Mean	Lower Process Limit	Upper Process Limit
73.8	54.9	92.7





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

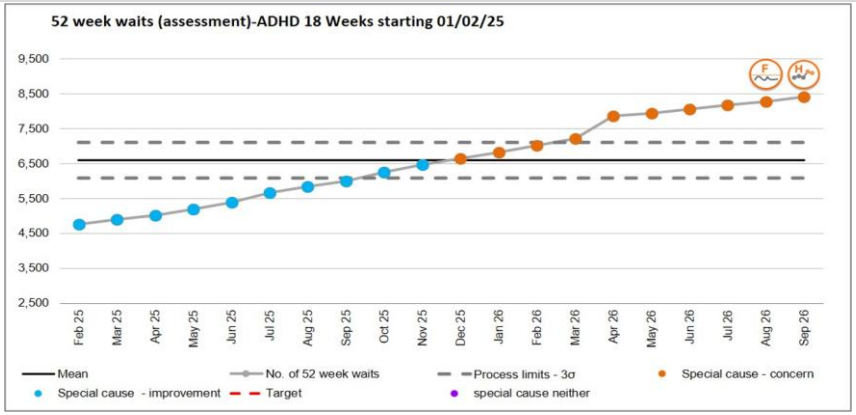
Actions	Timescales	Consequences	RAG
Exploring new opportunities to reduce waits to treatment recognising the challenge in the context of referral volumes and staffing capacity.	Dec-26	New models of delivery will support reduced waiting times.	
Maintain oversight of increasing referrals for cancer with associated risk of increased waits.	Dec-26	Early sight of pressures enables escalatation as required.	

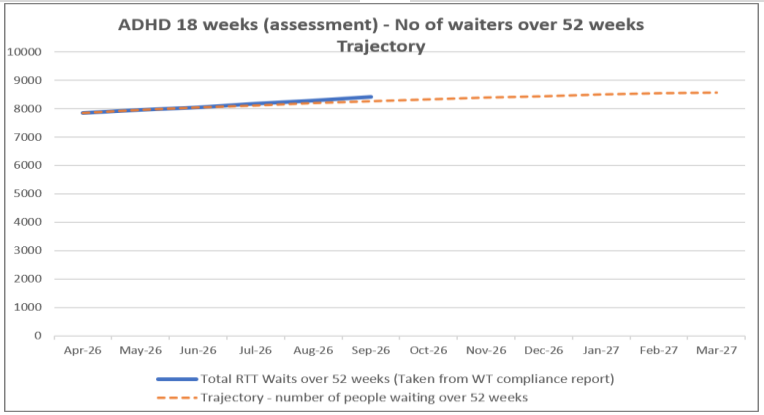
Achievements

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

DMH	Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
	0	6250	6464	6639	6830	7023	7211	7860	7951	8053	8181	8278	8414

Mean	Lower Process Limit	Upper Process Limit
6595.6	6083.6	7107.5





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

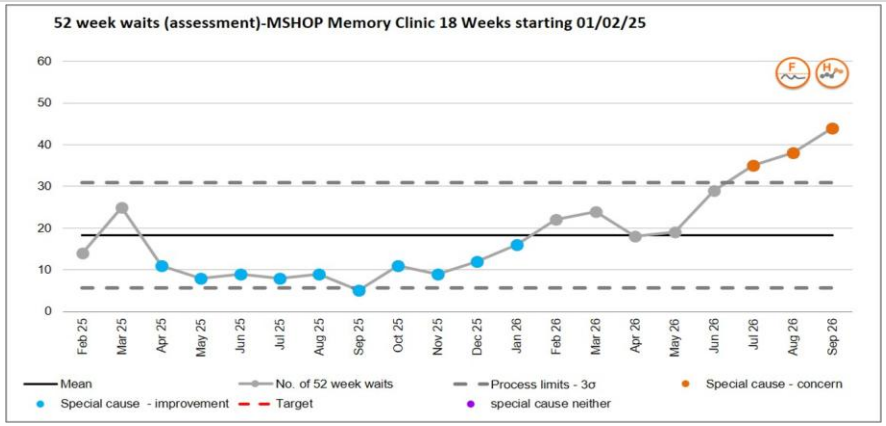
Actions	Timescales	Consequences	RAG
System-wide transformation of ADHD pathway will to improve access and reduce waiting times. Will focus on piloting AI Scribe to support improved efficiency across the pathway enabling increased availability of clinical appointments. Working with ICB and HEIM to assess opportunites 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.	
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, LHIS, 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.	
New provider (COGS AI) commissioned for pre/post diagnostic support.	Complete	Psychological and psychoeducation support provided to patients whilst waiting.	

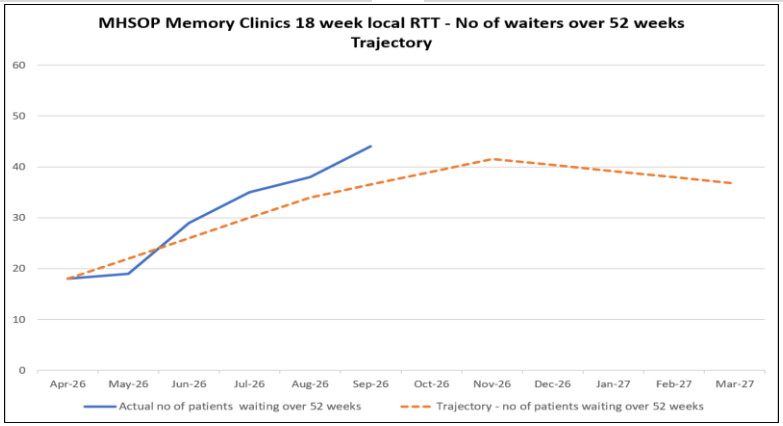
Achievements

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

DMH	Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
	0	11	9	12	16	22	24	18	19	29	35	38	44

Mean	Lower Process Limit	Upper Process Limit
18.3	5.7	30.9





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.	
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 substantivley resolve capacity gap. Additional capacity commenced August 2026 enabling Saturday clinics to increase assessment capacity. 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.	Sep-26	Increase capacity enabling waiting times / number of over 52 waits to be reduced.	
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.

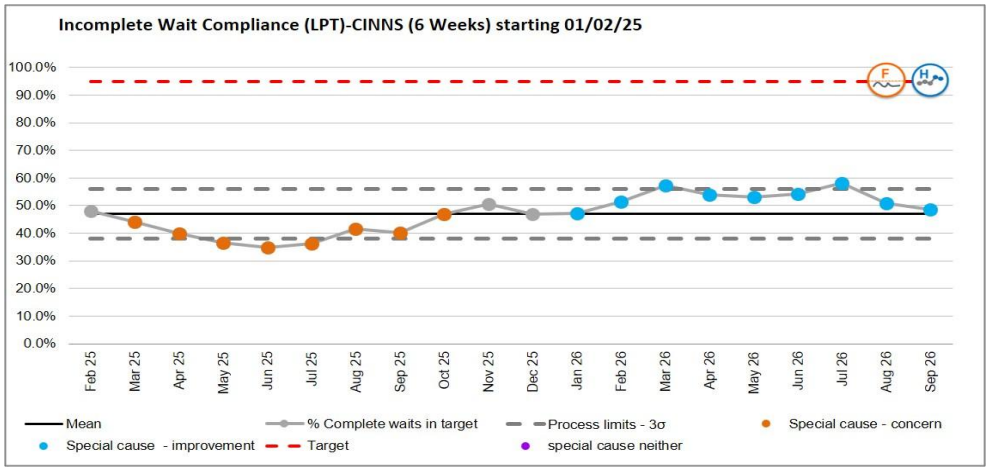
Operational Performance - CHS Waiting Times Dashboard

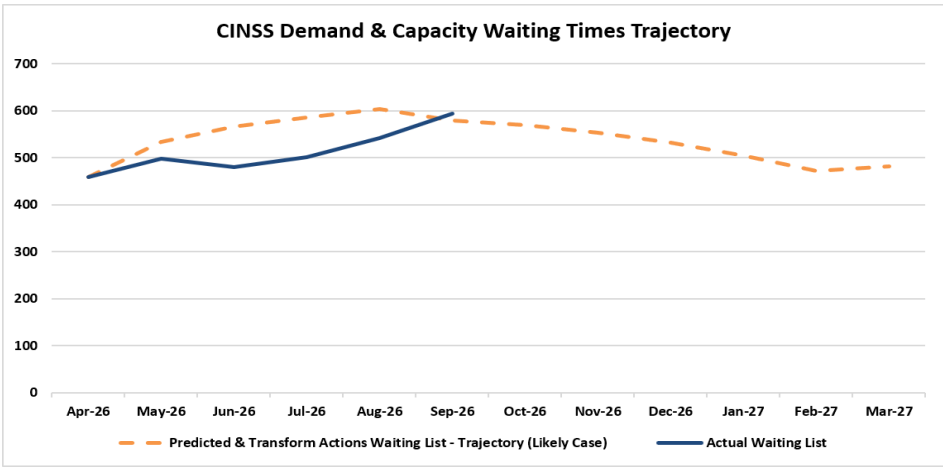
Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Operational Performance - Access Waiting Times	TRUST	Monthly (In Arrears)	CINSS (6 weeks) - Incomplete Pathway	>=95%	Sep-26	48.5%	50.7%				
	TRUST	Monthly (In Arrears)	Speech Therapy - Voice, Respiratory and Dysfluency - Routine (6 weeks) - Incomplete Pathway	>=95%	Sep-26	64.3%	53.0%				

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

CHS	Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
	>=95%	46.9%	50.6%	46.9%	47.3%	51.4%	57.4%	54.0%	53.0%	54.2%	58.2%	50.7%	48.5%
No of Referrals		188	178	180	174	169	212	181	178	203	222	200	213

Mean	Lower Process Limit	Upper Process Limit
47.0%	38.0%	56.0%





Analytical Commentary

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

Operational Commentary

Actions	Timescales	Consequences	RAG
Energy Management Group to be rolled out	Dec-26	Increase capacity and throughput of patients; reduce numbers waiting	
Re-exploring bank opportunities across Physio & OT	Complete	Increase capacity and throughput of patients; reduce numbers waiting	
Dictation software option has been approved and funded - CINSS priority service	Apr-27	Releasing Time to Care	
SystmOne holistic templates to be reviewed - change request to be submitted	Nov-26	Releasing Time to Care	
Scoping Face to Face Group work for executive functioning	Apr-27	Increase in productivity	
Explore options for Clinical Assessment Day (CAD)	t.b.c.	Increase in productivity	

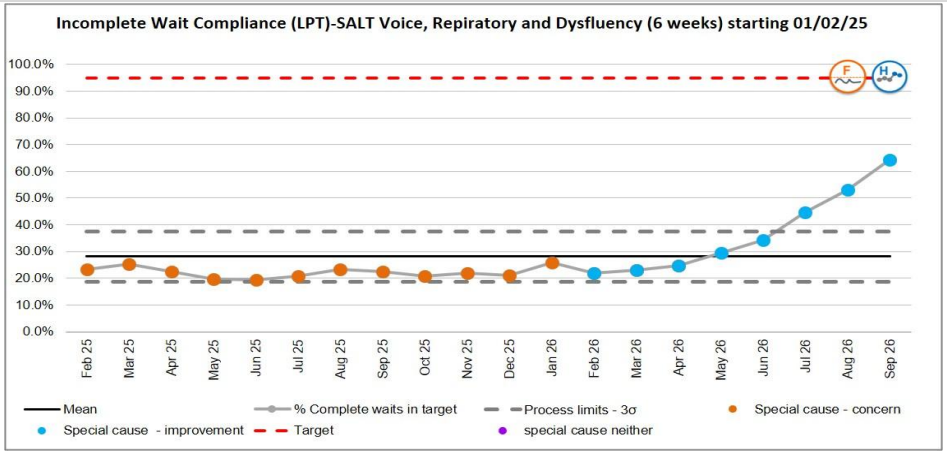
Achievements

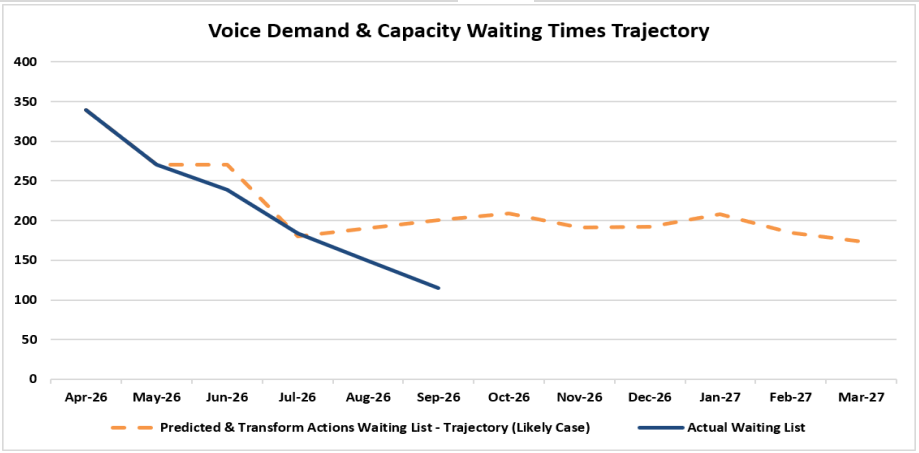
95th percentile waiting list is now 16 weeks. All patients waiting over 17 weeks have an appointment booked in the next 6 we eks. 93.59% of patients are waiting within 18 weeks.

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

CHS	Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
	>=95%	20.7%	21.9%	21.2%	25.9%	22.0%	23.1%	24.6%	29.6%	34.2%	44.6%	53.0%	64.3%
No of Referrals		72	56	74	88	45	63	69	57	74	70	63	66

Mean	Lower Process Limit	Upper Process Limit
28.1%	19.0%	38.0%





Analytical Commentary

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

Operational Commentary

Actions	Timescales	Consequences	RAG
Recruitment to voice therapist vacancy	Nov-26	Increase clinical capacity; reduce waiting list.	

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 13 weeks.

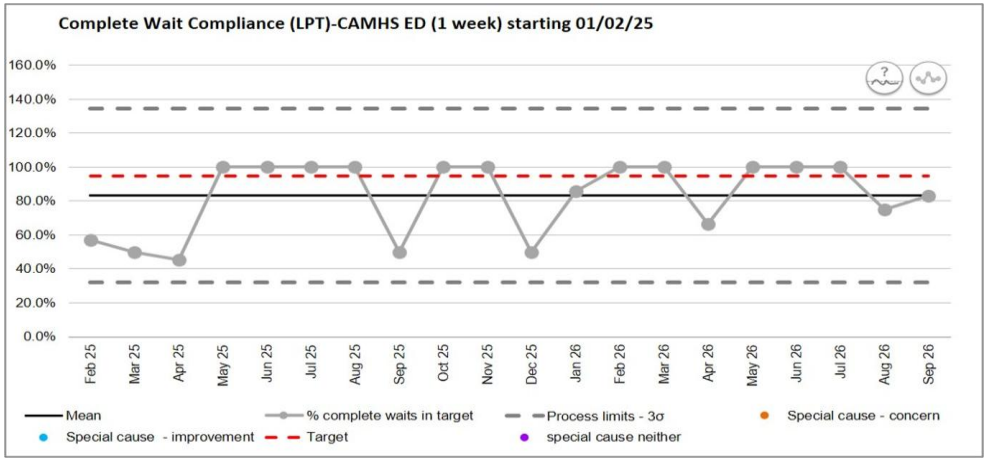
Operational Performance - FYPCLDA Waiting Times Dashboard

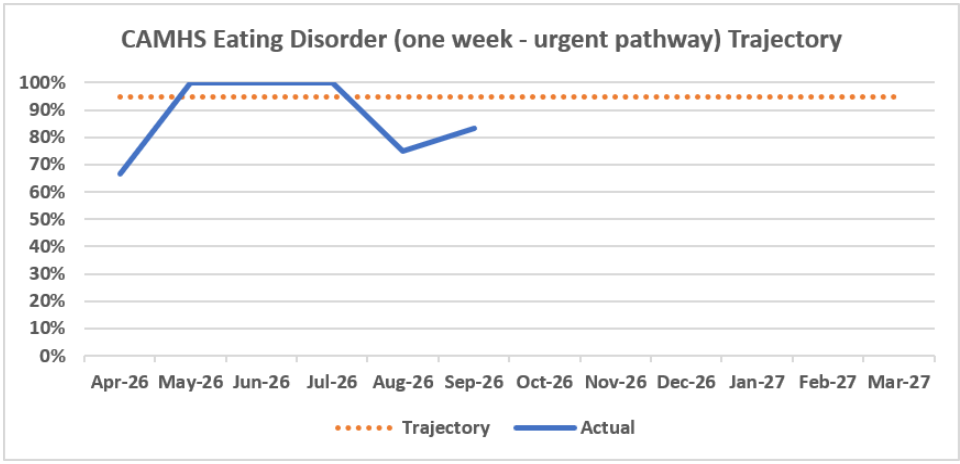
Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Operational Performance - Access Waiting Times	TRUST	Monthly (In Arrears)	CAMHS Eating Disorder (one week) - Complete pathway	>=95%	Sep-26	83.3%	75.0%				
	TRUST	Monthly (In Arrears)	CAMHS Eating Disorder (four weeks) - Complete pathway	>=95%	Sep-26	92.9%	80.0%				
	TRUST	Monthly (In Arrears)	Community Paediatrics (18 weeks) - Incomplete pathway	>=92%	Sep-26	6.6%	7.1%				
	TRUST	Monthly (In Arrears)	Childrens Audiology (6 week wait for diagnostic procedures) - Incomplete pathway	>=99%	Sep-26	31.0%	29.5%				
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)		Oct-26	31.6%	40.7%				
	TRUST	Monthly	(5-18yrs) Percent of RHAs sent to LA in month within 12 months of previous assessment (City/County/Rutland)		Oct-26	98.7%	97.4%				
	TRUST	Monthly	(0-4yrs) Percent of RHAs sent to LA in month within 6 months of previous assessment (City/County/Rutland)		Oct-26	82.8%	93.5%				
Operational Performance - 52 Week Waits	TRUST	Monthly (In Arrears)	Community Paediatrics - assessment waits over 52 weeks - No of waiters	0	Sep-26	7831	7834				
	TRUST	Monthly (In Arrears)	Community Paediatrics - assessment waits over 52 weeks - Longest waiter (weeks)		Sep-26	246	242				
	TRUST	Monthly	Community Paediatrics Treatment (excl ND) - No of waiters	0	Oct-26	0	0				
	TRUST	Monthly	Community Paediatrics Treatment (excl ND) - Longest waiter		Oct-26	33	44				
	TRUST	Monthly	All Neurodevelopment (inc CAMHS, SALT, PAEDS) - Treatment waits - No of waiters	0	Oct-26	1558	1582				
	TRUST	Monthly	All Neurodevelopment (inc CAMHS, SALT, PAEDS) - Treatment waits - Longest waiter (weeks)		Oct-26	252	246				
	TRUST	Monthly	CAMHS - Treatment waits (excl ND) - No of waiters	0	Oct-26	0	0				
	TRUST	Monthly	CAMHS - Treatment waits (excl ND) - Longest waiter (weeks)		Oct-26	0	0				
	TRUST	Monthly	All LD - Treatment waits - No of waiters	0	Oct-26	0	0				
	TRUST	Monthly	All LD - Treatment waits - Longest waiter (weeks)		Oct-26	39	51				
	TRUST	Monthly	Children's Physiotherapy - No of waiters	0	Oct-26	0	0				
	TRUST	Monthly	Children's Physiotherapy - Longest waiter		Oct-26	36	44				
	TRUST	Monthly	Audiology - No of waiters	0	Oct-26	0	0				
	TRUST	Monthly	Audiology - Longest waiter		Oct-26	31	33				
	TRUST	Monthly	Adult Eating Disorders Community - Treatment waits - No of waiters	0	Oct-26	0	0				
	TRUST	Monthly	Adult Eating Disorders Community - Treatment waits - Longest waiter (weeks)		Oct-26	46	46				

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

FYPCLDA	Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
	>=95%	100.0%	100.0%	50.0%	85.7%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	75.0%	83.3%
No of Referrals		5	1	3	10	4	1	3	1	1	6	5	6

Mean	Lower Process Limit	Upper Process Limit
83.2%	32.0%	134.0%





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
Daily service led PTL's with bi-weekly oversight PTL supported by the Business Team.	Complete	Early intervention where children at risk of breaching target so improving adherence to KPI	

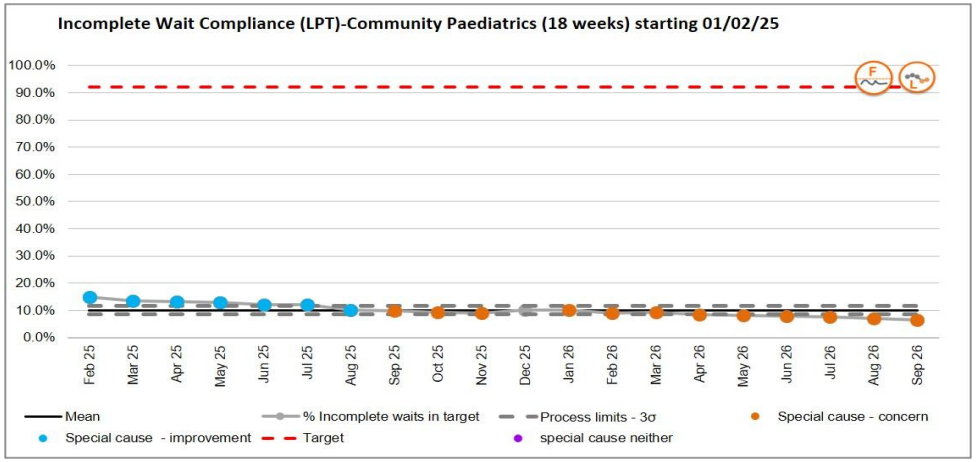
Achievements

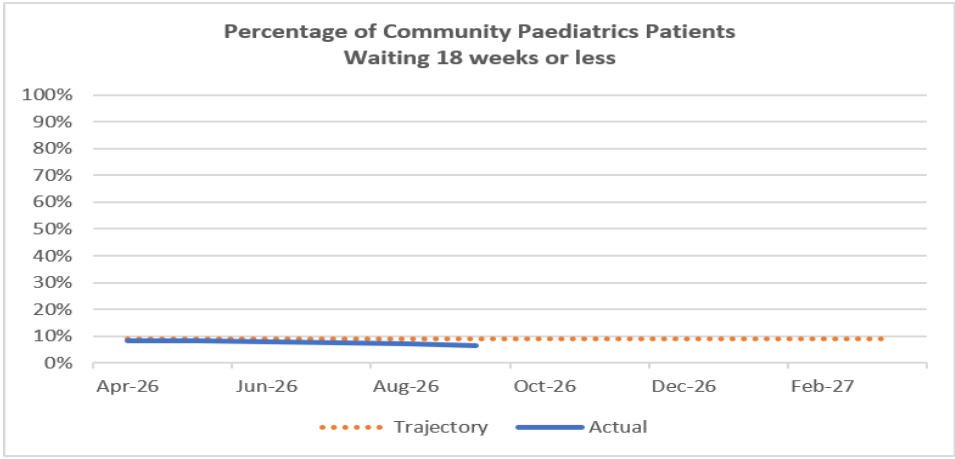
Target achieved for 7 out of last 12 months. Improvement in compliance for September.

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

FYPCLDA	Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
	>=92%	9.3%	9.0%	10.1%	10.0%	9.1%	9.4%	8.3%	8.1%	7.8%	7.6%	7.1%	6.6%
No of Referrals		295	226	278	299	377	446	176	191	205	220	116	191

Mean	Lower Process Limit	Upper Process Limit
10.1%	8.0%	12.0%





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

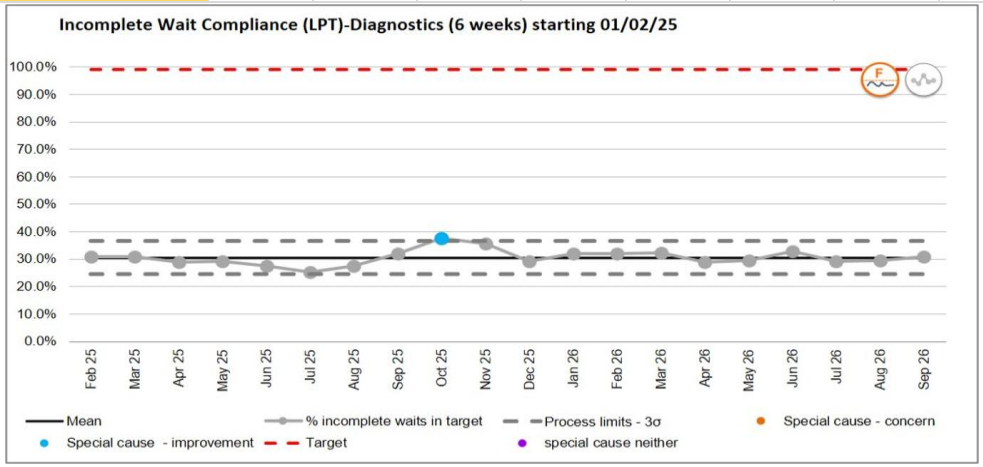
Actions	Timescales	Consequences	RAG
Recruitment and onboarding of non-medical prescriber.	Complete	Increased capacity enabling increased throughput to enable waiting times to be reduced.	
Participation in piloting the ND profiling tool	Nov-26	Provide support at early identification stage, which may reduce demand for specialist assessment and treatment.	
Implementation Plan for the single ND front door transformation programme to be agreed with associated timescales and task & finish groups.	Nov-26	Streamline service provision	

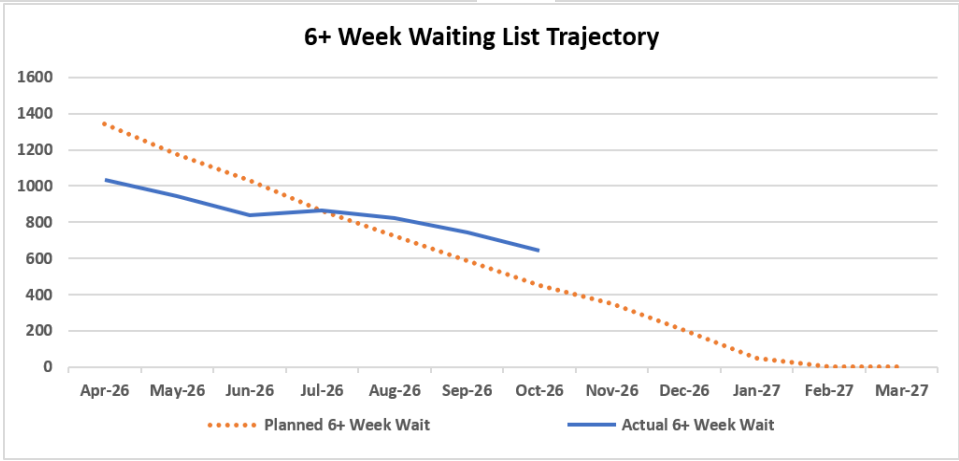
Achievements

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

FYPCLDA	Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
	>=99%	37.6%	35.7%	29.2%	32.0%	32.0%	32.4%	28.8%	29.4%	32.9%	29.1%	29.5%	31.0%
No of Referrals		271	205	166	238	255	292	243	179	249	194	167	198

Mean	Lower Process Limit	Upper Process Limit
30.6%	25.0%	37.0%





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 - UPDATE: Handover of new estate delayed due to additional capital works on site.	Sep-26	Increased capacity, reduced requirement for repeat tests to support maximim throughput.	
Recruitment to all vacant posts	COMPLETE	Fully established service	

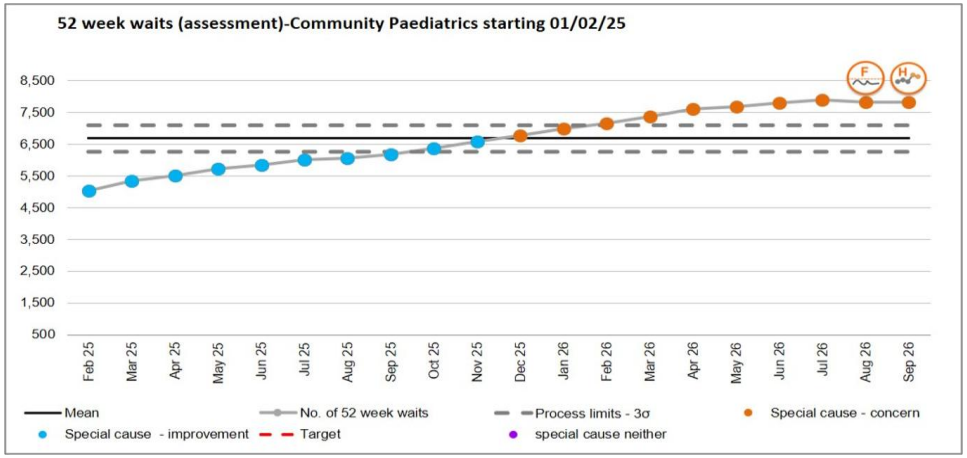
Achievements

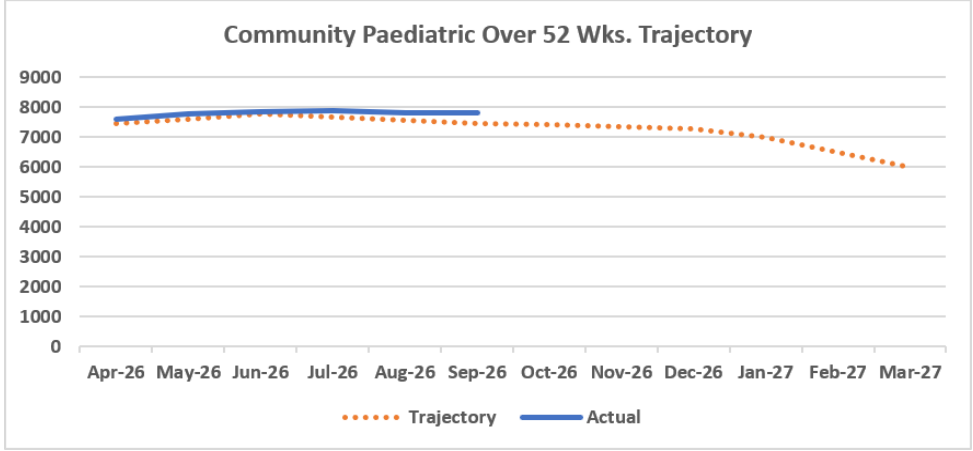
No +52 week waits for past 2 months alongside improving compliance for wider 6 week target despite increasing numbers waiting .

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

FYPCLDA	Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
	0	6380	6585	6782	7003	7154	7385	7604	7684	7795	7899	7834	7831

Mean	Lower Process Limit	Upper Process Limit
6683.8	6274.58	7093.02





Analytical Commentary

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

Operational Commentary

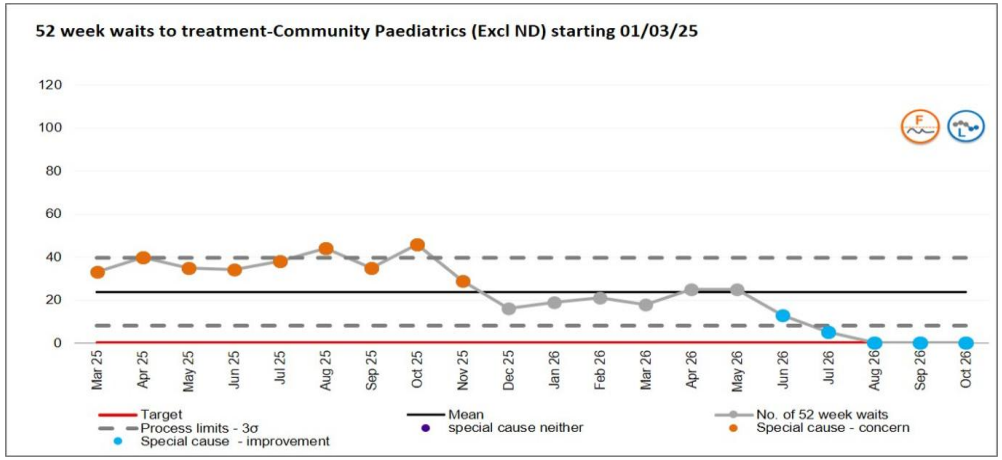
Actions	Timescales	Consequences	RAG
Recruitment and onboarding of non-medical prescribers.	Complete	Increased capacity enabling increased throughput to enable waiting times to be reduced.	
Participation in piloting the ND profiling tool	Nov-26	Provide support at early identification stage, which may reduce demand for specialist assessment and treatment.	
Implementation Plan for the single ND front door transformation programme to be agreed with associated timescales and task & finish groups.	Nov-26	Streamline service provision	

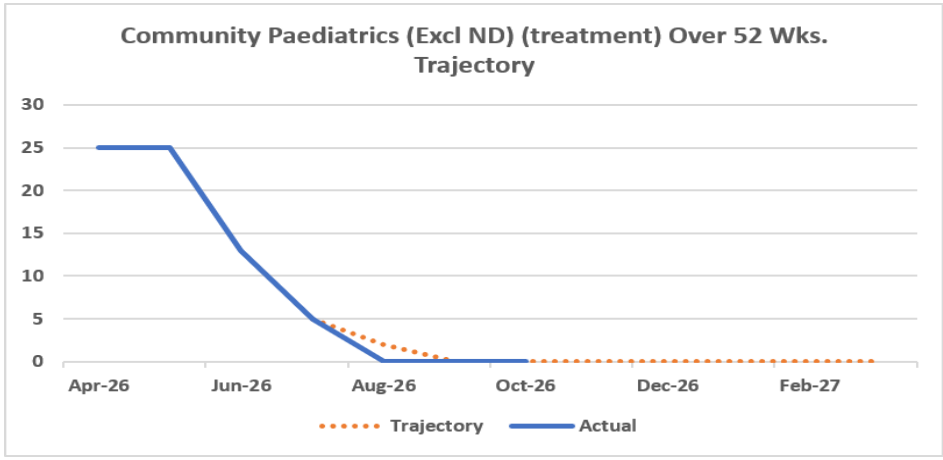
Achievements

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

FYPCLDA	Target	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
	0	29	16	19	21	18	25	25	13	5	0	0	0

Mean	Lower Process Limit	Upper Process Limit
23.8	7.98	39.62





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

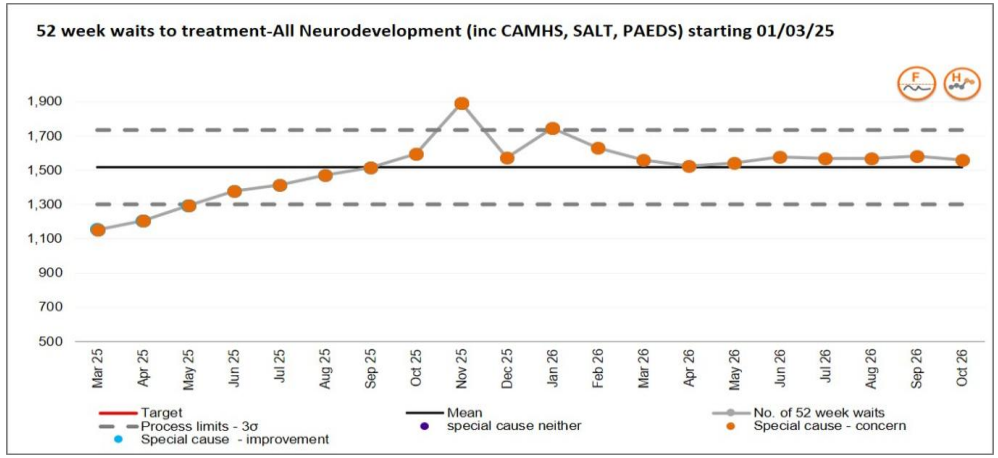
Achievements

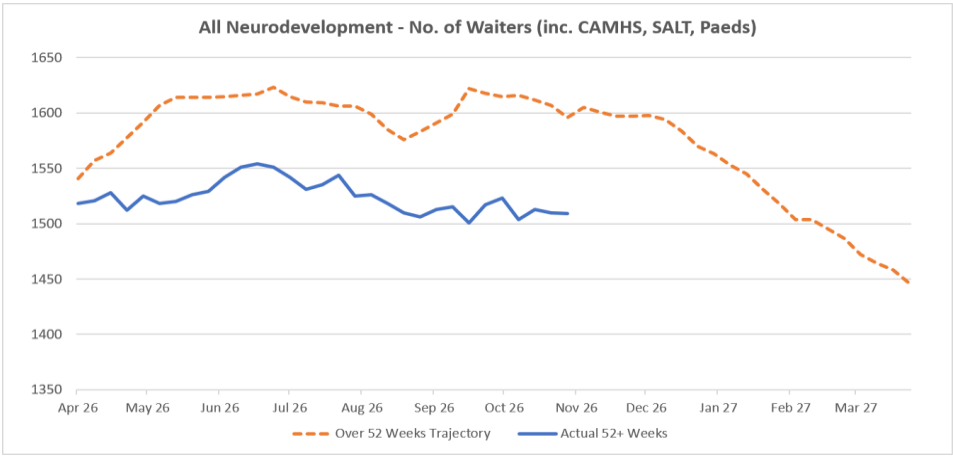
Zero 52 week waits posiiton sustained

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

FYPCLDA	Target	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
	0	1893	1575	1747	1632	1562	1523	1544	1578	1570	1568	1582	1558

Mean	Lower Process Limit	Upper Process Limit
1518.4	1300.65	1736.05





Analytical Commentary

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

Operational Commentary

Actions	Timescales	Consequences	RAG
Recruitment and onboarding of non-medical prescribers for CAMHS with 6 out of 14 in process of completing competencies. Prescribers for Comm Paeds in situ	Sep-26	Increased capacity enabling increased throughput to enable waiting times to be reduced.	
Participation in piloting the ND profiling tool	Nov-26	Provide support at early identification stage, which may reduce demand for specialist assessment and treatment.	
Implementation Plan for the single ND front door transformation programme to be agreed with associated timescales and task & finish groups.	Nov-26	Streamline service provision	

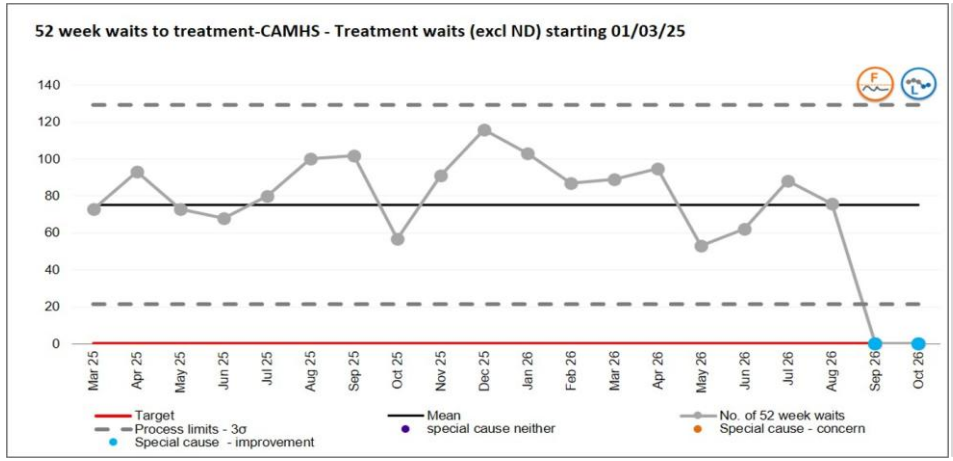
Achievements

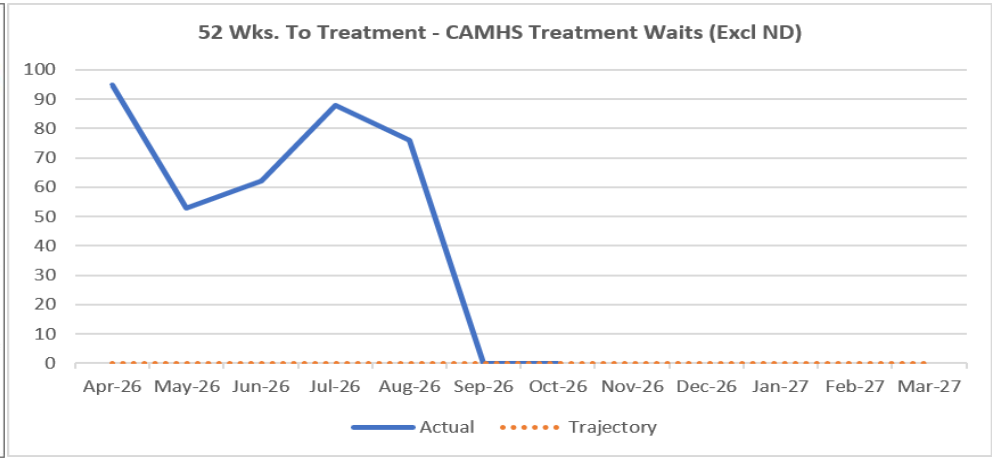
The service is over-delivering on the trajectory for reducing over 52 week waits

EXCEPTION REPORT - CAMHS (excl ND)(follow up waits) - No of waiters over 52 weeks

FYPCLDA	Target	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
	0	91	116	103	87	89	95	53	62	88	76	0	0

Mean	Lower Process Limit	Upper Process Limit
75.3	21.4	129.2





Analytical Commentary

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

Operational Commentary

Actions	Timescales	Consequences	RAG

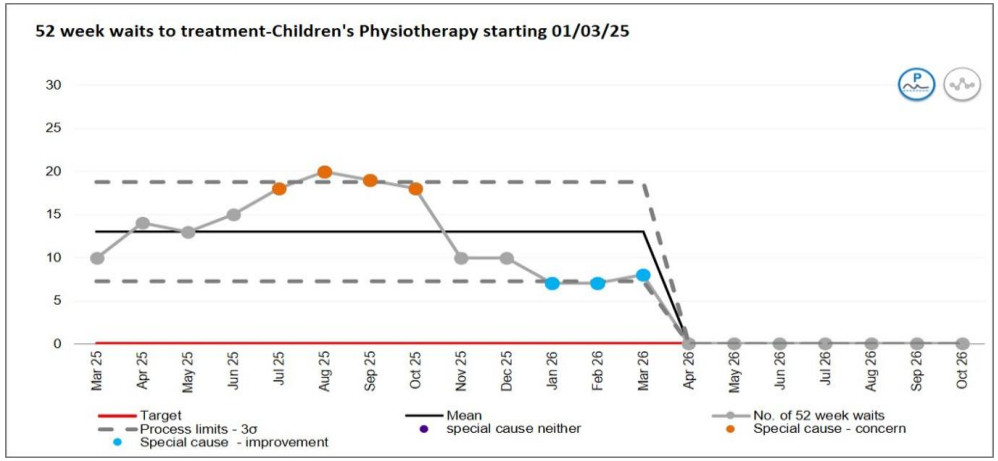
Achievements

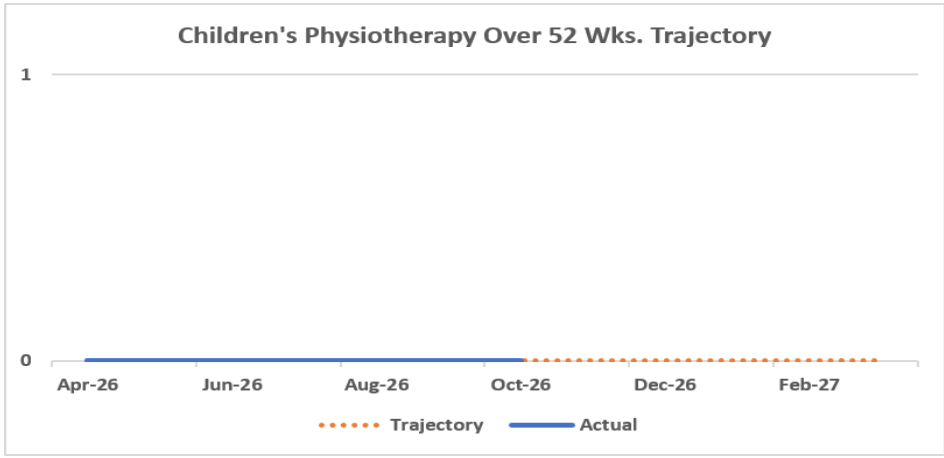
Zero 52 week follow up / treatment waits

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

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

Mean	Lower Process Limit	Upper Process Limit
0	0	0





Analytical Commentary

The metric is showing common cause variation with no significant change. The metric will consistently pass the target.

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 no oveer 52 weektreatment wwaits 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.

P

Leicestershire Partnership NHS Trust

Public Trust Board 24th November 2026

NHSE Core Standards for EPRR – Final Position

EPRR Policy and Resource Approval

Purpose of the Report

This report provides assurance of Leicestershire Partnership NHS Trust's (LPT) compliance with the NHS EPRR Core Standards 2026, aligned to the LPT EPRR Policy and the Civil Contingencies Act (2004).

The report outlines the Trust's final compliance position, including areas of disagreement with NHS England Midlands, and seeks Board approval of the Trust's EPRR and Business Continuity Policy, associated resource allocation and future governance arrangements.

Analysis of the Issue

Compliance with the NHS Core Standards for EPRR

The NHS EPRR Core Standards are assessed annually through an organisational self-assessment, followed by a formal confirm and challenge process undertaken by the relevant Integrated Care Board (ICB) and NHS England Midlands. This process reviews the evidence submitted against each applicable standard to establish the organisation's overall compliance position.

Compliance is measured using a four-tier assurance rating system, as outlined below.

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

T H R I V E

In 2026, LPT was required to report against 58 applicable Core Standards, encompassing 484 individual requirements as detailed within the NHS England Midlands EPRR Core Standards Assurance Guidance, across the 10 domains listed below. Each applicable requirement was individually reviewed and evidenced as part of the Trust's self-assessment. There was no Deep Dive assessment this year.

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

EPRR Core Standards Score – 2025 (previous year)

Following the NHS England and ICB confirm and challenge process, LPT was assessed as Fully Compliant (100%) against the 2025 NHS EPRR Core Standards, with all 58 applicable standards assessed as fully compliant.

EPRR Core Standards Score – 2026 (current)

LPT has completed its self-assessment against the applicable NHS EPRR Core Standards for 2026. Following the ICB and NHS England Midlands confirm and challenge process, the Trust maintains its position of **Full Compliance (100%)** against all applicable standards.

Having achieved Full Compliance in 2025, LPT has maintained this position in its 2026 self-assessment. All applicable standards have been accepted as fully compliant by the ICB and NHS

England Midlands, except for two of the individual requirements to meet Core Standards 2 (EPRR Policy) and 44 (Business Continuity Policy), which remain subject to an unresolved disagreement.

The disagreement relates specifically to the requirement for formal Trust Board approval of these policies and does not relate to the policies themselves or the Trust's arrangements and processes. The Trust maintains its assessment of full compliance, supported by its established governance arrangements and legal advice. This difference in interpretation is outlined below for the Board's consideration.

Core Standards – Areas of Disagreement

Following the confirm and challenge process, NHS England Midlands has challenged LPT's assessment of full compliance against Core Standards 2 (EPRR Policy) and 44 (Business Continuity Policy). The Trust's Business Continuity Policy is incorporated within its overarching EPRR Policy, an established and previously agreed approach to meeting the requirements of both standards.

The challenge centres on the requirement for formal Trust Board approval of these policies. NHS England Midlands' position is that the supporting guidance requires approval directly by the Board, rather than through delegated governance committees; this requirement is not specified within the National framework and only referenced in the guidance for Midlands

The Trust does not agree with this assessment. LPT has established governance arrangements through its EPRR Steering Group and Health and Safety Committee, which provide senior oversight and approval of EPRR and Business Continuity arrangements. The Trust has also sought legal advice, which confirms that Core Standard 2 does not explicitly require Board approval of the EPRR Policy and recognises the general ability of Trust Boards to delegate policy approval functions in line with NHSE Insightful Boards.

The legal advice also recognises the requirement for top management approval of the Business Continuity Policy, which has been interpreted as the Board by the Midlands team

The Trust therefore maintains its 2026 self-assessment of full compliance, recognising that the disagreement relates to the interpretation and application of policy approval requirements by NHSE Midlands, rather than the existence or operational effectiveness of the Trust's EPRR and Business Continuity arrangements.

NHS England Midlands has maintained its challenge to this assessment and advised that for them the relevant standards are not recorded as fully compliant. This position is explicitly brought to the Board's attention for consideration alongside the Trust's final compliance assessment.

EPRR Policy, Resource Approval and Governance Arrangements

To strengthen governance arrangements for the 2026/2027 Core Standards assessment cycle, the Trust is seeking formal Board approval of the existing LPT EPRR Policy (Version 8.4), provided at **Appendix 1**, which incorporates the Business Continuity Policy.

The policy sets out the Trust's EPRR resource arrangements under **Section 5.4**, including workforce, budget and incident response resources, and its Business Continuity arrangements under **Section 7.0**.

The Trust also seeks to formalise the ongoing governance arrangements for the policy, with responsibility for routine review and maintenance continuing through the EPRR Steering Group and

Health and Safety Committee, with appropriate delegated authority documented within the Trust's governance framework.

Proposal

To provide assurance of LPT's final 2026 EPRR Core Standards compliance position and seek formal Board approval of the Trust's EPRR Policy, associated resource arrangements and future governance arrangements.

Decision Required

The Trust Board is asked to:

1. **Endorse** LPT's final 2026 EPRR Core Standards self-assessment of Full Compliance (100%), acknowledging NHS England Midlands' differing interpretation of Core Standards 2 and 44 and its advice that these standards should not be assessed as fully compliant.

2. **Approve** the existing LPT EPRR Policy (Version 8.4), incorporating the Business Continuity Policy, as provided at Appendix 1.

3. **Approve** the EPRR resource arrangements outlined in Section 5.4 of the policy, in accordance with Core Standard 5 (EPRR Resource).

4. **Approve** the continued review and oversight of the policy through the EPRR Steering Group and Health and Safety Committee, with future policy approval arrangements formalised through the Trust's governance framework, subject to applicable Board approval requirements.

Appendices

Appendix 1 – LPT EPRR Policy (Version 8.4)
Provided as a separate document for Trust Board approval.

Governance Table

For Board and Board Committees:	LPT Trust Board
Paper sponsored by:	Jean Knight – Accountable Emergency Officer
Paper authored by:	Dan Adamson – Shared Head of EPRR
Date submitted:	06/11/2026
Name and date of other committee / forum at which this report / issue was considered:	
Level of assurance gained if considered elsewhere	☐Assured ☐ Partially assured ☐ Not assured
Date of next report:	N/A
THRIVE strategic alignment:	☒ **T**echnology ☒ **H**ealthy communities ☒ **R**esponsive ☒ **I**ncluding everyone ☒ **V**aluing our people ☒ **E**fficient and effective
Board Assurance Framework considerations: (list risk number and title of risk)	BAF 3.1
Is the decision required consistent with LPT's risk appetite:	n/a
False or Misleading Information (FOMI) considerations:	n/a
Positive confirmation that the content does not risk the safety of patients or the public:	Y
Equality considerations:	Y

NHS
Leicestershire Partnership
NHS Trust

T H R I V E

EPRR Policy

This Policy describes how Leicestershire Partnership NHS Trust will comply with all applicable EPRR obligations.

Key words: Emergency Planning, Emergency Preparedness, Business Continuity, Resilience, Major Incident

Version: 8.4

Approved by: Health and Safety Committee

Ratified By: Health and Safety Committee

Date this version was ratified: July 2026

Date issued for publication: 21 July 2026 (Minor Change)

Review date: 31st October 2026

Expiry date: 30th April 2027

Type of Policy: non-clinical

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Policy On A Page

SUMMARY & AIM

This Policy provides the framework which Leicestershire Partnership NHS Trust (LPT) follows in establishing, maintaining and continually improving a Business Continuity Management System and Incident Response Plan that complies with all applicable Emergency Preparedness, Resilience and Response obligations.

KEY REQUIREMENTS

Adherence to the NHS Core Standards for EPRR, which equates to 58 Standards across 10 domains that are applicable to LPT

TARGET AUDIENCE:

All LPT staff

TRAINING

Training identified within this policy is desirable or development for staff and can be accessed locally or through the Trust learning management system (ulearn).

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1.0 Quick look summary

Please note that this is designed to act as a quick reference guide only and is not intended to replace the need to read the full policy.

1.1 Version control and summary of changes

Version number	Date	Comments (description change and amendments)
1	September 2013	New Policy
2	July 2015	Updated to reflect the new policy template, new EPRR guidance and changes in EPRR reporting structures within LPT. Addition of reference to: - • HIS IT Services Recovery Plan • Information Risk Policy
3	July 2016	Updated to reflect the following: • New definition for the term Major Incident Inserted the correct minimum frequency for command post exercises
4	February 2018	Policy Review • Updated definitions that apply to this policy table. References updated
5	March 2021	3.1 Reference to 2015 EPRR framework updated to 2018 4.2 Amendment to state surge capacity plan is validated by LHRP Sub Operational 4.10 Updated to state EPRR Manager will provide quarterly report to the Health and Safety Committee not Finance and Performance Committee.
6	February 2023	Updated aligned to feedback from the EPRR Core Standards Assurance process Oct 2022. Inserted reference to Minimal Occupational Standards Updated continuous improvement section to include the regional shared learning that is

Version number	Date	Comments (description change and amendments)
		coordinated through the LHRP Addition of Key Performance Indicators (KPI)
7	April 2023	Updated post Consultation with NHSE
7.1	July 2023	Addition of EPRR Governance Structure – Appendix 6
8	February 2024	Policy shared for consultation. Updated reference to reviewed NHS Standard Contract 2022/23 (SC 30) Addition of the link to the LPT Risk Appetite Statement p19 para 5.4.2 Strengthened the narrative how the trust capture and embed learning from incident and exercise. P20/21 para 5.4.4 Policy Monitoring Section (Appendix 1) p26 – KPIs updated, and RAG rated
8.1	Apr 2024	Strengthened external supplier paragraph para 3.3 p10
8.2	June 2025	Minor Amends - Admin Update New Policy Template Separated Risk Management for a bespoke section Added documentation retention period Replaced EPRR Manager with Head of EPRR Included and strengthened Resource Section
8.3	March 2026	Admin Update – minor changes
8.4	June 2026	Admin update Added Planned Work Coordination Process (minor) Expanded Site BCP section, inc. Rapid Response Box detail (minor) Minor amendments to improve alignment with current EPRR arrangements, operational resilience and organisational governance

For Further Information Contact:

LPT EPRR Team

lpt.emergencyplanning@nhs.net

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1.2 Key individuals involved in developing and consulting on the document

Name	Designation
Accountable Emergency Officer (AEO)	Deputy CEO/Managing Director
Author(s)	Head of EPRR
Implementation Lead	Head of EPRR
Core policy reviewer group	EPRR Working Group
Wider consultation	Health and Safety Committee
	Trust Policy Experts
NHSE Regional EPRR Team	Regional EPRR Colleagues
LLR ICB and wider Emergency Planning peer group	LLR EPRR Peer Group

1.3 Governance

Level 2 & 3 approving delivery group	Level 1 Committee to ratify policy
EPRR Steering Group & Health and Safety Committee	Quality and Safety Committee

1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 (Amendment) Regulations 2023 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

If you would like a copy of this document in any other format, please contact lpt.corporateaffairs@nhs.net

1.5 Due Regard

LPT will ensure that due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010 (Amendment) Regulations 2023. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.

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- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 3) of this policy

1.6 Definitions that apply to this policy.

Consent: a patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:

- be competent to take the particular decision;
- have received sufficient information to take it and not be acting under duress.

Due Regard: Having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

2.0 Purpose and Introduction/Why do we need this policy

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from severe winter weather to an infectious disease outbreak or a major transport accident. This work is referred to in the health service as 'Emergency Preparedness, Resilience and Response' (EPRR).

The Purpose of the Policy is: -

- To ensure that LPT can provide an effective, robust and co-ordinated response to a disruption to business continuity or to a major incident / emergency that is affecting the wider community, or another NHS funded organisation.

The Objective of this Policy is to provide an EPRR structure through which: -

- LPT can meet its obligations to all appropriate EPRR guidance and the NHS core standards for EPRR; and the Civil Contingencies Act 2004.
- The emergency preparedness, resilience and response roles and responsibilities

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of employees are defined.
- An Incident Response Plan is maintained to implement an effective response to a major incident / emergency.
- The reputation of LPT is not compromised, by failure to adequately plan.
- That LPT shares information with partner agencies to enhance co-ordination and co-operation.
- A comprehensive BCMS is established and maintained, following the principles of PAS 2015 & ISO 22301.
- LPT has identified those activities which are critical to the delivery of patient care.
- The level of risk to the provision of health care is assessed and risk mitigation strategies are applied to reduce the impact of a disruption to business continuity.
- Business continuity plans are developed, tested and regularly reviewed to ensure that LPT can deliver an effective response to a disruption to service delivery.
- An annual cycle of EPRR exercises is held to test the effectiveness of LPT's response to a business continuity disruption and major incident.
- LPT annually reviews the BCMS and emergency preparedness with the aim of agreeing EPRR objectives and strategies to drive continual improvement.
- That in responding to a major incident or business continuity disruption, LPT considers the needs of all communities it serves and ensures that no group is discriminated against.
- The LPT Audit and Assurance Committee and Board can be assured that the BCMS and emergency preparedness is maintained, ensuing that LPT can deliver an effective and robust response to a major incident or business continuity disruption in line with our EPRR obligations. **Appendix 6** illustrates the Governance Structure for EPRR within LPT.

3.0 Policy Requirements

Under the requirements of new NHS EPRR guidance[1] LPT is required to: -

- Have suitable and up to date incident response plans which set out how LPT would respond to and recover from a major incident / emergency which is affecting the wider community or the delivery of services; and
- Adopt business continuity plans to enable LPT to maintain or recover the delivery of critical services in the event of a disruption.

Planning for emergencies has developed significantly since the introduction of statutory duties under the Civil Contingencies Act 2004. 'Category One' responders, must show that that they are working with other responders to assess risks, develop and maintain plans, share information and co-operate on civil contingency response.

[1]NHS England Emergency Preparedness Resilience and Response Framework 2022

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LPT does not meet the legal definition of a Category One, however under EPRR guidance the Department of Health and NHS England expects all NHS funded organisations to plan for and respond to incidents in the same way as a Category One responder, though in a manner which is proportionate to the scale and services provided.

With the aim of developing effective business continuity plans, LPT as an NHS funded organisation is encouraged to develop, maintain and continually improve business continuity management system (BCMS) that follow the principles of ISO 22301 (International Standard for Business Continuity) and the Department of Health PAS 2015 (Framework for health services resilience).

The BCMS establishes a strategic and operational framework, enabling LPT to proactively implement resilience to any disruption to critical activities. Business continuity requires planning across many facets of LPT; therefore, its resilience depends equally on its management and operational staff, as well as technology.

This Policy outlines the organisational arrangements for implementation of the policy and how our emergency preparedness and business continuity plans will respond to incidents which might affect delivery of critical services or affect the wider healthcare community.

This Policy applies to all employees of the organisation, but especially to those with specific responsibility, or accountability for ensuring that LPT complies with its EPRR obligations.

4.0 Duties within the Organisation

4.1 Chief Executive Officer

The Chief Executive Officer has overall responsibility for: -

- Ensuring that the organisation prepares, maintains, reviews and continually improves business continuity plans to maintain or recover the delivery of critical activities during business continuity disruptions.
- Ensuring that the organisation has an Incident Response Plan in place for responding to a major incident or emergency; and
- Appointing a board level member of staff to fulfil the role of the Accountable Emergency Officer (AEO) and ensures that the AEO reports the EPRR preparedness statement at least annually to the board.

4.2 Accountable Emergency Officer

The Accountable Emergency Officer role is fulfilled by the Deputy Chief Executive Officer (DCEO) and is responsible for ensuring that the organisation: -

- Is compliant with the EPRR requirements as set out in the CCA 2004; the

Health and Care Act (2022); NHS EPRR core standards; NHS England Emergency Preparedness, Resilience and Response framework (2022), and the NHS standard contract as applicable.

- Is properly prepared and resourced for dealing with major incident, or emergency.
- Has robust business continuity planning arrangements in place which follow the principles of the Framework for Health Services Resilience (PAS 2015) and ISO 22301.
- Has a robust Incident Response plan that provides an integrated organisational response and that it has been annually signed off by the governing committee for EPRR and shared with the Integrated Care Board (ICB).
- Complies with any requirements of the ICB and NHSE, in respect of the monitoring of compliance against EPRR Standards and Guidance
- Provides NHSE, with such information as it may require for the purpose of discharging its functions.
- Is appropriately represented at, and effectively contributes to, any governance meetings, subgroups or working groups of the LHRP or LRF.
- Can assure the Board that LPT is compliant with all its EPRR obligations and presents a formal report stating the trusts level of preparedness no less than annually.
- In the absence of the AEO a nominated executive will represent the trust at the LHRP and LRF Executive meetings

4.3 Deputy Director of Safety and EPRR

The Shared Deputy Director of Safety and EPRR:

- Has delegated responsibility to oversee the day-to-day management of EPRR for LPT and will escalate matters as required to the AEO.
- Ensures that the Head of EPRR is adequately supported to allow them to fulfil their role and responsibilities.
- Ensures that adequate resources and funds are made available to allow LPT to effectively respond to a disruption to business continuity and to a major incident or emergency.

4.4 Head of EPRR

The Head of EPRR is responsible for:

- Ensuring that LPT meets its statutory obligations under the Civil Contingency Act 2004; EPRR core standards and complies with all relevant EPRR guidance.
- Developing and delivering the LPT's emergency preparedness and business continuity planning, improving standards of emergency preparedness across LPT.

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- Providing leadership on specialist emergency preparedness and resilience issues.
- Reviewing emergency preparedness considering new and emerging risks, recommendations, guidance and statutory requirements and organisational changes.
- Keeping the AEO and Deputy Director of Safety and EPRR updated on matters related to emergency preparedness,
- Ensuring that the organisation maintains an up-to-date Incident Response Plan and has Incident Coordination Centres (ICC) available; this includes the ability to activate a virtual incident response.
- Co-ordinating the development and maintenance of LPT's BCMS.
- Reviewing and updating the LPT Training Needs Analysis (TNA) for EPRR no less than annually
- Providing advice and training to appropriate staff in relation to emergency preparedness, resilience and response.
- Liaising with emergency partners and within the organisation to ensure we can support the response to a major incident or emergency affecting the wider community.
- As appropriate, ensuring post incident reviews are conducted so that lessons may be learned. The post incident review actions are to be monitored by the EPRR team to ensure pan-trust actions are closed and lessons shared.
- Ensuring auditing is undertaken of LPT business continuity plans with the aim of continual improvement in performance.
- Producing an annual EPRR Work Plan that includes training and exercises with the aim of testing the effectiveness of LPT's BCMS and Incident Response, whilst updating EPRR process and procedure aligned to new national guidance, reportable bi-monthly via EPRR Steering Group
- Providing the LPT Health and Safety Committee with quarterly reports on EPRR preparedness.
- Providing the Health and Safety Committee, and Trust Board with an annual report on the performance of LPT's business continuity management system.
- Provision of information to NHSE and the LLR ICB in support of assessment of LPT EPRR preparedness
- Seeking assurance from external service providers that relevant and robust business continuity plans are in place, tested and fit for purpose.
- Supporting relevant teams (IG/LHIS) in the submission of the annual Data Protection and Security Toolkit annual assessment, where relevant to Business Continuity

4.5 Directors of Services

All Directors of Services are responsible for:

- Being familiar with this Policy and to ensure that business continuity is part of the everyday culture of the organisation.
- Ensuring the Policy is followed and implemented within their areas of responsibility.
- Ensuring adequate resources from within their Service are made available to ensure that business continuity plans are developed and maintained.
- Monitoring and auditing of their service's Business Continuity Plans; and
- Testing their plans in line with this policy.

4.6 On-Call Directors and On-Call Managers

On-Call Directors and On-Call Managers are responsible for:

- Ensuring they attend EPRR training when requested and no less than annually.
- Maintaining an awareness of LPT Incident Response Plan and the Business Continuity Management System; and
- Leading the Service or LPT response to a significant disruption to business continuity or a major incident.

4.7 Service Business Continuity Leads

Services Business Continuity Leads are responsible for:

- Supporting and assisting the EPRR Team in the development and maintenance of a Business Continuity Management System and plans and arrangements for responding to a major incident.
- Ensuring that service area business continuity plans are developed and maintained; and
- Ensuring that business continuity arrangements are regularly reviewed tested and maintained.

4.8 Heads of Services

Heads of Service are responsible for:

- Supporting the Service Business Continuity Leads and Head of EPRR in the development, maintenance and further improvement of the BCMS and preparedness for major incidents.
- Ensuring that a suitable business continuity plan is in place for each of their sites and teams.

4.9 Team Managers:

Team Managers are responsible for:

- Ensuring their business continuity plan is up to date and relevant for their site / team / service area, reflecting critical patient functions and the risk to service delivery.
- Ensuring staff and especially those who would be expected to take the lead for their site / team / ward, understand their role under the business continuity plan to ensure a prompt and effective response to any disruption to business continuity.

4.10 All Staff:

All Staff must ensure they:

- Are familiar with their site / team Business Continuity Plan.
- Undertake basic awareness training in emergency response.
- Understand where to locate emergency resources in an incident and understand what action to take.
- Staff at all levels are responsible for building, promoting and embedding a business continuity culture that reflects our organisational core values and vision to achieve our strategic objectives.

4.11 Health & Safety Committee

The LPT Health & Safety Committee and Directorate Health, Safety and Security Action Groups are responsible for:

- Providing opportunities within existing meetings for the consideration of EPRR issues, approving actions as necessary to ensure LPT maintains effective emergency plans and Business Continuity Management System.
- Have sign off authority of EPRR plans and Policy post a period of consultation.

5.0 Building and Maintaining EPRR

PAS 2015 promotes the use of the Integrated Emergency Management (IEM) approach to building resilience within NHS funded organisations. IEM is based on following a life cycle of planning, testing, reviewing and the setting of fresh objectives or targets to drive continual improvements in an organisation's emergency preparedness.

Through IEM, LPT assures itself that it has developed flexible and adaptable plans, enabling the implementation of an effective response to a disruption to LPT business continuity or to a major incident affecting the wider community.

5.1 The Principles of Integrated Emergency Management

Table 1: Principles of Integrated Emergency Management

	LPT achieves this in the following ways:
Anticipate	Through horizon scanning, gain an awareness of the hazards that could affect LPT service delivery.
Assess / Prevent	Assess the likely impact of hazards on LPT's critical services and identify measures to prevent or mitigate the hazards.
Prepare	Develop business continuity plans, hazard specific incident response plans and supporting planning arrangement to ensure LPT is prepared to respond to disruptions to business continuity.
Respond	Adoption of tried and tested Incident Response Plan to ensure LPT can implement an effective response to a major incident or disruption to business continuity.
Recover	To be able to manage the longer-term consequences of a disruption to business continuity or major incident and to be able to recover normal levels of service delivery as quickly as possible.

5.2 The Civil Contingencies Act 2004

The principles of Integrated Emergency Management; dovetails with LPT's EPRR obligations as an NHS funded organisation, under the Civil Contingencies Act 2004, and with the principles of ISO 22301 and obligations under PAS 2015 and National EPRR guidance. Several of LPT's obligations to the Civil Contingencies Act 2004 will be achieved through co-operation and joint working with healthcare and emergency planning partners under the activities of the Leicestershire Leicester & Rutland (LLR) Local Resilience Forum (known as LLR Prepared). Table 2 outlines how LPT will meet the obligations to the Civil Contingencies Act 2004.

EPRR Obligations under the Civil Contingencies Act 2004		**How the Obligation is met by LPT**
Co-operation and Sharing information	• Co-operate with other responder organisations to enhance co-ordination and efficiency when planning for an emergency.	• Executive Director representation on the LRF Executive Group • Senior Manager Representation on the Local Health Resilience Partnership (LHRP)

EPRR Obligations under the Civil Contingencies Act 2004		How the Obligation is met by LPT
	• Co-operate with other responder organisations to enhance coordination and efficiency when responding to and recovering from an emergency. • Share information with other local responder organisations to enhance co-ordination both ahead of and during an emergency.	• Head of EPRR membership of the Health Emergency Planning Operational Group (HEPOG). • Membership of the LLR Prepared (Local Resilience Forum) sub-groups. • Day to day co-operation between LPT Head of EPRR and equivalents in partner agencies. • Day to day co-operation between LPT senior staff and equivalents with partner agencies. • Sharing appropriate information with partner agencies in planning for and responding to a major incident. • Under the LHRP Memorandum of Understanding NHS England are empowered to call upon the resources of LPT to assist in the response to a major incident. • Annual membership to the LRF
Risk assessment	• Assess the risk of emergencies occurring within their area and use this to inform contingency planning. • Collaborate with other organisations to compile community, local or national risk registers. • Ensure internal corporate risk management processes include risk to continuation of services.	• LLR Prepared undertakes risk assessment of the hazards within Leicestershire. LPT reviews this work in considering the risk to this organisation. • LPT will support the LLR Prepared objective to deliver an annual review of the hazards in Leicester, Leicestershire and Rutland. • LPT Risk Management Strategy requires LPT to assess the risks to the Trust's Strategic objectives, including those risks with potential to affect service delivery. • LPT carries out an annual business continuity risk assessment of the implications on LPT of the hazards present within Leicestershire.

EPRR Obligations under the Civil Contingencies Act 2004		How the Obligation is met by LPT
		• LPT standard business continuity plan requires sites and services to identify the key risks to service delivery.
Emergency planning	• Ensure emergency plans are in place to respond to emergencies. • Ensure validation and exercising of emergency plans. • Ensure appropriate senior level command and decision making is available 24/7. • Ensure appropriate Incident Coordination Centre (ICC) facilities are available to control and coordinate the response to an emergency. • Ensure relevant response staff are trained to an appropriate level for their roles. • Ensure robust communication mechanisms.	• Development and maintenance of a Incident Response Plan, hazard specific incident response plans and business continuity plans to enable LPT to implement an effective response 24/7 to a major incident or significant disruption to business continuity. • Availability of an Incident Coordination Centre, 24/7. • Trained LPT Directors responsible for managing the LPT response to a major incident or serious disruption to business continuity. • Trained LPT Managers responsible for managing a site or service response to a serious disruption to business continuity. • Agreed mutual aid to and from health providers and partner agencies in support of the response to an emergency or major incident.
Warning & informing	• Maintain arrangements to make information available to the public on emergency preparedness matters. • Maintain arrangements to warn inform and advise the public in the event of an emergency.	• LPT co-ordinates activities with LLR Prepared partners on sharing information with the public on preparing for emergencies and during the response to emergencies. • LPT releases appropriate information to the public on its EPRR preparedness. • In the event of a disruption to service provision, LPT would use all available and appropriate routes to inform service users and the wider public of the nature of the disruption and LPT's efforts

EPRR Obligations under the Civil Contingencies Act 2004		How the Obligation is met by LPT
		to maintain or recover services delivery.
Business continuity	• To maintain plans to ensure that we can continue to deliver functions in the event of an emergency as far as is reasonably practicable. • Assess both internal and external risks whilst developing and reviewing Business Continuity Plans.	• Development and maintenance of a Business Continuity Management System following the principles of ISO 22301 and PAS 2015. • Annually review the Business Continuity Management System to demonstrate continuous improvement. • Sites and Services required to have a Business Continuity Plan, utilising the LPT standard template. • Agreed mutual aid to and from health providers and partner agencies in support of the response to a disruption to business continuity.

Table 2: Obligations under Civil Contingencies Act 2004

5.3 Risk Management

Using the LLR Prepared Community Risk Register the Head of EPRR undertakes an annual review of the hazards present within Leicester, Leicestershire and Rutland to determine the implications for LPT. The Head of EPRR will maintain an EPRR Risk Register that considers and scores against relevant risks using the Trust's Risk Scoring Matrix. Where necessary, mitigation measures will be recommended to address any identified risks to service delivery.

Any risk included into the EPRR Risk Register will be recorded on ULYSSES.

LPT Risk Appetite Statement can be found in the **LPT Risk Management Policy, p.15 Section 11**

LPT's risk treatment for identified risks to business continuity is to: -

- Eliminate the risk by removal of the hazard(s).
- Tolerate the level of risk faced, usually due to the low likelihood of the hazard occurring or the presence of existing mitigation measures; or
- Implement appropriate measures to reduce the potential effects of those incidents, such as through adoption of Business Continuity Plans.

5.4 EPRR Resource

It is the responsibility of the Accountable Emergency Officer to ensure LPT is properly prepared and resourced to deal with an incident, from Business Continuity Incident, Critical Incidents and Major Incidents. This includes resources to efficiently enable the planning towards incidents.

5.4.1 EPRR Workforce

The EPRR team consists of the Head of EPRR, EPRR Advisor and EPRR Coordinator. The team report to the Deputy Director of Safety and EPRR.

5.4.2 EPRR Budget

The EPRR team has its own budget allowance/cost code for planned expenditure and is used for on-call arrangements, training, and exercise expenses. This is via the Health and Safety budget and is owned by the Shared Deputy Director of Safety and EPRR.

5.4.3 Incident Response

Strategic Commanders have the authority to commit additional resources required in response to an incident or emergency. They are required to control and capture any financial costs incurred. They will alert the Finance Director during operational hours to any financial commitments made,

It is the Strategic Commanders duty to ascertain if the resources requirement to deal with an incident outweighs the Trust's ability to provide. In those circumstances it will be necessary to escalate the incident from a business continuity incident to a critical incident or major incident through discussion with Leicester, Leicestershire and Rutland Integrated Care Board.

6.0 Incident Response

It is the nature of business continuity disruptions and major incidents or emergencies that they are unpredictable, and each will present a unique set of challenges. Therefore, a key outcome from the EPRR work is the adoption and maintenance of

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plans which would enable LPT to implement a planned, co-ordinated, tested, effective and flexible response.

The intention is that any disruption to business continuity would be tackled by the local service area or site, responding to the cause or incident in line with their local business continuity plans. Where the disruption escalates or is very disruptive from its outset, the response may have to be escalated to senior managers including as appropriate the Trust On-Call Managers and Directors.

Where LPT is alerted to a major incident in LLR or a serious disruption to LPT business continuity, it is the responsibility of the Director On-Call to assess the situation and determine whether to activate the Incident Response Plan and convene an Incident management Team to co-ordinate the LPT response. If deemed appropriate, the Incident Management Team would utilise an LPT ICC (or alternative), which provides the team with a 24/7 resourced centre of operation.

As appropriate, in responding to an incident, LPT may request the support of mutual aid from partner agencies or may itself be asked to provide support to other agencies within Leicestershire, or potentially cross the border in the event of larger and wider scale incidents. Guidance on Mutual Aid can be found at section A13 in the LPT Incident Response Plan.

7.0 Business Continuity

There is an expectation from our service users and their families, the public, NHSE, LLR ICB and partner agencies who we work with, that in the event of a disruption to service provision, LPT can implement a swift recovery of critical activities.

A BCMS following the principles of PAS 2015 and ISO 22301 enables LPT to maintain and continually improve its preparedness for disruptions to business continuity and meet the expectations of our stakeholders.

LPT will follow the principles of Integrated Emergency Management, operating a Business Continuity Management System that follows a life cycle of planning, operating, reviewing and improving business continuity planning.

All business continuity documentation must be reviewed annually.

7.1 Plan and Establish the Business Continuity Management System

The aim of this element of business continuity planning is to: -

- Ensure business continuity planning reflects LPT's Mission, Vision, Values and Strategic Objectives.

- Consider and understand LPT's EPRR statutory duties and obligations, commercial obligations and the views and needs of interested parties.
- Outline the commitment of senior management to the EPRR initiative, especially through the leadership provided by the Board level Accountable Emergency Officer (AEO).
- Provide the necessary resources to facilitate the development of a BCMS; and
- Ensure staff have the awareness and competence to develop and maintain business continuity plans and respond to any disruptions to business continuity.

7.2 Planned Work Coordination

LPT recognises that planned works, service changes, estates activity, infrastructure maintenance, digital change, utility interruptions and contractor activity have the potential to disrupt service delivery and impact patient care if not effectively coordinated.

All planned work with the potential to affect clinical or operational services must be subject to proportionate assessment and coordination arrangements to ensure risks are identified, mitigated and communicated appropriately prior to implementation.

The Planned Work Coordination process supports:

- Identification of potential operational and business continuity impacts.
- Appropriate stakeholder engagement and communication.
- Escalation and approval where required.
- Consideration of contingency arrangements and service recovery actions.
- Coordination between operational services, Estates, Digital, contractors and other relevant teams; and,
- Reduction in the likelihood of avoidable service disruption or incidents arising from planned activity.

The EPRR team acts as a coordinating link between corporate support functions undertaking planned work activities (including Estates, LHIS and external contractors where applicable) and operational services impacted by those activities. This supports early identification of operational risks, appropriate business continuity considerations, effective communication and coordinated mitigation planning to minimise disruption to patient care and service delivery.

Where a planned activity presents a significant risk to service continuity, patient safety, infrastructure, utilities, digital systems or site operations, additional business continuity arrangements may be required and should be developed in conjunction with the EPRR team.

The EPRR team will support the Planned Work Coordination process where there is a requirement for business continuity advice, incident preparedness considerations or assessment of wider organisational resilience impacts.

7.3 Implementing and Operating the BCMS

LPT has a service prioritisation list that describes the trusts services in a hierarchy of priority. LPT expect priority services to have Business Continuity Plans (BCP) in place to maintain their service delivery during a disruption. To enable an effective BCP, a Business Impact Analysis (BIA) should be undertaken to identify risk to service provision and document the impact to service delivery.

LPT sites and services are required to meet this element of a BCMS by: -

- The plan owner undertaking a Business Impact Analysis using the BIA Template adapted from the NHSE BC Toolkit (V2 2023). Part 1 – Plan - Resource B. A copy of this will be held centrally by the EPRR team and reviewed annually with the BCP. Both the BIA and BCP are stored together and are subject to audit.
- Identifying those services which are patient critical.
- Determining the time for recovering the patient critical services.
- Considering the key risks to service provision and ensuring suitable mitigation measures are in place.
- Ensure the BCP is tested no less than annually, and any learning is fed back into the plan and recorded in the version control section of the plan. Any updated BCP should be shared and be accessible in hard copy to the staff who are expected to use it.

The LPT standard business continuity plan incorporates Action Cards that outline the actions to respond to and mitigate the main risks to business continuity (loss of utilities, loss IT). Where necessary a site or service must amend the Action Cards or prepare specific ones to ensure measures are in place to respond to risks that are specific to them.

LPT therefore focuses its planning on critical activities, but also recognises that other less critical activities would need to be recovered to a pre-determined level of service within a pre-determined time as defined in the business continuity plans.

The level of risk is understood to be specifically in respect of LPT's critical activities and the risk of a disruption to the delivery of patient care. Critical activities are underpinned by resources such as people, premises, technology, information, supplies and stakeholders. LPT services and sites in developing their business continuity plans must understand the risk to these resources, the vulnerabilities of each resource, and the impact that would arise if incident occurred and caused a business disruption. This includes understanding the interdependences between

services, as the loss of an activity could have implications for another critical activity with LPT or partner agencies.

Sites and services are required to review their business continuity plans on an annual basis, or if there are significant changes in service delivery.

7.4 Site Business Continuity Plans

Site Business Continuity Plans (Site BCPs) support the management of site-based disruption affecting multiple services, infrastructure, utilities or operational functions. They provide site-specific information to support Tactical and Strategic coordination during incidents, emergencies and disruptive events.

Site BCPs are designed to support Managers On-Call, Directors On-Call, Incident Coordination Centres (ICCs) and operational teams by providing information relating to:

- Site-specific risks and hazards
- Utilities and infrastructure dependencies
- Access and egress arrangements
- Lockdown and restricted access arrangements
- Site escalation and coordination arrangements
- Temporary loss of facilities or services
- Evacuation and shelter considerations
- Key contacts and supporting services
- Emergency response resources
- Site command and coordination facilities
- Immediate operational response and business continuity considerations.

Site BCPs support, but do not replace, Service Business Continuity Plans and should be used alongside relevant operational procedures, emergency response arrangements and Trust-wide EPRR plans.

Site BCPs will be developed and maintained by the EPRR Team with support from operational services, Estates, Digital, Health and Safety and other relevant support services as required. Relevant services and departments are responsible for supporting the review, accuracy and ongoing maintenance of site-specific information contained within the plans

7.5 Rapid Response Boxes

Rapid Response Boxes (RRBs) are maintained at identified LPT sites to support the initial management of incidents, emergencies and disruptive events.

RRBs support the activation of Site Business Continuity Plans, incident coordination arrangements and immediate operational response activity. Contents may include site-specific plans, action cards, registers, communication information, site maps and other emergency response materials relevant to the site.

The EPRR Team is responsible for the oversight and assurance of Rapid Response Boxes, with relevant services and departments supporting the maintenance and review of site-specific contents.

7.6 Monitor and Review the Business Continuity Management System

LPT needs to ensure that the BCMS capability and Incident Response Plan remains effective, fit for purpose and up to date.

It is the responsibility of the LPT Head of EPRR to -

- To annually audit and review the BCMS and Incident Response Plan to identify good practice, potential non-conformities and any necessary corrective actions.
- Identify any changes to LPT's services which may require additional business continuity plans or measures or risk to the BCMS.
- Review incident reports from Safeguarding that relate to impacts on service provision identifying lessons learnt and any necessary mitigation measures; and
- Facilitate/develop exercises to test LPT's preparedness to respond to disruptions to business continuity and major incidents.

Regular testing and exercising of LPT's business continuity plans and Incident Response Plan provides assurance that the plans would prove effective if utilised.

Exercising is also essential to developing teamwork, competence, confidence and knowledge which are vital at the time of an incident.

In line with the requirements of NHS EPRR guidance, the LPT Head of EPRR will be responsible for ensuring that LPT as a minimum will undertake: -

- A communication exercise every 6 months (both in and out of hours).
- A tabletop exercise every 12 months.
- Command Post exercise every 3 years.
- A Live exercise every 3 years.

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In addition, LPT will aim to participate in exercises and training organised by partner agencies and involve partner agencies in its own exercises to facilitate an effective multi-agency response to a disruption to business continuity and a major incident.

The LPT Head of EPRR will provide quarterly EPRR reports to the LPT Health and Safety Committee outlining the status of LPT's emergency preparedness and business continuity planning and forwarding recommendations for improvements to EPRR arrangements.

7.7 External Suppliers Business Continuity Arrangements

LPT will seek assurance from external organisations who are contracted to provide services in support of LPT critical activities, that they have effective business continuity plans in place to maintain or recover their service provision.

- It is a responsibility of the LPT Procurement Team to request that all external contractors and Suppliers have business continuity arrangements in place to support LPT Critical services and to maintain their service delivery.

- It is the responsibility of the LPT Head of EPRR to audit no less than annually suppliers connected to the trust's critical services business continuity arrangements.

- LPT Procurement Team can request support from the EPRR team to review and comment on suppliers' business continuity at the tendering stage, as per the **LPT Procurement Manual, p.15/16, sect 8.3.3**.

- If any concerns relating to a supplier's business continuity arrangements are identified through subsequent audits, these are to be shared with the Head of Procurement for information / action.

The LPT Head of EPRR is to provide evidence of the annual audit of external suppliers as part of the national assurance process for EPRR.

7.8 Continual Improvement of the BCMS

An annual review of the BCMS will be undertaken through assessment of lessons learned from incidents and exercises, and the results of internal and external audit. To reinforce this process NHSE share accumulated regional learning that can be used to support the development of EPRR plans and processes.

The aim of the review is to enable LPT to assure itself of the effectiveness of the BCMS and emergency preparedness or where deemed necessary to identify the need for changes to this policy, and review or amendment of existing EPRR strategy

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7.9 Shared Learning Process

The trust has a process for capturing lessons identified from training, incidents and exercise and transforming them into embedded learning: summarised as **CAAPE** **C**apture-**A**sses-**A**ction **P**lan-**E**mbed.

Capture: Opportunities for learning are captured through Post Exercise or Post Incident Reports and through other organisational learning that is coordinated external to LPT and shared nationally and regionally for information.

Assess: All lessons and opportunities are reviewed by the LPT Head of EPRR or LPT EPRR team and cohorted into a table that identifies if they are a Business Continuity, Emergency response or Other (Such as Estates and Facilities) piece of learning.

Action Plan: The tubulised learning points are distilled into an Exercise or Incident Action Log that sets out each individual action, the detail required, an action owner and a delivery date.

The Action Logs are held centrally by the EPRR team who oversee and manage the delivery of actions and are responsible for the action log management to its closure. Any shared learning from an external organisation will be picked up as EPRR business as usual work and reported back through the EPRR Quarterly Report. Exercise and Incident Action Logs are presented to the EPRR Steering Group for review and sign off to close and archive.

Embed: Any learning opportunities that requires Business Continuity Plans or Incident Response Plans to be updated or new processes to be introduced are implemented at source but shared through the EPRR Governance structure to ensure opportunity for widest distribution across the trust. Biannually, or as required, learning points from internal exercises or incidents are shared with NHSE to support their regional shared learning document.

The LPT Head of EPRR will provide the LPT Audit and Risk Committee (ARC) with an annual report of the BCMS outlining any opportunities for improving the effectiveness of the BCMS.

8.0 Training and Awareness

There is a need for training to be identified within this policy and set out in the LPT Training Needs Analysis (TNA) for EPRR which is reviewed annually. In accordance

with the classification of training outlined in the National Minimum Occupational Standards for EPRR combined with the Trust Learning and Development Strategy supported by the LPT TNA for EPRR a training and exercise schedule is written into the EPRR Work plan and targets reflected as Key Performance Indicators (KPIs) in this policy.

The course directory will identify who the training applies to, delivery method, the update frequency, learning outcomes and a list of available dates to access the training. A record of the event will be recorded on the Trusts electronic training system (ULEARN). A record of Personal Development Portfolio (PDP) for everyone who has a role in incident response will be held by the LPT EPRR team and be subject to audit.

The governance group responsible for monitoring the training is the LPT Health and Safety Committee.

To be successful, business continuity management must become part of the way the organisation is managed. All staff must understand that business continuity is an important issue for the organisation and that they have a duty of care in maintaining the delivery of patient care. Staff at all levels are responsible for building, promoting and embedding a business continuity culture that reflects our organisational core values and vision to achieve our strategic objectives.

The LPT Head of EPRR working with the LPT Services will be responsible for ensuring that staff awareness is increased and developed. This will be achieved through: -

- Using the LPT Health and Safety Committee structure submit an EPRR AAA Report no less than quarterly, which will be presented at directorate Health and Safety Action Groups to give EPRR the widest reach across the trust.
- Discussion of business continuity plans and emergency preparedness in e-newsletters and team briefings.
- Inclusion of business continuity planning and emergency preparedness on LPT's Staffnet, this will include an annual Business Continuity Awareness Week (BCAW)
- Learning from internal and external incidents, utilising the regional shared learning from exercises and incidents; and
- Exercising and Testing business continuity plans no less than annually. The learning from this is to be captured in the version control box in each plan.

The organisation will ensure that all personnel who are assigned responsibilities under business continuity planning, and incident response are competent to fulfil their role aligned to the standards set in the Minimum Occupational Standards for EPRR. To this end the LPT Head of EPRR will ensure that the On Call Framework receive regular emergency preparedness training to ensure they feel confident in

managing the response to a disruption to business continuity and to a major incident.

The LPT Head of EPRR will be responsible for providing Executive level staff and all other staff as appropriate, briefings and updates on new and emerging risks or incidents that could impact on the trust delivering its critical services.

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9.0 Monitoring Compliance and Effectiveness

Monitoring tools must be built into all procedural documents in order that compliance and effectiveness can be demonstrated.

Be realistic with the amount of monitoring you need to do and time scales

Page/Section	Minimum Requirements to monitor	Method for Monitoring	Responsible Individual /Group	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group). Frequency of monitoring
All duties, plans/arrangements, roles and responsibilities and actions covered by this policy	NHS Core Standards for EPRR	External Assurance process NHSE Core Standards for EPRR	AEO Head of EPRR EPRR Steering Group	EPRR Steering Group (annually) Health and Safety Committee (annually) Trust Board (annually)
All duties, plans/arrangements, roles and responsibilities and actions covered by this policy	NHS Core Standards for EPRR	Internal monitoring of adherence to policy	AEO Head of EPRR EPRR Steering Group	EPRR Steering Group Health and Safety Committee Trust Board (annual)

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Standards and Frameworks:

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10.1 LPT Related Protocols and Plans

- Incident Response Plan
- New and Emerging Pandemic Plan
- Site and Service Area Business Continuity Plans
- LHIS IT Disaster Recovery Plan
- Cyber Incident Response Plan
- Lockdown Plans
- Evacuation and Shelter Plans
- Incident Reporting Policy
- Information Governance Policy
- Inspection Policy: Health and Safety Inspections
- Fire Risk Assessments

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- Fire Evacuation Plans
- Security Policy
- Risk Management Strategy

11.0 Fraud, Bribery and Corruption consideration

The Trust has a zero-tolerance approach to fraud, bribery and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.

Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.

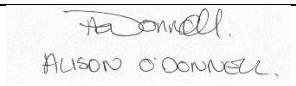
If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trusts Local Counter Fraud Specialist (LCFS) for assistance.

Appendices

Appendix 1 Training Needs Analysis – Principles of Incident Response

Training required to meet the policy requirements must be approved prior to policy approval. Learning and Development manage the approval of training. Send this form to lpt.tel@nhs.net for review.

Training topic/title:	Principles of Incident Response		
Type of training: (see Mandatory and Role Essential Training policy for descriptions)	☐ Not required ☐ Mandatory (must be on mandatory training register) ☐ Role Essential (must be on the role essential training register) X Desirable or Developmental		
Directorate to which the training is applicable:	X Directorate of Mental Health X Community Health Services X Enabling Services X Estates and Facilities X Families, Young People, Children, Learning Disability and Autism X Hosted Services		
Staff groups who require the training: (consider bank /agency/volunteers/medical)	All staff groups		
Governance group who has approved this training:	Health and Safety Committee	Date approved:	June 2025
Named lead or team who is responsible for this training:	EPRR Team		
Delivery mode of training: elearning/virtual/classroom/ informal/adhoc	Virtual/MS Teams		
Has a training plan been agreed?	Yes		
Where will completion of this training be recorded?	X uLearn ☐ Other (please specify)		
How will compliance with this training to be audited?	X Manager ulearn report X Local manager personal records ☐ StatMand (Flash) topic compliance report X Other please specify Bespoke completion report from ulearn monitored by H&S Committee		

Signed by Learning and Development Approval name and date		Date: 24th June 2025

Appendix 2 The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

Shape its services around the needs and preferences of individual patients, their families and their carers Answer ~~yes/~~no to all

Respond to different needs of different sectors of the population ~~yes/~~no

Work continuously to improve quality services and to minimise errors yes~~/no~~

Support and value its staff yes~~/no~~

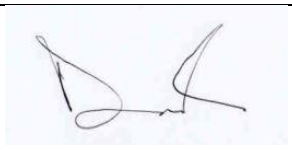
Work together with others to ensure a seamless service for patients yes~~/no~~

Help keep people healthy and work to reduce health inequalities yes~~/no~~

Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance yes~~/no~~

Appendix 3 Due Regard Screening Template

Section 1	
Name of activity/proposal	EPRR Policy
Date Screening commenced	01.06.2025
Directorate / Service carrying out the assessment	Safety and EPRR
Name and role of person undertaking this Due Regard (Equality Analysis)	Dan Adamson, Head of EPRR
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: Provision of a framework for establishing, maintaining and continually improving a Business Continuity Management System and Incident Response Plan that complies with all applicable Emergency Preparedness, Resilience and Response obligations.	
OBJECTIVES: To set out the EPRR requirements of the Trust, including roles and responsibilities, business continuity, incident response, training, and monitoring.	
Section 2	
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details
Age	N/A
Disability	N/A
Gender reassignment	N/A
Marriage & Civil Partnership	N/A
Pregnancy & Maternity	N/A
Race	N/A
Religion and Belief	N/A
Sex	N/A
Sexual Orientation	N/A
Other equality groups?	N/A
Section 3	
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.	
~~Yes~~	No ✓
High risk: Complete a full EIA starting click here to proceed to Part B	Low risk: Go to Section 4. ✓
Section 4	
If this proposal is low risk please give evidence or justification for how you reached this decision:	
This policy describes the Trust's arrangements for complying with all applicable Emergency Preparedness, Resilience and Response obligations within all Trust	

areas and department's where Trust staff are located or co-located.			
Signed by reviewer/assessor		Date 1 June 2025	
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		Date 1 June 2025	

Appendix 4 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	**EPRR Policy**	
Completed by:	**Dan Adamson**	
Job title	**Head of EPRR**	**Date 16 June 2025**

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	No	
7. As part of the process outlined in this document, is the information about	No	

individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.		
8. Will the process require you to contact individuals in ways which they may find intrusive?	No	
If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.		
Data Privacy approval name:		
Date of approval		

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

Appendix 5 Definitions

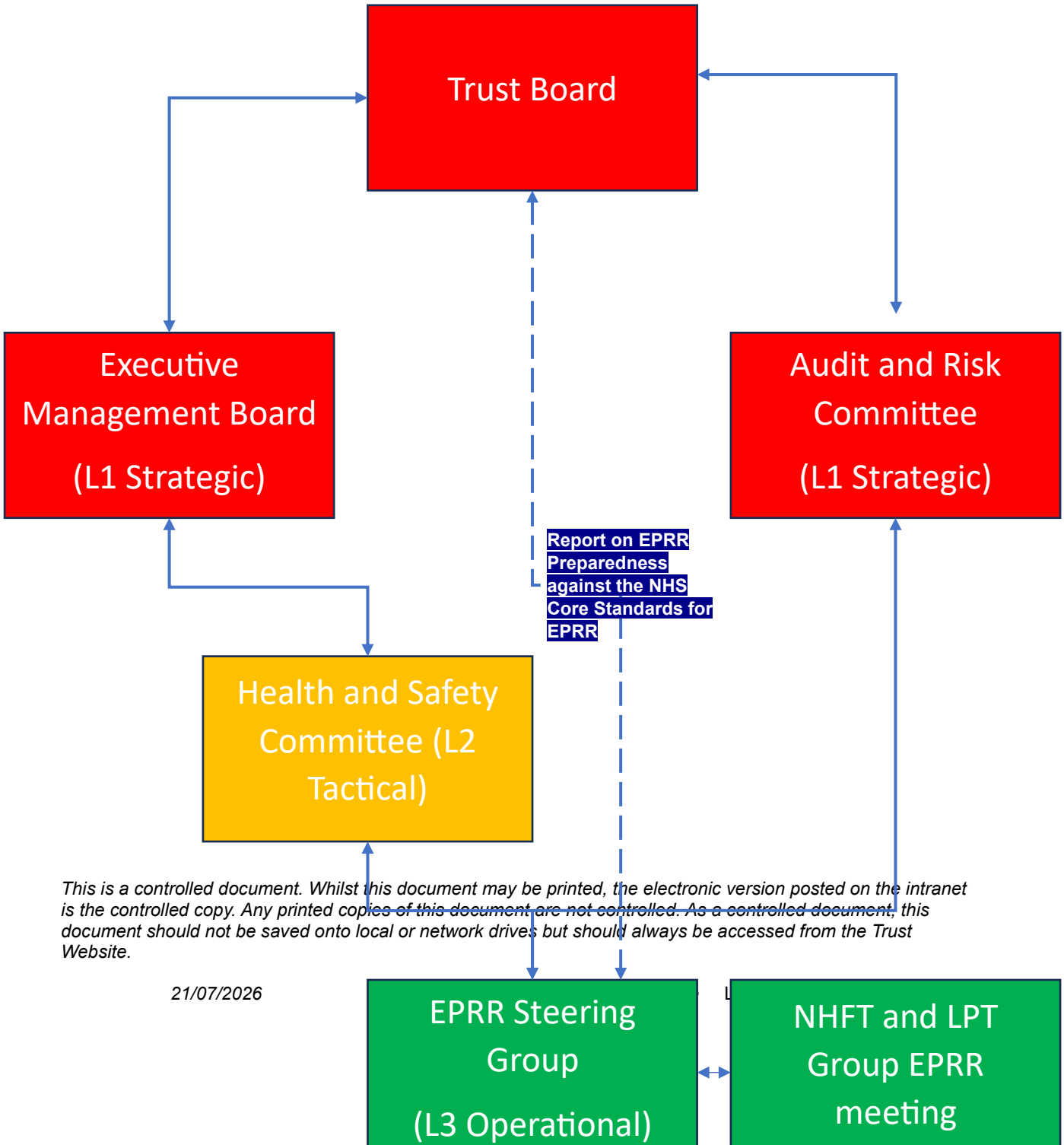
AEO	Accountable Emergency Officer
Business Continuity	The capability of an organisation to continue to deliver services at acceptable predefined levels following a disruptive incident.
Business Continuity Management	A holistic management process that identifies potential hazards to an organisation and the impacts on service delivery of those hazards, if they occur, and which provides a framework for building organisational resilience with the capability for an effective response that safeguards the interests of its key stakeholders, reputation, brand and value-creating activities.
Business Continuity Management System (BCMS)	Part of the overall management system that establishes, implements, operates, monitors, reviews, maintains and improves business continuity.
Business Continuity Plan	Documented procedures that guide organisations to respond, recover, resume and restore service delivery to a pre-defined level of operation following a disruption.
BIA	Business Impact Analysis
Category 1 Responders	Category 1 responders are those organisations at the core of an emergency response and are subject to the full set of civil protection duties.
Category 2 Responders	Category 2 responders such as utility providers and transport providers, are critical partners in EPRR that are required to co-operate with and support other Category 1 and Category 2 responders. They are less likely to be involved in the heart of planning work but will be heavily involved in incidents which affect their sector. Category 2 responders have a lesser set of duties, which are to co-operate and share relevant information with other Category 1 and 2 responders.
CCA 2004	Civil Contingencies Act 2004

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Due Regard	Having due regard for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
Emergency / Major Incident	An event or situation, with a range of serious consequences, which requires special arrangements to be implemented by one or more emergency responder agencies.
Emergency Preparedness, Resilience and Response (EPRR)	The extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of and response to incidents and emergencies. Ability of the community, services, area or infrastructure to detect, prevent and, if necessary, withstand, handle and recover from incidents and emergencies. Decisions and actions taken in accordance with the strategic, tactical and operational objectives defined by emergency responders, including those associated with recovery.
International Standard for Business Continuity (ISO 22301 & ISO 22313)	International standard for the development of Business Continuity Management Systems. All NHS funded organisations are encouraged to align their Business Continuity Management Systems to the standard.
Publicly Available Specification 2015:2010 (PAS 2015)	NHS guidance outlining the principles which should be followed by NHS funded organisations in developing business continuity plans.
Incident Co-ordination Centre (ICC)	A focal point for coordination of a response and the gathering, processing, archiving and dissemination of information across the NHS and externally, as required.
IEM	Integrated Emergency Management
ICB	Integrated Care Board
ICS	Integrated Care System
ARC	Audit and Risk Committee
Local Health Resilience Partnership (LHRP)	The strategic forum in Leicestershire for facilitating joint health community emergency planning.
LLR Prepared	Leicester, Leicestershire and Rutland (LLR) Prepared is the principal forum in Leicestershire for multi-agency cooperation between Category 1 and Category 2 Responders (the common term within UK emergency planning for this forum is the Local Resilience Forum (LRF).
LRF	Local Resilience Forum

Incident Response Plan	Clearly identified plan to be used to implement an effective and co-ordinated response to an emergency or major incident.
Resilience	Ability of an organisation to adapt and respond to disruptions, whether internal or external, to deliver agreed critical activities.
SC 30	2025/26 NHS Standard Contract Service Conditions (SC 30)

Appendix 6 - Governance Structure for EPRR in LPT



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Appendix 7 LPT's EPRR System Hierarchy of Documents

Documents	Objective of the Documents
Emergency Preparedness, Resilience and Response (EPRR) Policy	• Sets the framework and strategic direction for LPT's BCMS and emergency preparedness.
LPT Incident Response Plan	• Outlines how LPT co-ordinates its response to a serious disruption to the trust's business continuity and to a major incident in the wider community.
LPT EPRR Risk Register	• Assesses the implications to LPT of the hazards present within Leicester, Leicestershire and Rutland.
Business Continuity Plans	• Details how a critical service would be recovered or maintained in the event of a disruption. • Outlines the risks to people, premises, technology, information, supplies and stakeholders and how any disruption to service delivery would be mitigated.

Documents	Objective of the Documents
Training Needs Analysis	• Determines the skills and knowledge required by staff to support the EPRR policy and fulfil LPT's EPRR obligations. • Determines the training necessary to meet the Training Needs. • Aligns to the Minimum Occupational Standards for EPRR (June 2022)
Training Programme and Portfolio of Training	• Agreed annual programme of training. • Provision of bespoke training to On-Call Directors and other appropriate members of staff on their role in managing response to a major incident or disruption to business continuity. • Personal Development Portfolios (PDP) to evidence training
LPT Annual Work and Exercise Programme	• Agreed Annual Programme of Work that will support LPT in discharging its EPRR Obligations. • Tests the effectiveness of plans in responding to disruptions to business continuity and to major incidents.
Incident, exercise and audit report and EPRR Quarterly reports to the trust	• Ensures the occurrence of and response to incidents of business continuity disruptions and major incident are reported and investigated. • Undertaking of an annual audit of business continuity plans to assess their effectiveness and compliance with the BCMS.
Internal Audit - Annual Management Review	• Provides the LPT Audit and Assurance Committee with an annual report of the effectiveness of the BCMS and the preparedness for emergencies.
External Audit – 360 Assurance	• The LPT BCMS and EPRR Policy is subject to external audit by 360 Assurance. The agreed compliancy and exit reports will be communicated to the Audit and Risk Committee
EPRR Plan Consultation Log	• This demonstrates continuous improvement of plans and process allowing peers to input into LPT Emergency Planning

Documents	Objective of the Documents
EPRR Exercise and Incident Action Log	• To capture actions from exercises incidents and training to enhance LPT EPRR Plans and processes

Appendix 8 EPRR Documentation Retention Periods

Record Description	Retention Period
EPRR Decision Log, Pocket Log Book, On Call Log Book, Incident-related documents including Debrief Records/Lessons Identified and documents of potential legal interest i.e. major/critical/business continuity/serious incident logs from predecessor organisations, documents presented in court/to coroners, plans, communications, organisational structures and other documents that could fit into this category. Format of records - mixture of paper and electronic.	20 years
EPRR Decision Log, Pocket Book, On Call Log, Logbook, post-exercise reports/Lessons Identified. Format of records - mixture of paper and electronic.	10 years
EPRR Decision Log, Pocket Book, On Call Log, Log Book, on-call-related documents including handover records, reviews/Lessons Identified and documents of potential legal interest i.e. event logs from predecessor organisations, documents presented in court/to coroners, plans, communications, organisational structures and other documents that could fit into this category. Format of records - mixture of paper and electronic	10 years

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EPRR - Incident Response Plans, Business Continuity Plans, EPRR Guidance, Standard Operating Procedures, Policy, Strategy, EPRR Core Standards Assurance reviews and reports. Format of records - electronic.	20 Years
EPRR Information Sharing Protocols and Memorandum of Understanding, Mutual Aid Agreements, Service Level Agreements. Format of records -mixture of paper and electronic.	10 years
EPRR Local Health Resilience Partnerships and subgroups- minutes, papers, action logs, Risk Registers. Format of records – electronic	20 years
EPRR Ambient voice recording, telephone recording in relation to incident coordination centre. Format of records - electronic.	20 years

Appendix 9 LLR Prepared Constitution

1. INTRODUCTION

This constitution has been developed to clearly define the working principles for LLR Prepared, ensuring a common understanding of arrangements across partner organisations.

2.LEICESTER, LEICESTERSHIRE AND RUTLAND (LLR) PREPARED AIM AND OBJECTIVES

2.1 Aim

LLR Prepared is an ‘umbrella’ partnership which facilitates local multi-agency emergency preparedness arrangements. Its overall purpose is to ensure that there is an appropriate level of preparedness to enable an effective multi-agency response to emergencies which may have a significant impact on the communities of Leicester, Leicestershire and Rutland.

Through working together LLR Prepared aspires to be a national exemplar of best practice in multi-agency resilience preparedness.

2.2 Objectives

In order to meet this aim LLR Prepared must meet specific objectives:

- To share joint strategy and policy approaches to planning and response
- To ensure robust risk processes are in place to enable the production of a Community Risk Register which provides the basis for planning
- To commission, develop, test and review LLR Prepared emergency plans and procedures
- To commit sufficient resources to successfully deliver a collectively agreed work programme
- To engage with communities to help them be more able to cope with, respond to and recover from emergencies
- To communicate effectively; across and throughout partner organisations and with the public
- To work together in an efficient way, ensuring value for money across all projects

Q

NHS
Leicestershire Partnership
NHS Trust

Alert, Advise and Assure Highlight Report

Charitable Funds Committee, 23 September 2026

Meeting Chair and Report Author - Faisal Hussain

Quorate Y

Policies and expiry date:

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

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
None				

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

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Matters Arising/Action Log	CFC/26/035	Kamy Basra	The Trust's Joint Head of Estates has an action to take a paper to the Executive Management Board (EMB) to give an update on how the Charity's work will better align and integrate into the Estates workplan to ensure maximum business benefits when capital work	

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
			expenditure is being considered by RH.	
New Bids	CFC/26/039	Faisal Hussain	Committee approval was requested for funding to support one year's rent for the Mental Health Neighbourhood Hub in Blaby. The funding is covered through a combination of a donation & local funds. The Committee approved the funding for one year only.	

ASSURE: Inform the Board where positive assurance has been received

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Review of Charitable Funds Risk Register	CFC/26/036	Jackie Moore	The Committee are aware of the one risk, related to cash balances which exceed the amount of cover available under the Financial Services Compensation Scheme (FSCS) limit. We have reduced this risk by moving some cash into the new Cazenove deposit account. The committee approved the risk register.	
Quarterly Finance Report including Pipeline Report, investment performance & legacies	CFC/26/038	Jackie Moore	• The overall fund balance for Quarter 1 closed at £2.915m. This is an increase of £248k (9%) since the start of the financial year. • Expenditure totals £95k, with the majority of spend supporting patient wellbeing & amenities (£26k) and charity running costs (£48k). • The balance sheet shows that the overall funds increased by £248k during the year. • Fixed asset investments increased by £239k due to an improvement in the investment return. • The closing cash balance at the end of Quarter 1 is £667k; an increase of £6k since the start of the year.	

Agenda Item:	Reference:	Lead:	Description:	BAF Ref

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

Agenda Item:	Reference:	Lead:	Description:	BAF Ref
Promoting Charitable Funds and Delivering the Strategy: Fundraising Managers' Report	CFC/26/037	Magdalena Korytkowska	Raising Health is the finalist of the Health Tech Newspaper Awards 2026 as part of the 'Most Promising Pilot' category. Winners will be announced on 7 October.	
Promoting Charitable Funds and Delivering the Strategy: Fundraising Managers' Report	CFC/26/037	Magdalena Korytkowska	We will be celebrating Raising Health's 10th anniversary in person on 27 October at County Hall. Trusts and Foundations, local community groups and businesses who have supported us will be invited so that we can thank them for their support and share the impact that they have helped us achieve. The event will highlight the key projects we have worked on and show the difference the funding has made to our services.	
Promoting Charitable Funds and Delivering the Strategy: Fundraising Managers' Report	CFC/26/037	Magdalena Korytkowska	Sensory Integration Therapy Room at Bradgate Unit – this project has now been completed and is being used as a pilot to roll out more sensory rooms across mental health services.	